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Asif Zia

Learning Disability Psychiatry

Newsletter of the Faculty of the Psychiatry of Learning Disability

In this issue

Training update

It has been a frenetic year for those involved in education in the Royal College of Psychiatrists and the College Faculty of the Psychiatry of Learning Disability. I will try to indicate some of the underpinning ideas that we are applying to curriculum development, the future direction of training in learning disability psychiatry and the means by which we as a specialty can maintain standards of good practice in education. Defining what educational standards are required dovetails with Faculty work on the role of the consultant. Our credibility as a specialty depends on delivering consistently highly trained consultants in the psychiatry of learning disability. (p. 5)

Is patient choice another term for Hobson's choice?

'Choice' is an act to enable selection from a reasonable set of alternatives. 'Patient Choice' is a Department of Health initiative giving clients more choice about when, where and how their healthcare needs are met, including choice over hospitals, improving the flexibility of public services, and making the National Health Service (NHS) more patient-centred. (p. 6)

Accessible information leaflets for service users and carers

Use of accessible information and involvement of people with learning disability in the healthcare they receive is central to many of the Department of Health strategies. One of the Core Standards (C18) of the Care Quality Commission (2009) stipulates that healthcare organisations should 'enable all members of the population to access services equally and offer choice in access to services and treatment equitably'. 'Choice' pertaining to all decisions including access to healthcare and treatment is one of the key principles in Valuing People Now (Department of Health, 2009) as well. (p. 7)

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

4-Year View from the Chair

Sabyasachi Bhaumik

bhaumikuk@yahoo.co.uk

This is my opportunity to thank all the members of the Faculty for the support, encouragement and participation in achieving the goals we set for the Faculty during the 4 years of my tenure as Chair.

When I took up this post, I already had some experience of the workings of the College, mainly through my role as Chair of the Trent Division (2003–2007) and also as a Faculty Executive and Academic Secretary. The College has a good governance structure but, because of the organisational complexity, it takes some time to understand the mechanisms that make it work. The key for taking up any new College role is to develop close working relationships with others and have a wide overview of the College's strategy and objectives.

During these 4 years, I have been able to develop a reasonable understanding of the other faculties' priorities and future directions and have therefore been able to explore areas of mutual interest that benefit the outcome of care for our patients. As the chair of the Trent Division I managed to establish, for the first time in the history of the College, meetings between the division and faculty chairs. This arrangement is still continuing and on every Council meeting the chairs meet at lunchtime to discuss the key issues for faculties and divisions. Although there were some challenges on the way, nothing proved to be insurmountable.

As Faculty chair, I had an opportunity to work with two College presidents (three if I include my term as the Division chair). Each president came with his or her own vision and this is reflected on a smaller scale for each faculty with each newly elected chair. My own vision for the Faculty was related to the quality agenda and supporting the wider membership. I am pleased to state that I have achieved most of what I wanted to do through the establishment of task and finish groups with clear objectives, responsibilities and timelines.

The main projects included copying clinical letters to patients, guidelines on the use of high-dose antipsychotics in people with learning disability, good practice guidelines for the Black and minority ethnic population with learning disabilities, joint guidelines with the British Psychological Society and the Faculty of Old Age Psychiatry (*Dementia and People with Learning Disabilities*), information for users and carers, *The Future Role of Psychiatrists in Learning Disability* (in print) and, finally, care pathways and payment by results for learning disability services. The last piece of work on care pathways is ongoing and is likely to be published next year.

During the past 4 years the Faculty has been very active and has had extremely good participation from members, not only in conferences but also in other initiatives. I particularly wish to thank our user and carer groups for their invaluable participation and comments on key Faculty documents. As far as interface working with other faculties is concerned, we have prioritised some key areas of development:

- meeting the mental health needs of adults with a mild learning disability (Faculty of General and Community Psychiatry)
- establishing care pathways for offenders with learning disabilities (Faculty of Forensic Psychiatry)
- transition of children with learning disabilities into adult services (Faculty of Child and Adolescent Psychiatry).

