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Learning Disability Psychiatry

Newsletter of the Faculty of the Psychiatry of Learning Disability

In this issue

Can clinicians influence policy?

I am really not sure where my anorak-like obsession with the world of politics and policy came from. Perhaps it was my father's influence. A fine Irish storyteller, his favourite stories came from history and, in particular, political history. I suppose working as a senior civil servant in the Department of Health only served to enhance my interest yet further. I had plenty of exposure to politicians intent on 'reform', 'patient-centeredness', 'choice' and a number of other worthy policy goals. So, whether it is nature or nurture, I am, boring as it may sound, fascinated by all questions concerning policy formulation and implementation. When asked then to write about the subject of whether clinicians can influence policy there was no hesitation.

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In-patient learning disability psychiatry – a personal reflection

As part of a major service redesign in Leeds, we reconfigured consultant medical staffing into a structure approaching that of the functional model, with an in-patient consultant and a number of community consultants. This was initially for pragmatic operational reasons but has proved an interesting experience that I will outline in this article.

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The David Wilson Unit at Rampton

In June 2010, the National High Secure Learning Disability Service moved to a new home in the David Wilson Unit at Rampton Hospital. Since the previous accommodation was built in the 1920s, much has changed in the services for men with a learning disability needing care under conditions of maximum security. The new buildings (named in memoriam of a former clinical director of the service) provide therapy and activity facilities; all wards are on the ground floor with direct access to outside space. All the service staff are on site in the integral office suites. At the start, one patient said that this is 'a service built around us, for us!'

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<http://www.rcpsych.ac.uk/specialties/faculties/learningdisability.aspx>

View from the Chair

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It is an honour and a privilege to be elected Chair of the Faculty. Since I took up the post in June last year, I have been kept very busy with all the different work programmes the Faculty is involved with. But it is too easy just to continue with existing work streams, and get caught up in the College bureaucracy. It is really important that the Faculty membership has input

into the direction the Faculty takes and the priorities it sets itself. We achieve this partly through the regional representatives who come to the strategy setting day in June, but it is also great to hear comments and suggestions from individual members. Please contact us through Kitti Kottasz, the College officer who supports the Faculty (kkottasz@rcpsych.ac.uk), or email me directly.

For me the core purpose of the Faculty must be to improve the mental health of people with learning disability. All that the Faculty does should have this ultimate aim in mind. This means we need a strong and united profession. The work of the Faculty Education and Curriculum Committee, led by Jo Jones, is crucial in ensuring that training meets high standards, and that people with learning disability can access well-trained specialists. But we also need to protect and develop services, and the work that Ashok Roy and Sab Bhaumik lead on care pathways and payment by results should help with this, as will the Faculty report *Future Role of Psychiatrists Working with People with Learning Disability*, which sets out a vision for the specialist role of our profession in the future. This work should help us address the challenges of health service reform, particularly

with regard to outcome measures and general practitioner commissioning.

Working with people with learning disability is complex and challenging, so building networks is essential. We continue to maintain strong links with other Faculties in the College, and Harm Boer has set up a new working group with the Forensic Faculty to look at care pathways. We also need to further develop our networks outside the College, particularly with Mencap, the British Psychological Society (where Roger Banks has taken the lead) and with the National Autistic Society. We have also recently met with the National Director for Learning Disability in England, Ann Williams, who came to our meeting in Barcelona in 2009. Suggestions for other links or contacts would be more than welcome.

For most of us, the Faculty's academic meetings are central to what the Faculty delivers for its members. They also play an essential role in encouraging recruitment into the profession, particularly through encouraging participation from trainees and medical students. Feedback from the residential meeting in Leeds in October 2010 has been overwhelmingly positive, and the attendance figures broke all records. Very many people contributed to the success of the meeting, but I wanted to pay special tribute to the Conference Office, and to Regi Alexander, our Academic Secretary, who put together a brilliant programme. It was particularly gratifying to see contribution from trainees and medical students, and of such a high standard. Congratulations again to the winners of the Alec Shapiro Prize, Dr Radhakrishnan and Dr Gangavati. In response to members' suggestions, next year we are introducing a poster prize for medical students, to be named after the late Dr Jack Piachaud who did a great deal to promote undergraduate education about people with learning disability.

Finally, I would like to pay tribute to two former Chairs of the Faculty. Sheila Hollins has been made a life peer, and as Baroness Hollins, will be, I am sure, a staunch ally of the Faculty in the House of Lords. Sab Bhaumik led our Faculty for the past 4 years and achieved a great deal. ■

Submitting articles

This is the Faculty members' newsletter and we encourage anyone to submit articles.

To ensure that deadlines are met articles must arrive no later than mid-June (September publication) or mid-October (February publication). Articles should be brief (from 500 to maximum 700 words) with a short reference section where appropriate. Text-based copy should be in a Word document. Images should not be embedded in Word documents, but sent separately as JPG or TIFF files. Minimum resolution is 300dpi at the size intended for print. All articles are reviewed by the editorial board. You may be asked to make revisions before your article is finally accepted. All this will be done in a fairly informal and hopefully un-intimidating way.

Please email articles to either Dr Geoff Marston, Editor (geoff.marston@covwarkpt.nhs.uk) or Kitti Kottasz, Faculty Committee Manager (kkottasz@rcpsych.ac.uk).

Disclaimer

The views expressed in this publication are the personal views of the authors and do not necessarily reflect the College's position.

Letter from the Editors



2010 was a busy and eventful year for the Faculty, what with all the activities of the Executive, a new Chair, one former Chair being given a peerage and another running for College

President, not to mention a very successful and well-attended conference. On top of all this, there has also been a need for learning disability services nationwide to adapt to a newly elected and massively reforming government. As a tonic, the Newsletter hopes to bring you a reflective and 'progressive' mix of celebration, information and achievement to kick-start your 2011.