On research and standards setting, we have been able to work closely with the College Centre for Quality Improvement (CCQI) in setting the standards for accreditation of in-patient services for adults with learning disabilities and on the antipsychotic use project for the Prescribing Observatory for Mental Health (POMH) UK. We have also established a clinical research committee for the Faculty, focusing on health services research and supporting the wider membership in their projects. Recently, with support from Paul Lelliott, CCQI director, we have suggested two key priority topics in learning disability for the National Institute for Health and Clinical Excellence Topic Selection Working Group.

Taking a wider perspective, for the first time the Faculty managed to develop an overseas links programme with input from the Board of International Affairs. I wish particularly to thank those members who tirelessly work to improve the awareness and standards of service delivery and training in low- and middle-income countries.

The Faculty has also strengthened its own position within the College and in the wider political environment. Through various initiatives, we managed to establish excellent relationships with the national Valuing People Team, Care Quality Commission and other organisations such as the British Psychological Society, the Royal College of Nursing, the Royal College of General Practitioners and Mencap.

I hope I have been able to increase the productivity and output from the Faculty, which has clearly set an example within the College. The drive for efficiency, quality and productivity is very clear now within the ethos of the working of our Faculty.

Personally, I enjoyed every moment of my work as Faculty chair, although at times it has been stressful and challenging. During those difficult times, I was touched by the support I received from the wider membership, Executive colleagues and College Officers. I am heartened by the fact that we have been able to bring together clinicians from diverse backgrounds to actively participate in the

College and Faculty work. I will continue the work on care pathways, seeing it through to completion, and will carry on my international activities and key functions within the College as requested by the President.

I wish to convey my best wishes and support for the new chair of the Faculty, Dr Ian Hall, and the newly elected Executive Committee members. No doubt they will move the Faculty forward towards a very bright future.

Letter from the Editors

The Faculty newsletter, under the editorial Board led by Dr Angela Hassiotis, has become a valued and professional publication covering a wide range of topics, keeping our membership up to date with key issues within learning disability psychiatry and the work of the Faculty Executive.

In March 2010, the editorial team changed, with Geoff Marston, Asif Zia, Regi Alexander, Satheesh Gangadharan and Vishwa Radhakrishnan becoming the editorial board. We want to maintain the excellent quality of the newsletter, while revising the structure and adding regular content sections to include:

- Training Forum: providing space for trainees, trainers and those involved in education to share information.
- Horizon Scanning: providing summaries and links to new documents and initiatives that have come to the Faculty's attention and have general relevance to all.
- From the Frontier: providing examples of service innovation and good practice from around the regions, with signposting for more information.
- Partnership Working: updating members as to Faculty partnership working with other organisations.
- Achievements: Celebrating Faculty members' achievements such as Fellowships, prizes, national excellence awards and appointments.
- Regional Representatives and Workforce: highlighting issues of local and national concern, feedback on workforce issues (possibly to include signposting for job vacancies).
- Academic Meetings and Faculty Events.

This is your newsletter and we would like to hear your views on its format and content. Likewise, we would encourage submission of articles for publication.

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

Thanks again to Angela and the previous editorial team. We hope the newsletter will continue to go from strength to strength, remaining a valued publication for all our members and others who read it. Thanks also for your support and in anticipation of your views and continued submission of articles.

If you wish to submit an article or have any views on content and format, please contact the editorial team, care of Dr Geoff Marston (Editor) geoff.marston@covwarkpt.nhs.uk or Kitti Kottasz (Faculty PA) kkottasz@rcpsych.ac.uk.

2011 Burden Research Prize

The Burden Trust invites applications for the 2011 Burden Research Prize. The prize, which consists of an award of £1000, has been running since 1969 to recognise outstanding original research in the area of learning disabilities. The prize can be awarded for a single piece of work or a cluster of projects, but the work submitted for consideration must have been published, accepted for publication or presented as a paper to a learned society between 1 January 2006 and 31 December 2010. The prize is open to any registered medical practitioner who spends the majority of his/her time working in the field of learning disabilities in the UK or Ireland. Work as part of a team can be submitted so long as the individual contributed substantially to the research.