We have paired articles on influencing services and policy from two keynote speakers at last year's conference (pp. 6–8). There are reflections on experience in learning disability from six medical students (pp. 3–4); an interview with Baroness Hollins (pp. 11–12); and insights into service models from around the country, including the new-look Rampton Hospital (pp. 8–9).

We wish you all a happy and successful new year. Enjoy! ■

Medical students' experience of learning disability psychiatry

After presenting posters and talks at the annual residential conference in Leeds in June 2010, six medical students from the universities of Manchester, Glasgow and Liverpool were asked by the Editors to write about their experiences.

Sarus Jain (2nd year, University of Liverpool) and Ashwin Roy (3rd year, University of Manchester)

To a medical student, early association with any medical Royal College is something one could only imagine. So being able to present at a Royal College of Psychiatrists' conference, to consultants from around the country and worldwide, as well as learning along the way was an invaluable opportunity.

Our interest in psychiatry developed before we joined medical school when our school assigned us a task of conducting an investigation of our choice related to science. We chose to carry out an audit of patients in a learning disability

psychiatric service: 'Improving recordings of capacity to consent and explanation of side-effects of medication in a psychiatric service for people with a learning disability'. The audit was repeated annually for 3 years and was an excellent way to improve our knowledge about the practical aspect of medicine as well as heightening our interest in studying psychiatry. After compiling the results, we gave presentations of the findings and recommendations to the consultant committee and subsequently submitted a paper for publication. We then presented a poster of our findings at the Learning Disability Annual Residential Meeting 2010 in Leeds.

The speakers at this conference provided us with a more detailed picture of learning disability psychiatry, which as medical students we found extremely useful. We also had the opportunity to talk to numerous consultants as well as being given advice on submitting a paper to a journal, by the likes of the Editor of the *British Journal of Psychiatry* who was speaking at the conference.

Having started our clinical years, we have begun working in different wards and meeting a large variety of patients; it is evident that the doctor-patient relationship outside the field of psychiatry is different. In learning disability psychiatry, the doctor not only has to constantly relate to the patient but liaise with their family, carers and various teams of healthcare professionals. The care provided is much more long-term and as a result, the experience seems to be much more rewarding. All in all, seeing a patient having some form of relief from their symptoms and experiencing the happiness shared by the patients' families makes psychiatry seem like a very interesting and satisfying profession, one which we will enjoy studying further.

So, as medical students, the confidence and knowledge we gained was very precious and has helped us to improve our views on working with people who have a learning disability as well as the general outlook at medical school. It has also created a desire to attend more conferences such as this one, achieve more publications and affirm our interest in psychiatry.

Danielle Goldberg and Rachel Campbell (5th year, University of Glasgow), Katie Reid and Sadaf Shah (4th year, University of Glasgow)

During our medical school career, we do not often have the opportunity to meet people with learning disabilities.



Ashwin, with Ian Hall, presenting his and Sarus' poster

As doctors, however, we will come across such people in whatever specialty we choose to join. As people with learning disabilities can face difficulties and prejudice, it is important for doctors to help raise awareness, challenge misconceptions and act as advocates for this patient group. We feel that the importance of gaining experience in learning disability is underestimated in medical school careers and so we were grateful for the opportunity to undertake research projects in this area during our intercalated degree year. Not only did this allow us to meet people with different learning disabilities and appreciate their needs, but it also highlighted the growing research in this field and the areas which still need addressing.

We embarked on diverse projects, examining areas such as stress and sleep problems in autism, and anxiety and pica in people with learning disabilities. We became passionate about our projects and they propelled us into positions of expertise in our small, but nonetheless important, areas of interest. The idea that our work might help improve quality of life for these patients motivated us to achieve results.

As Student Associates of the Royal College of Psychiatrists, we were aware of the various conferences scheduled and we were honoured that our research was accepted for presentation at the annual Faculty of the Psychiatry of Learning Disability conference in Leeds. For all of us, this was our first chance to present at a conference, and the fact that it was south of the border made it seem all the more special and daunting!



Conference poster presentation

The conference was an invaluable experience – as senior medical students, we will be able to take the skills and the confidence we acquired for our presentations and use them as a reference for future presentations. It was also nice to feel part of the Faculty for a couple of days – to talk with clinicians with shared interest and goals and to feel that we were part of a team.

Regardless of our chosen careers in the future, our experience in learning disabilities will hold us in good stead. We are much more understanding of the complex needs of this patient group and of the barriers faced in carrying out research. Being accepted to partake in the annual Faculty meeting and having our research and enthusiasm both respected and encouraged has been very welcoming and we would recommend the opportunity to any student considering pursuing a career in psychiatry. We now feel that the door to learning disability psychiatry is wide open to us. ■

Views from the 2010 Psychiatry of Learning Disability Higher Trainees' Conference

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Last year the Annual Psychiatry of Learning Disabilities Higher Trainees' Conference was organised by trainees in Cambridge. This 2-day residential conference has been a great way for higher trainees to meet each other and find out about the latest developments in the specialty.

The conference was well attended and the excellent programme included speeches on a range of current topics relevant for the delegates. We were able to listen to a number of speakers (order as mentioned in the programme).

- Day one
Dr Laurence Mynors-Wallis, Dr Ulrich Muller, Dr Howard Ring, Mrs Walding (carer), Professor Tony Holland
- Day two
- Dr Sabyasachi Bhaumik (past Chair of the Faculty of the Psychiatry of Learning Disability), Dr Harm Boer, Dr Georgina Parkes, Professor Simon Baron-Cohen and Dr Helen Miller.

We were also lucky to have Dr Ian Hall, Chair of the Faculty of the Psychiatry of Learning Disability, speaking on day two.

The programme included workshops by Dr Asif Zia, Dr Anton Canagasabay and Mr Tom Cahill focusing on the dreaded experience for every trainee otherwise known as 'consultant interview'. We enjoyed the fiery debate on whether learning disability services should provide psychiatric care for people with Asperger syndrome or high-functioning autism. The opposing teams were led by Dr Ekkehart Staufenberg and Dr Helen Miller (for), and Dr Regi Alexander and Dr Asif Zia (against), and the final vote revealed that the majority of delegates were against the notion.

The first day of the conference finished with a grand dinner. We then danced the night away at the Møller Centre's bar.

Being a small specialty, higher trainees in the psychiatry of learning disability have a sense of being a part of a group with shared interests. Every trainee should attend this conference as it is one of the few opportunities to meet fellow trainees from around the country. We look forward to this year's conference, which is being organised by higher trainees in Leicester. ■

Innovation in teaching: communication skills training for undergraduate medical students and healthcare professionals using simulated patients with learning disabilities

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The main recommendation in *Healthcare for All*, published in response to the deaths of people with learning disabilities in acute hospital care in England, was that to improve the care and experience of people with learning disability in the health system, undergraduate and postgraduate clinical training curricula must include mandatory training in learning disabilities (Michael, 2008).

St George's Hospital Medical School in London has led the way in involving people with learning disabilities in undergraduate teaching. Such an innovation in teaching helped to change medical students' attitudes towards people with a learning disability (Hall & Hollins, 1996). The participating students improved their understanding of non-verbal cues and developed more thoughtful and thorough approaches to circumvent diagnostic overshadowing (Thacker et al, 2007).

In University College London (UCL) we aimed to develop a programme to help undergraduate medical students and postgraduate trainees to improve their skills in communicating with people with learning disabilities through teaching sessions that have input from 'simulated patients' with learning disabilities. The project is a joint venture between UCL and University College London Hospitals NHS Trust, Camden and Islington NHS Foundation Trust, and Barnet, Enfield and Haringey Mental Health Trust. The UCL has funded the project with an ESCILTA grant¹ to train and employ individuals with intellectual disabilities as simulated patients.

Progress so far

We worked with Access Simulations (www.access-simulations.co.uk), a team that is led by Alice Thacker and

1. ESCILTA grants support UCL departmental or faculty initiatives in teaching, learning and/or assessment. The projects should demonstrate benefit to staff or students and provide a model for development that can be promoted outside the department and is transferable.

several colleagues with learning disabilities, and undertook simulated training. A pilot training session took place in the University College Hospital Education Centre and was attended by 15 participants from University College Hospital, National Hospital for Neurology and Neurosurgery, and Eastman Dental Clinic, who attended on a voluntary basis. The 1-day training was split into two sessions: lectures in the morning to set the scene and practical sessions with simulated patients in the afternoon.

The afternoon session involved each participant going through four simulated patient scenarios depicting common clinical scenarios involving people with learning disabilities – taking blood, performing a clinical examination, giving information about medication, breaking bad news – followed by feedback and small-group discussion. The day ended with a debriefing session summarising the key points and gaining feedback from the participants on the areas they considered needed further development. All participants were given a DVD of the scenario in which they participated to help them reflect on their daily practice and improve on the areas required.

Twenty-one service users interested in training as simulated patients attended the pilot training session. Many were supported by their carers. They observed the afternoon session through a video link and were given an opportunity to meet the actors.

Feedback from participants

Feedback from participants was positive – the majority rated the presentations, role plays and debriefing as excellent or good. They suggested some areas for improvement such as more group participation rather than didactic lectures and for participants to complete a task with service users during the lunch break. The participants appreciated the involvement of service users in the role-play scenarios.

Future plans

We are conducting interviews for service users interested in training as simulated patients. We plan to recruit eight service users who will receive a 6-week training programme on working as a simulated patient. We have obtained support from our co-facilitators in our local boroughs to continue training the group after the initial training session. We hope to employ this group of actors to train healthcare professionals to improve their communication skills with patients, and to participate in undergraduate medical student training and examinations. We aim to improve the assessment skills of medical students by involving adults with learning disabilities acting as simulated patients in teaching and clinical Objective Structured Clinical Examinations (OSCEs). We plan to include feedback from simulated patients on the students' performance. The programme offers an employ-

ment opportunity for people with learning disabilities to develop their acting skills.

More information about materials and teaching plan, can be requested from the authors. ■

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Challenges for specialist mental health services for people with a learning disability

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England has probably the most comprehensive service in the world for people with a learning disability who have mental health problems. Local initiatives have resulted in a diverse range of facilities, including specialist admission units, community-based teams, behavioural support teams, small forensic units and supported living schemes. This contrasts with the situation in many other countries, where people with learning disability and mental illness are usually admitted to generic mental health services. Their experience has been of insufficient clinical skills in the specific needs of this group of patients, and boundary disputes between services reluctant to treat them. These factors have gradually led to the development of a more specialist approach in several countries.

Results from research confirm a broad consensus on the array of specialist services needed for people with a learning disability and mental disorders. As with generic mental health services, specialist services should respond rapidly to crises, be available out of hours and on a domiciliary basis, train and support patients' families, and provide access to occupational activities and housing. Yet generic mental illness admission facilities usually lack staff with specialist skills, and patients with a learning disability often find it difficult to cope with the pace of ward life and are vulnerable to exploitation. These problems are made worse by the 'community treatment paradox', in which the

expansion of domiciliary care for acute mental illness has resulted in higher levels of acuity among the patients that are admitted and hence less safe in-patient environments (Cumella, 2009).