An application form and further details may be obtained from:

Dr Peter Carpenter, Kingswood Learning Difficulties Service, Hanham Road, Bristol BS15 8PQ, Tel: 01454 862480, Email: peter.carpenter@nhs.net. The closing date for applications is 31 March 2011.

The prize winner will be expected to give a lecture at the time of the presentation of the award, which is expected to be at the International Congress of the Royal College of Psychiatrists in 2012.

Yahoo group for higher trainees

Vishwa Radhakrishnan

vishwa.radhakrishnan@gmail.com

Higher trainees (ST4–6) have a Yahoo group which has been an effective forum for discussion and dissemination of training-related information. We would like to invite members of the Faculty of the Psychiatry of Learning Disability to register their email with the group if they wish to establish an e-link with existing trainees. Current members of the group include ST4–6 trainees and consultants from around the country. Information regarding national audits and surveys, job vacancies, events and training issues is circulated through the forum.

Please follow these steps to register:

1 Log on to http://uk.groups.yahoo.com/

2 In 'Find a Yahoo group' search field enter 'ldpsychiatry' and click 'search'

3 On the group description page click on 'Join this group' and follow instructions to register your details.

Following registration you will automatically receive group emails from other members and can contact the entire group by sending an email to ldpsychiatry@yahoogroups.co.uk. If you have any difficulty with registering, please contact me on vishwa.radhakrishnan@gmail.com. We look forward to welcoming you to the group.

Asperger syndrome and learning disability – a heart-sink patient?*

Tracy Norwich

tan4@leicester.ac.uk

Throughout my time at medical school I repeatedly saw examples of patients with learning disabilities not receiving equality in healthcare. One patient in particular highlighted this; a lady with Asperger syndrome who had been treated by an orthopaedic surgeon several times previously.

When my consultant realised this lady was the next patient there was a shift in attitude, from the consultant and the nursing staff. This young lady was a 'heart-sink' patient. There had been considerable input but no progress had been made. The question which sprung to my mind was: is that the fault of this patient or has the system failed her?

My conclusion would be the system failed her and unfortunately many other patients with learning disabilities. The consultant failed to communicate adequately with her to the point of antagonising her, resulting in a display of physical aggression. There was inadequate interaction with the support workers working with this patient. Finally, physiotherapy failed resulting in several manipulations under anaesthesia; perhaps this could have been avoided had the correct services been accessed, for example referral to a physiotherapist registered with the Association of Chartered Physiotherapists working with People with a Learning Disability (HM Government, 2009*a*).

Learning disabilities, Asperger syndrome and autism are common diagnoses and doctors will frequently meet people with varying degrees of severity of these conditions. It is estimated that the prevalence of learning disability is 1–2% of the population (www.ncl.ac.uk/nnp/teaching/disorders/learning). Therefore at some point during their careers it is highly likely every doctor will have to treat a patient with learning disabilities.

Instead of developing a sense of dread we need to be taught more than just the raw facts: the diagnostic criteria of learning disabilities, the triad of impairments with regards to autism, the self-injurious and challenging behaviour these people sometimes display. This knowledge is important but should be provided on a background of what it is actually like to work with and be around people with learning disabilities.

Medical students need to learn what it is like to interact with people with learning disabilities. We create these scary, inaccurate schemas which are far worse than the reality. Medical students are the consultants of the future. They will be the ones introducing medical students to people with learning disabilities, showing them how to interact and provide the best treatment possible for them. But how can they do this without positive exposure and learning these skills themselves?

At medical school we try to see the patients as people, but for many reasons we often do not. I think that is one thing I learnt from this patient. She came into the consulting room as 'learning disabilities and Asperger syndrome', not as a person. We failed to see past the label to the person. I believe this ultimately had an adverse impact on the level of care she received.