Specialist mental health services for people with a learning disability accept referrals of patients with a wider range of disorders than generic psychiatric services, and treat many patients with autism and behavioural disorders. Many patients need joint psychiatric and psychological assessment and treatment, and the most efficient arrangement is therefore a local mental health and behavioural service (LMHBS). Each such service should comprise a core interdisciplinary team, responsible for assessing and monitoring mental state and medication, providing rapid reaction to crises and out-of-hours support, including treatment and support on a domiciliary basis. There should be access to crisis accommodation and day-treatment facilities which specialise in the care of people with severe and acute mental illness and behavioural disorders. These should be small and domestic in scale.

The effectiveness of treatment services for people with a learning disability and mental disorder is often compromised by bed-blocking, because admission often coincides with loss of accommodation and the lack of alternative support services. Outreach services are therefore needed to provide crisis and long-term support to prevent re-admission. Patients should also have access to further education beyond the age of 18 to improve their skills, and to services that develop occupational skills and support people in work. There are small numbers of people with a learning disability with severe and long-term disorders who need long-term specialist residential facilities and day activities. These include facilities for people with a learning disability who have offended, some of whom have severe psychopathologies.

We may face increasing difficulties in achieving this pattern of comprehensive services for people with a learning disability and mental disorders, largely because of the severe round of cuts in health and social care implemented by the government, coupled with a rushed reorganisation of the commissioning function of the National Health Service (NHS). Cuts in public services, despite frequent claims otherwise, usually impinge most on those with the least political muscle. Reductions which will have a major impact on the lives of people with a learning disability include the closing of the Independent Living Fund, ceasing payments of the mobility component of Disability Living Allowance for people in residential care, and a 28% reduction in local authority budgets over 4 years, with the largest cuts occurring in low-income areas. The last will significantly reduce social care services and has led many councils to restrict provision only to those they deem in 'critical' or 'substantial' need.

Health and social care is a single complex system, and a disruption on one part will have an impact on the rest

(Hollins, 2010). We can expect that acute admission units will find it increasingly difficult to discharge patients or support those living in their own homes. More limited social care support for people living at home and for their carers may also increase the incidence of acute mental illness among people with a learning disability.

It is difficult to anticipate the impact of the reorganisation of the NHS commissioning system on mental health services for people with a learning disability. As yet, it is not clear whether these services will be commissioned locally by general practitioner (GP) consortiums or by the central commissioning board (Department of Health, 2010). Although many GPs probably have limited experience of mental health services for people with a learning disability, local consortiums may be more accessible to persuasion than central government. An important part of the work of psychiatrists and other professionals working in services for people with a learning disability and mental disorders in the next few years is to make this a case. ■

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Can clinicians influence policy? Yes they can! (And do!)

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(continued from p. 1)

To influence policy one has to influence politicians. Understanding them, their priorities and preoccupations is key. A minister in the Department of Health will have many 'constituencies' to consider – the one that elected them, Parliament, cabinet (if they are a secretary of state) and of course their own Department of State and its agendas, in our case the National Health Service (NHS). All of these competing interests and agendas combine to make policy-making a bumpy and less-than-perfect ride. Political leaders, like any other leader in a highly complex and large organisation, value and therefore give more 'airtime' to those who bring solutions rather than problems.

So the first of my top tips for influencing policy is to attempt to understand the nature of political commitment, the agenda of political leaders and their humanity in seeking out those who can provide answers rather than those who pose further questions.

Ten tips for clinicians on influencing national policy

- 1 The people who support the politicians are important as well. Political advisors and senior officials, who are close to ministers, are of vital importance in shaping policy. Although the final decision ultimately rests with the politician, their top civil servants and personally appointed advisors have direct access and are, therefore, well worth establishing as part of your network.
- 2 Participation in key groups. Task forces understand the structures and who the power players are – an invitation to participate in a working group, particularly one developing policy, is well worth accepting. You get an inside track and lots of new contacts, and you can shape the direction of policy to boot.
- 3 Do not neglect other government departments. Over the past two administrations the concept of cross-government working has become a much more established practice. For services such as mental health and learning disability there is a great need to connect with departments that develop policy on local government, benefits, housing, education, etc.
- 4 Local MPs can be influential. In fact, 'local' is getting even more important than ever – with the Prime Minister's 'Big Society' concept taking, hold the mantra of 'locally determined' is not going away. Local MPs and local government are key contacts for senior clinicians working in local services.
- 5 Elections are good times. Those seeking a mandate want to listen, manifestos are important – politicians want your vote. Talk to them about your ideas and what you would hope for if they came to power.
- 6 Style and approach is everything. As I have already stated, solutions are welcome, but bringing politicians more problems is not. Do not tell them off for their failings, but rather think how you can help them be successful.
- 7 Have a strategy and remember the context. There is not much point in asking for money nowadays.
- 8 Clarity over strategic objective. Have clear objectives when you meet an MP. Try to understand their agenda and establish how your goals can fit with theirs. Have priorities, and not too great a number of them either.
- 9 How will you help change the culture? So many MPs want to make changes in how the NHS deals with patients. They become frustrated as to why there is no

rapid change in the culture of the NHS. If you can help with this, you will be very well thought of.

10 The problems cannot all be out there. Like all of us, ministers like a nice combination of intelligence and humility in those they meet. Accepting the need for change and having a sense of how change will happen goes down well. Similarly, taking responsibility for some issues helps. Politicians cannot be totally to blame...can they?!

So build your networks, focus on solutions, understand the political imperative and prioritise your objectives are all the order of the day in terms of being influential. Nothing akin to rocket science there you might say and you would be right. However, right now perhaps more than any other time a strong membership organisation walking the corridors of power influencing in the right manner is essential. Much is changing within the NHS. Our current Secretary of State, Andrew Lansley, has set out a bold, some commentators argue foolhardy, agenda for change.