There have been several Government initiatives to try to ensure that people with learning disabilities receive the same level of care as those without learning disabilities. However, in 2009 the paper *Valuing People Now* stated that there has been insufficient change and there are still vast inequalities in healthcare (HM Government, 2009*a*,*b*).

I think that change in this area is incredibly difficult for many reasons. As a patient group people with learning disabilities often do not have the communication skills necessary to make their needs known. With their limited independence

they are often reliant on carers or family members to firstly notice there is a problem and then make the arrangements to access healthcare.

My time with this patient did several things for me. It made me learn a lot about myself, my preconceptions, my inadequacies and where I see my career developing. It also made me reflect about people with learning disabilities and how medical students learn about them. I also realised how important the reactions of supervising consultants and doctors are in shaping our judgements about this group of people and consequently how we will interact with patients with learning disabilities in the future.

Of huge importance to me is the training and exposure of medical students to people with learning disabilities. I understand that it is not feasible to do a specialised block in learning disabilities, which is unfortunate as these placements are incredibly effective at changing attitudes towards patient groups. However, I really believe that spending at least a few days working in day centres or supported living homes would be beneficial for medical students and ultimately for people with learning disabilities. ■

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**This essay won the 2010 Joan Bicknell Essay prize. It is reprinted here in an abridged version. The original essay is available from the author on request.*

The Annual Psychiatry of Learning Disabilities Higher Trainees Conference 2010

Training update

Jo Jones

jo.jones@nottingham.ac.uk

Curriculum development and assessment

(continued from p. 1)

The Postgraduate Medical Education and Training Board (PMETB), whose functions have now been taken over by the General Medical Council (GMC) reviewed the curriculum for learning disability psychiatry as well as the five other major psychiatric curricula. We have been required to provide standards for core training in learning disability psychiatry and give guides to standards and assessment for specialty trainees years 4–6. These assessment standards have been approved and the core standards are available on the College website (www.rcpsych.ac.uk/training/localeducationproviders/wpbaguide.aspx).

In essence, we picked out key aspects of core training and specified what was meant by the particular aspects of competence. This gave us an opportunity to define what trainees should achieve and to 'unpack' the curriculum, which only refers to learning disability psychiatry obliquely.

This was approached by considering the distinct competences of developmental psychiatry (paralleled in child and adolescent psychiatry), providing descriptions of how each competency is met. The example in Box 1 is the descriptor for history taking (Intended Learning Outcome 1), from which we derived standards for assessment.

Standards were described under the headings 'Competence not demonstrated', 'Some competence but further development needed' and 'Competence achieved'.

This process enabled us to see that there were discontinuities from the core curriculum in the structure of the advanced curriculum. We have the opportunity this autumn to try to reorganise some of the advanced competencies to enhance continuity and (we hope) make the curriculum easier to grasp. We also realised that some of our important competences (e.g. in pharmacotherapy, psychotherapeutic approaches, autism, and forensics) could also be better worded or elaborated on.

The curriculum forms the basis for assessment; the suggested methods we have been required to submit include an emphasis on the educational supervisor's report and reflective practice pieces rather than an exhaustive list of workplace-based assessments. The reason for this is to enable more ongoing and global judgements to be made in the context of good supervision, and well-documented trainee portfolios. We have suggested some pilot reports and any other examples of useful templates would be gratefully received, particularly via the training programme directors.

Box 1 Aspects of history taking in learning disability psychiatry

- Adaptation of history to account for basic developmental history schooling; understanding of impact of deficits in cognitive ability including activities of daily living, support required; behavioural history and its impact on carers and other family members/residents; physical history in relation to both underlying syndromes or subsequent ill health, including sensory impairments; history of seizures; identification of major indicators of presence of autistic-spectrum disorder.
- Ability to elicit information sensitively from family/carers and assessment of the quality of this information.
- Communication with people with learning disabilities, ability to recognise and adapt to additional communication difficulties associated with other impairment, such as physical disability, sensory impairments, autistic-spectrum disorder.

I hope that you will all peruse the curriculum as it comes out. Parts of the study guide have been incorporated (including advice on 'additional core experience' and structures of training programmes) and you will see that we are encouraging a more specialist third year of training, where possible, to reflect the ever changing demands on new consultants.