Whatever you feel about this policy there can be no doubting that Andrew Lansley is a vastly experienced politician who understands the NHS well. During his many years shadowing the health brief in opposition he must have spoken to numerous clinicians. Have they been influential over his current plans? You bet they have. Is everything set in stone so that there is limited scope to influence further? Absolutely not. Our future will be contingent on clinicians leading, influencing and creating policy at all levels, including nationally.

The Learning Disability Faculty has a tremendous track record in terms of influence. I remember well being a senior official during Sheila Hollins' presidency. Her style, approach, intelligence and gravitas made an enormous impact. She took time to understand the political agenda and build relationships. I can offer no better role model than Sheila and also perhaps my friend and colleague Sab Bhaumik who has been pivotal to developing learning disability policy. I am sure that the College and Faculty will again benefit from a President and Chair who understand the benefits of being on the inside track, who understand the politics of policy and the psychology of politicians.

The new Department of Health White Paper, *Equity and Excellence: Liberating the NHS* (2010) sets out:

- 'relative' protection for NHS finances
- dramatic changes to the commissioning system, including new roles for local government working with general practice/primary care
- 'market' strengthening
- a very different Department of Health 'arms-length management' of the NHS through an independent board.

What does the next phase hold for us, who really knows? I do know that a continued focus on what patients, staff and the public want is a good thing to keep in mind. Clinical leadership is a huge part of our future and therefore political influence is a necessary part of the job. If you are in political circles I hope my top ten tips (actually eleven!) will help. Oh, and one other thing – best not to mention the second homes scandal for a little while yet! ■

National High Secure Learning Disability Service – the David Wilson Unit at Rampton Hospital

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(continued from p. 1)

Therapy at the core

A combination of staff requirements for improved direct visibility for safety and security and patient requests to have access to 'more activities to keep busy' has led to a 'village design', increasing opportunities for the development of progressive security regimens and sharing of activities. Not isolated from the main hospital, additional 'talking therapy' and 'skills activity' rooms will allow an increase in direct therapy time for patients with staff from all professional groups. Patients will attend the core facilities every day, with evening and weekend sessions planned. A range of large and small rooms in the Southwell building allow meetings to take place away from the wards, with the smaller interview or one-to-one rooms catering for support meetings, family visits and professional interviews without disrupting other patient timetables.

Houses (wards)

The four wards are built surrounding a central activity and circulation space. Split into two halves, each house caters for 13–14 patients. Staff-only areas are discretely located towards the back of each house. The standard design increases consistency of space for observation and learning, allowing energy to go into design of care plans around personal rather than environmental risks.

A central office with uninterrupted views of the ward opens to wide circulation and activity areas on each side of the house, with sitting and dining areas separated. Bedroom doors are in full view of the office, with additional safety and security as well as privacy and dignity provisions



David Wilson Unit, 3-D model

built in. Facilities for those with special/separate care needs are designed to be flexible and distributed in each house. Ground floor accommodation, internal and external design innovations, improved access and lighting all improve the provision for those with exceptional behavioural or physical healthcare needs.

This new accommodation is intended to take high secure care into the future. Please contact us if you would like more information on environmental or design issues, on the development of secure care therapeutic packages, or if you would like to visit. ■

An intensive support service for people with learning disabilities, challenging behaviour and mental health needs

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The intensive support service (ISS) is a joint funded initiative of health and social services in response to the Northamptonshire Healthcare NHS Foundation Trust community care plan and forms part of the recommendations found in the Mansell report (2007), *Valuing People* (Department of Health, 2001) and *Valuing People Now* (Department of Health, 2009), which all highlighted the need to develop specialist local services.

The ISS consists of a ten-bed assessment and treatment unit (Vale ATU) and a newly formed community-based multiprofessional intensive support team (IST). The team uses a non-evasive, constructional approach, aiming to replace challenging behaviour with more socially and functionally appropriate behaviour. The ISS works closely with four local community teams for people with learning

disabilities (CTPLD) to support patients with significant challenging behaviour and/or mental health needs who require intensive assessment, support and/or intervention.

The team is guided by the following service principles:

- people with learning disability should not have to live in hospitals or institutionalised establishments
- people with learning disability should be included and supported within the community services
- people with learning disability should have access to staff with specialist knowledge and skills to enable access to life opportunities.

Individuals referred to the service meet the following criteria:

- there is a likelihood of an individual's exclusion from community facilities (residential or day care)
- their behaviours pose serious risk to themselves or others
- the behaviour seriously hinders their personal development.

Case-load commitment needs to be taken into account, although obviously challenging behaviour, if life-threatening or dangerous to others, will automatically be made a top priority.

The function of the ISS is to facilitate and prevent admission into the ten-bed Vale ATU. Part of its remit is to support people who need admission for a short period for assessment and treatment and discharge them back into the community for intensive support to prevent reoccurrence of admission.

A recent service review of the ISS, the first since its inception, looked at patient contact during the period from April 2009 to September 2010 using the care pathway for the team. During the initial 18 months of service, 110 referrals were made through the four CTPLD teams in the county. Age and gender distribution analysis revealed almost twice as many men (33) as women (17) in the 21–40 years age group, with equal numbers of men (26) and women (25) in the 41–60 years and over group; in the under-20 group there were 7 men and only 2 women.

The majority of individuals (63) were referred to the service because of challenging behaviour, whereas 11 either had standalone or coexisting mental health needs; approximately 80% had mild to moderate learning disability.

Twenty-six patients were admitted to the Vale ATU. The length of admission ranged between 5 and 192 days (average bed stay 58 days). Bed occupancy during the period studied was 80%.