Faculty Education and Curriculum Committee (PLDFECC)

The old Specialty Advisory Committee was replaced by PLDFECC, but some of its advisory functions were superseded by the College Quality Assurance Committee. In various ways PLDFECC has become almost redundant in its current form. Deadlines for revisions of curricula, policies and other work mean that meeting infrequently was unhelpful. In effect, we need a virtual group to work on the curriculum. Within this a smaller group could deputise for, and communicate with, the Chair on the ever increasing central committees. We also need to get feedback and ownership from the training programme directors (TPDs) and trainees.

To this end the Faculty has agreed to disband PLDFECC in its present form and allow the Chair to convene a small virtual group linked to a TPD network. This will provide the means to widely disseminate ideas and developments rapidly and to enhance debate. I also hope that this will promote engagement of all schemes and trainees in this process.

We also have to quality assure our training from a specialty perspective. Being so small, we are at risk of drift. In order to prevent this I suggest that the TPDs meet at our residential meeting to discuss such matters and I am planning another TPD workshop for the spring. The aim is to support each other in ensuring that our trainees are 'fit for purpose' and maintain the standards of training within our specialty.

If anyone has a view on these matters I will be at the Leeds Residential Conference in October (p. 12), or you can email me. It would help me enormously if each TPD would email me with their address, so I can keep the College updated and also have an easy contact list myself.

Is patient choice another term for Hobson's choice?

Rohit Shankar

haritsa@doctors.org.uk

Patient choice as a government objective

(continued from p. 1)

The government has two broad objectives for enhancing choice in the NHS. The first involves responding to patients' desires for more control over their treatment. Government documents cite surveys suggesting that 66% of the public would like to choose their treatment provider, with 76% believing that involving patients more in choices over their treatment was the 'main priority for healthcare' (Department of Health, 2006). This begs several questions: Who decides what the choices need to be? Is what is available of good quality and appropriate to choose from? Can too much choice be stressful for some people? Should we restrict it if it were?

The second government objective is choice as a mechanism to improve quality in the NHS, when coupled with 'payment by results', and fostering more competition between providers. The theory is that when presented with the incentive of extra funding by attracting patients (or faced with the loss of income if patients avoid them) providers will improve service quality accordingly (Thorlby, 2007). Here, too, there is an abstract element. How would this work in places where there is little or no service competition? Is service competition a good thing? In our attempts to keep the patients and their funding with us, would we end up at times providing the wrong choices?

Choice for people with learning disabilities

Let us look at choice in learning disability psychiatry. Simplistically, it would mean putting on offer whatever is available for the patient to choose from.

Choice is much more complex. It needs to involve an ongoing dialogue between service user and provider. *Valuing People Now* (HM Government, 2009) seems to be the new Bible for service development in learning disability health and social care. However, it provides no definitive template but tries to convey the right 'spirit' in which we need to deliver care. Although having the right spirit is important, one needs to factor in workforce and service delivery costs which prevent the NHS from delivering all

treatment possibilities to all patients, all of the time. This inevitably leads to service providers making choices what to offer from available resources, which in some sense devalues the concept of patient choice.

On the flip side, when working with fixed resources and funding limitations, balancing acts are necessary; it is then imperative that equitable distribution occurs depending on urgency of a patient's need. Depending on a situation and patient this could entail choosing from familiar, but limited local options, or being referred out of area to an unknown 'St Elsewhere' service. Is this acceptable?

Central to patient choice is informed consent. However, the capacity of people with learning disabilities to consent to medical and social interventions may not routinely be assessed. Patients with learning disabilities may be assumed to be incompetent to make decisions about their healthcare. Consequently, they may be subjected to 'best interest' interventions that they have not agreed to (Lodge, 2005). Conversely, 'patient choice' may be used as a reason for non-intervention. We need to be mindful of the possible misuse that the umbrella term 'patient choice' can foster.

Central to choice and consent is information and communication. We should endeavour to enable all available information resources to be user friendly and information delivery to be carried out through an appropriate, comprehensive, person-centred medium.

Having a duty of care, we need to strike a balance on what we have to offer from finite resources. Shared decision-making might be used to explain and decide on the limitations in the delivery of appropriate packages (Propper *et al*, 2006). This would, if worked in a constructive and flexible manner, prevent pressurising patients into decisions they are uncomfortable with. It would also lead to improved trust, better adherence and confidence in the service.

Choice is a much larger issue than core service provision. It also includes a consideration of a user's position on length of consultation, access to premises, timing and convenience of appointments.

If we believe that we can present fully objective choices, we are deluding ourselves. It would be better to accept and convey that our presented choices come tinged with limitations and bias linked to personal experiences.

I end with a thought of Robert Fritz: 'If you limit your choices only to what seems possible or reasonable, you disconnect yourself from what you truly want, and all that is left is compromise.' Do we want to give our patients compromised solutions or true solutions? It is a choice for each of us to make.

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Accessible information leaflets for service users and carers

Shweta Gangavati, Abdul Wahid Shaikh, Louise Talbott, Avinash Hiremath and Sabyasachi Bhaumik

Shweta.Gangavati@leicspart.nhs.uk

(continued from p. 1)

Making information accessible is part of the process of empowering people with learning disabilities in making choices about the treatment and care they receive. Information leaflets in an easy-read format are a tool that enables professionals to do so. Despite the fact that several leaflets about mental illness and psychotropic medications are available nationally, there is very little meaningful information accessible for those with learning disabilities.

As part of the service improvement programme in Leicestershire Partnership NHS Trust, a core group was established to develop accessible information specifically about mental illness, psychotropic medications and services provided by the learning disability team. The group involved psychiatrists, speech and language therapists and members from the Easy Write Team. They reviewed the content and quality of the nationally available accessible information leaflets. There was a paucity of accessible information on specific mental health-related topics such as dementia or autism.

One of the main tasks of the core group was to bridge this gap and to adapt and use the leaflets which were of good quality and deemed appropriate for people with learning disability. After reviewing all the available resources (websites and leaflets), the group felt that some of the existing information could be used but there was a need for the information to be simplified further.

Subsequently, leaflets were developed in line with guidelines devised by the speech and language therapists at the Trust, keeping the language very simple and using the appropriate pictures. Information leaflets on mental health problems include depression, psychosis, anxiety, bipolar affective disorder, autism, dementia, challenging behaviour, and epilepsy. Medication leaflets cover a wide range of antidepressants, antipsychotics, anti-dementia medications, and mood stabilisers.

After completion, leaflets were quality assured and shared with the Executive Committee and user and carer groups at the Faculty. Feedback received was used to further develop the leaflets, which will hopefully be available on the Faculty website. Locally, these leaflets are being used as part of the implementation of care pathways.

An audit to study the impact of these leaflets on the knowledge of services users and carers about their medications is ongoing. Results will help to improve the leaflets further. Ultimately, developing accessible information is a dynamic process and further work is needed in this area. ■

Acknowledgements

Thanks to Professor Shoumitro Deb and Gemma Unwin for permission to use content from their medication leaflets; members of the Faculty Executive, particularly Dr Paul Winterbottom, and the College user and carer groups for their valuable feedback.

The pictures for the leaflets have been taken from the CHANGE picture bank.

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Easyinfo website has Easy Write guidelines at http://easyinfo.org.uk

Offenders with learning disability in Egypt

Harm Boer, Gregory O'Brien

harm.boer@covwarktpt.nhs.uk

In January 2009, Dr Nasser Loza, psychiatrist and Secretary General of Mental Health at the Ministry of Health in Egypt, invited two speakers from the UK to conduct training workshops and to look at services for offenders with a learning disability in Cairo. We have been asked to take this on. After attempts to organise the visit in June and September 2009, it eventually went ahead in November 2009. We were joined by Dr Deji Oyebode, forensic psychiatrist and Vice Chair of the International Affairs Committee of the Royal College of Psychiatrists (now called International Advisory Committee), who had visited the forensic services in Egypt previously with Dr David Ndegwa, forensic psychiatrist.