The patients that came through the service had an outcome measure completed (Health of the Nation Outcome Scales for Learning Disability, HoNOS-LD) to monitor their progress. About 70% of individuals in the service showed a reduction in the HoNOS-LD scores by the time they were discharged. Steve Morgan's 'working with risk' assessments

(Morgan, 2000) were also completed in line with the trust's agreed overall risk framework on the complex considerations that inform the process of risk management. Some service users were under the care programme approach due to the complexity of their presentation in the service. The ISS has prevented out-of-county placements and repatriated some patients back into the county.

A possible drawback of the ISS is that the demand for involvement often outstrips the resources available to the service. The workload of each team member and the team as a whole should be such that everyone can apply themselves intensively to each case.

The clear difference between the ISS and other such teams is that it is a much smaller team. As the clinical focus of the service is changing, the original operational policy, process and standards require review. This is ongoing, with the intention of annually auditing the service to ensure it meets the users' requirements. ■

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In-patient learning disability psychiatry – a personal reflection

Liz Carmody

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(continued from p. 1)

Mainstream mental health

Within mainstream mental health the division into community and in-patient psychiatry has been a subject of much debate. The rationale for having a dedicated in-patient consultant has been fairly clear and arguably effective in addressing the problems described in acute in-patient settings. These problems included increased levels of disturbed behaviour, low levels of service user and carer satisfaction, operational inefficiencies such as multiple ward rounds, lack of clarity of purpose and of leadership,

resulting in an overall poor quality of care (Department of Health, 2002).

Some commentators went so far as to argue that in-patient psychiatry constituted a new subspecialty (Dratcu, 2006), with particular expertise required. This was felt necessary because of the symptom severity, high rates of comorbidity, complex psychosocial factors and high-risk presentations. In contrast, Holloway (2006), although agreeing with dedicated consultant input, does not see it as a separate specialty. Middleton (2006) agrees, seeing in-patient admission as part of an overall service user journey with the same range of skills and interventions used throughout.

More recently, the whole rationale for separate community and in-patient psychiatric care has been questioned, raising in particular the problem of discontinuity of care (Burns, 2010).

Relevance to learning disability

Some of the issues mentioned above are also true of learning disability in-patient services such as an increasing acuity and morbidity as community services become more developed. There have been higher rates of detention in the post-Bournewood years.

There has, however, been less of a focus on the concept of a dedicated in-patient consultant and few such posts exist outside the independent sector. This is understandable in view of the much smaller numbers of consultants in learning disability psychiatry. The problem of multiple ward rounds seen in adult psychiatry is rarely an issue, and many services have neither the bed numbers nor the medical workforce to support a dedicated consultant. I have been an in-patient consultant for almost 15 years, for most of that time also having a community patch but working exclusively in an in-patient setting for the past 3 years. It has been noticeable over that whole period that the number of admissions per year has reduced but average length of stay has increased. The latter happened because, as well as issues of acuity and risk, in-patients often have complex or unclear diagnoses and complex social care issues.

Consequently, the amount of consultant time required to manage in-patient care has increased over the years. This can be managed to some degree by the use of supporting medical staff but senior medical leadership is required to ensure active management and throughput of these individuals with complex problems. The changing legislative framework has added to the workload, with an increase in the number of mental health tribunals, their duration and complexity. The interface of the Mental Health Act and the Mental Capacity Act, implications of the Deprivation of Liberty Safeguards and community treatment orders all have to be considered and utilised appropriately. My impression has also been that complex family issues and safeguarding concerns are more prominent and occur in a higher proportion of admissions.

Service standards

The nature of the work outlined earlier can be onerous when not counterbalanced by less complicated clinical presentations such as those that occur in a community setting. (However, initiatives such as New Ways of Working propose that all consultant workload is of this complex nature, with more straightforward cases dealt with by other team members.) There is now greater clarity on the standards that in-patient services should work to, arising from initiatives such as the Care Quality Commission national audit (2007) and the Royal College of Psychiatrists accreditation scheme (Accreditation for Inpatient Mental Health Services – Learning Disability, AIMS–LD). This assists in clarifying the role and purpose of in-patient work and how it fits with other components of the service user pathway.

Personal view

The discontinuity and interface issues that cause problems in mainstream mental health are not as prevalent in learning disability psychiatry. The slower turnover and smaller number of community teams allow for good communication between the in-patient and team. As an in-patient service we have been able to develop good working relationships with other mainstream and specialist mental health services such as psychiatric intensive care unit and eating disorder services. The model works well for our service at this point in time and has many advantages. It will not be feasible or appropriate for all services but may be worth considering at times of service redesign. ■

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Interview with Baroness Sheila Hollins

Neil Mungur

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Sheila Hollins was appointed to the House of Lords on 5 October 2010 and awarded the title of Baroness. The accolade recognises her contribution to learning disability and mental health in the UK. Throughout her career in learning disability, which began as an academic at St George's, University of London, she has worked with people with learning disabilities and mental health issues. Her research, academic work and high-profile posts have influenced policy and practice in these areas. Since 2008, she has served as the chair of the World Health Organization's EURO Steering Group to develop a declaration and action plan on the health of children and young people with intellectual disabilities. She has also worked in a number of national advisory board roles, including as a member of the Independent Inquiry into Access to Healthcare for People with Learning Disabilities (2007–2008), was President of the Royal College of Psychiatrists (2005–2008) and has also written specialist books for people with learning disabilities, including the Books Beyond Words series.



What influenced you to take up medicine and then psychiatry as a career?

My mother left school at 16 and her parents only allowed her to work because it supported the war effort. However, my own parents were strong advocates of equal opportunities for both their sons and their daughters. I was always fascinated by hospitals and thought I would like to be a nurse. I became a keen St John Ambulance Brigade cadet. At my grammar school I found myself in the top stream and decided to take sciences so that I could try for medical school, although my best subjects and the best teaching were in English, French and history. Despite getting really bad A-level results, I was accepted at St Thomas' Hospital in London, in part because I had also been accepted to teach as a VSO volunteer in Nigeria for a year. I did no psychiatry as a student – it was not compulsory and I took holiday to get married and have

a honeymoon during the psychiatry firm. I trained as a general practitioner and became a principal in a practice in Tooting, near St George's Hospital. It was then that I realised I was ill-prepared to address the mental health problems brought by patients.

What led to you pursue a career in learning disabilities?

My son has a learning disability, the extent of which gradually became apparent during my psychiatric training. As a higher trainee in child and adolescent psychiatry, I began to take on families with a disabled child and realised that other team members were uncomfortable trying to help with the particular problems that these families would bring. Their attitude was that because the impairment was incurable, nothing could be done to help. I really hope that those stereotypes are a thing of the past in the psychiatric profession!

As a mother I knew that similar emotional and psychiatric issues needed to be addressed for these families and their children as for every other family, if not more so, and I found myself getting more and more involved. I was applying for consultant posts at the same time that Professor Joan Bicknell was taking up her post as the first UK professor in the psychiatry of mental handicap. She persuaded me to apply for a senior lecturer position.

What are you most proud of achieving during your time as Faculty Chair?

I am pleased that I got agreement for the section to become a faculty and that our name and function changed from 'mental handicap' to the 'psychiatry of learning disability', thus emphasising the mental health aspects of learning disability and also adopting a term which is accepted by users, carers and other professional groups – I guess I was seen as a moderniser.

What have been the most important developments in the field of learning disability over your career?

The way in which self-advocates and families have become so confident in speaking up for themselves.

What have been your concerns?

The slow rate of progress among health professionals, including some psychiatrists and a lot of managers, in being able to include people with a learning disability fully in their service.

What is your view about how people with learning disability are viewed and treated currently by society?

It is variable but I think many members of the public are very relaxed, patient and inclusive in their ways. However,

we have to be watchful, as too many people are still the subject of disability hate crime and abuse.

What challenges do you predict your new role will provide you with?

Learning how to use my influence to good effect in a new environment.

Given your background, do you hope to bring the field of the learning disabilities more focus politically?

As always – yes, but not just the learning disability field.

How do you manage your time and do you have any tips?

Sometimes I manage better than others! I find that organising things and planning works best. So, for example, I try to make phone calls in batches, set aside a time for doing emails (a nightmare currently, as with a new parliamentary account I now have three email accounts, all of which are very active), deciding on priorities and sticking to them.

How do you divide up your working week?

In theory, mornings for research and for Books Beyond Words (my new charitable company), afternoons and evenings for parliament and Fridays for my family including my grandchildren, when the House is not sitting.

How do you relax?

Walking on the North Downs with my husband Martin, listening to classical music or jazz, and occasionally painting or drawing.

Looking back, if you could change one thing in your career, what would it be?

Keeping up with playing the saxophone.

What one item could you not do without and why?

Not an item – but silence. I find silence essential to allow myself to be spiritually and emotionally grounded.

What is your favourite book/film/food?

It depends on my mood but shepherd's pie is high on the list. Film – Doctor Zhivago!

What is the most important lesson life has taught you?

Persistence pays off.

How would you like to be remembered?

As someone who did her best to be true to herself and her values even if she did not always succeed. ■

Behind the scenes

Harm Boer, Geoff Marston

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The Faculty of the Psychiatry of Learning Disability is a vibrant and active body supporting and promoting the needs of people with a learning disability, their carers and professionals working in the field. It does this in a variety of ways, some very visible and easily appreciated by others (e.g. conferences, websites, online training, occasional papers) and others not so apparent (e.g. forging liaisons with key partners such as the Department of Health, parliament, other medical Royal Colleges and important organisations; responding to policies and documents which might have an impact on people with a learning disability).

Members elect medical representatives to the national faculty executive and at a local level put forward or elect regional representatives. They are the most public faces of the Faculty and most likely to be acknowledged or credited for all that goes on. However, there are a group of people working tirelessly behind the scenes at the College and in the regions, who facilitate and coordinate all that the Faculty and the College do. There are too many to mention everyone individually, but some of the key people whose work is invaluable are:

- Kitti Kottasz (Faculty Committee Manager) is the lynchpin who ensures the smooth day-to-day functioning of the Faculty. She can assist all members with enquiries about Faculty matters, directing lost souls to the right person in the College. You can contact Kitti by emailing learningdisability@rpsych.ac.uk
- The Conference Office (Michelle Braithwaite, Dela Goka, Caroline Simms, Sonia Walter) do an excellent job of organising the Faculty's residential and 1-day meetings
- Charlotte Cox supports the Workforce Committee and coordinates census and recruitment data
- Quinn Golding supports the Faculty education and curriculum work and the network of training programme directors
- Kasia Krawczyk does a wonderful job typesetting and copy editing the Faculty newsletter to a very high standard
- Veena Verdi revamps and updates the Faculty web pages.

There are of course many others involved behind the scenes, for example in the Policy Unit, Library, Press Office, Finance Department, IT, Facilities, Publications, Membership Office, and Regional offices.

On behalf of the Executive and all faculty members we would like to thank them for their dedication, hard work and good humour in sometimes stressful situations. ■

Achievements since September 2010

Kitti Kottasz

learningdisability@rpsych.ac.uk

- Sheila Hollins has been made a Baroness
- Newly appointed regional representatives:
 - Dr Shaun Gravestock (London South East): reappointment
 - Dr William Howie (London South West)
 - Dr Sujeet Jaydeokar (London North East)
 - Dr Mo Eyeoyibo (Kent, Surrey and Sussex)
- Advisory Committee on Clinical Excellence Awards (ACCEA)
 - Unfortunately, no learning disability psychiatrist was awarded an ACCEA award in the 2010 round. The 2011 round is in progress now.
- Newly appointed trainee representative: Dr Miriam Isaac
- Awards and prizes
 - Brian Oliver Prize: Dr Bhatika Perera
 - Alec Shapiro Prize (oral): Dr Vish Radhakrishnan
 - Alec Shapiro Prize (poster): Dr Shweta Gangavati
 - The Professor Joan Bicknell Medical Student Essay Prize: Ms Emily Hart ■

Update on regional representatives and workforce

Richard Welfare, Geoff Marston

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Issues around evolving consultant roles, recruitment and retention, what makes an appropriate/doable job description and ensuring new consultants are supported are still the main areas of focus of the Faculty's regional representatives. We would like to make members aware of the following initiatives for 2011:

- new consultants' group and Yahoo forum: for details contact Dr Raj Attavar (rajnish.attavar@obmh.nhs.uk)
- survey of new consultants' experiences
- updating previous learning disability psychiatry workforce survey via regional representatives (tracking recruitment and potential cuts)

- guidance notes for assessing job descriptions to support regional representatives.

We hope you will be able to support these initiatives. For further information please contact us at the email addresses provided. ■

From the Academic Secretary

Regi Alexander

regialexander@btinternet.com

Joan Bicknell Medical Student Essay Prize 2010

This year's Professor Joan Bicknell Essay Prize was awarded to Ms Emily Hart. The competition was very stiff and the judges have recommended special certificates of commendation to eight other entries. Many thanks to all of you who encouraged their medical students to enter this competition.

Learning disability journals, the College library and reading lists

Subscriptions or exchange subscriptions have now been set up at the College library for the following journals: *Advances in Mental Health and Learning Disabilities*, *American Journal on Intellectual and Developmental Disabilities*, *British Journal of Developmental Disabilities*,

British Journal of Learning Disabilities, *Journal of Applied Research in Intellectual Disabilities*, *Journal of Intellectual Disability Research*, *Journal of Intellectual and Developmental Disability*, *Journal of Intellectual Disabilities* (formerly *Journal of Learning Disability*), *Journal of Mental Health Research in Intellectual Disabilities*, *Learning Disability Today*, and *Mental Health and Learning Disabilities Research and Practice*. Anyone who wishes to receive emails of the recent contents pages of these journals can contact Sally Blake, Library and Information Manager (sblake@rcpsych.ac.uk). The service that allows college members free copies of articles within the library collection and articles from outside for a small fee is still very much there. If you have suggestions for other journals, do email me. The reading list on the Faculty's website is being updated and we would welcome your suggestions about that too.

The Jack Piachaud Prize

The late Jack Piachaud was an inspirational teacher with a passion for working with medical students and trainees on issues of disability. It is indeed a fitting tribute to his memory that in 2011 the Faculty will introduce the Jack Piachaud Prize for the best research poster presented by a medical student at the Annual Residential Meeting.

Conferences 2011

The Faculty's 1-day spring meeting will be held at Centre Point, London, on 1 April 2011. The residential meeting will be held at Bristol, on 6 and 7 October 2011. Please continue to send in your suggestions about speakers and topics, and watch the College website for further details. ■

Epilepsy in People with Learning Difficulties: A National Conference

20 May 2011
Bristol Holiday Inn

For more details go to
www.idepilepsy.co.uk
or email idepilepsy@yahoo.com



Request for support from Kenya

Request for Support
Gibson School Nairobi, Kenya
Dr Angela Hassiotis

Dear Colleagues

While in Nairobi in June 2010, I visited a school for children with learning disabilities called Gibson's School (www.gibsonschool.co.ke). They are doing a great job trying to integrate the children in the community, finding work for them and pursuing an inclusive agenda.

The head teacher told me that they would be pleased to have professionals in a number of disciplines, e.g. speech and language therapy, occupational therapy, physiotherapy and so on who could offer consultations to the school and teach staff and community workers in the local area. Mr Godfrey Wamoyi (gwawire@yahoo.com) also said that he may be able to find ways to either pay or contribute to the individuals' stay there.

Please disseminate widely to interested professionals.

Personal Health Budgets in Mental Health Survey

Andy Clark, RCPsych Lead for Workforce

Personal health budgets may revolutionise how healthcare is commissioned and delivered by devolving much greater power and influence to the decision-making of the individual patient. **What are your views on this?**



The Royal College of Psychiatrists is collaborating on this survey being undertaken among psychiatrists and other professionals working with mental health service users. The survey should take no more than **10 minutes to complete**. Your answers to the questions will be **fully confidential**.

All members are encouraged to participate in the survey even if they have not yet had direct experience of personal health budgets. Please follow this link to go straight to the survey: <http://bit.ly/bAf1et>

Faculty of the Psychiatry of Learning Disability Annual Spring Conference

'Mental Health in Learning Disability – Treatments, Pathways and Costs'

Friday, 1 April 2011

CBI Conference Centre, Centre Point, London

Topics will include:

- Diagnosis of psychosis in autism
- Treatment-resistant epilepsy
- In-patient units and services for other developmental disabilities
- Drug treatment of sex offending behaviour
- Management of sleep disorders, depression, anxiety, dementia
- Mental healthcare for children with learning disability
- The 2011 Learning Disabilities Observatory report on mortality
- The interface with physical healthcare in developmental disability
- An update on the mechanics of payment by results and the learning disability clustering tool
- Value for money – who owns healthcare and why it matters

**Eight keynote lectures and eight master
classes to make it an away-day with
a difference!**

Last year's event was very informative and a great success. We aim to bring you another great event this year.

The conference also provides an essential opportunity for networking with like-minded colleagues interested in the psychiatry of learning disability. We hope you will be able to join us

To register your interest in this event please contact:

Dela Goka

RCPsych Conference Office

dgoka@rcpsych.ac.uk