Dr Loza, a Fellow of the College, had trained in London before his return to Cairo in 1987. He is the director and owner of a large private mental health hospital. Through his association with the Ministry of Health he had pushed for the first for 6 decades, new (well-received) mental health legislation in Egypt in 2009. The whole visit was coordinated by Dr Eman Sorour, MRCPsych, Director of International Affairs at the Psychiatric Division of the Ministry of Health.

Because of various administrative difficulties we were flown to Egypt via Amsterdam and we arrived in Cairo in the middle of the night. The next day we visited Abbasiya Hospital, a large mental health hospital, which had been converted from a royal palace in the 19th century and whose name had become synonymous with 'mad' or 'insane'. Following a tour of Abbasiya, we were driven to El-Khanka Hospital, a large forensic psychiatry hospital on the outskirts of Cairo (in the desert), with imposing walls and gates, and armed guards.

The patients in El-Khanka were housed in what would have been known as 'Nightingale wards', large halls where patients' beds are alongside each other, with limited space for personal belongings. We noted that in the ward for people with learning disability (including some who had offended against children) there were large photographs of happy, young children (toddlers) on the walls, some only partly clothed. We wondered whether such pictures could provide stimulation for people who had offended against children. However, we were pleased with the focus on organised recreation, games and physical activity within the hospital, and we found that the patients we saw were in good physical health and were not overweight (as is frequently found in similar hospitals in the UK), and looked fit and healthy. We were asked to and made in a formal

Presentation at the autism conference in Cairo. From the left: Prof. Gregory O'Brien, Dr Harm Boer, Prof. Fakhr El-Islam, Dr Eman Sorour, Dr Nassesr Loza and Dr Deji Oyebode

report, a number of recommendations including those regarding the issue of relational security.

On the Monday we attended a national conference on forensic psychiatry and autism organised by the Psychiatric Division of the Ministry of Health. Each of us gave a lecture and there were a number of lectures from Egyptian speakers, including trainee presentations which we were asked to judge (not an easy task). On the Tuesday Dr Oyebode led workshops on risk assessment, training and quality assurance, which left us free to explore Cairo, including the pyramids of Giza, the Sphinx and the Egyptian museum which holds the tomb of Tutankhamun.

On the Wednesday it was our turn to provide workshops on autism and treatment programmes to a group of more than 30 well-informed and enthusiastic trainees in psychiatry.

We were very privileged to have been invited by the Egyptian government. Our hosts, who joined us on most evenings, made us feel very welcome. As a number of psychiatric trainees are taking part in MRCPsych examinations, there was a high level of interest and engagement during our talks and workshops.

We feel that a number of steps have been made in order to improve conditions for psychiatric patients in Egypt. We would both be pleased to provide further input, and we have already been approached to deliver further training and support for forensic services for people with learning disability, and particularly autism, in Egypt.

Psychiatry of learning disability workforce

Geoff Marston, Regi Alexander
regialexander@btinternet.com

Over the past 4 years, the Faculty Executive has collected data on the workforce in learning disability psychiatry. The following are summary points.

The most recent (2007) census figures from the Royal College of Psychiatrists indicate that there are a total of 277 National Health Service (NHS) consultants in the psychiatry of learning disability in England (232 of whom are substantive – 142 male, 90 female; and 45 are locums – 31 male, 14 female, 32 long-term and 13 short-term). The 2009 census data are awaited.

In 2007, the Faculty surveyed the independent and charitable sector service provision and identified 52 employed psychiatrists. Forty were consultants, most of whom had previously been NHS consultants. A smaller subgroup of specialist registrars had moved directly from training to the independent sector. Following this survey, an Independent and Charitable Sector Psychiatrists subgroup was set up within the Faculty. Its current chair is Dr Ray Travers (ray.travers@healthlinc.co.uk). The group maintains the most up-to-date workforce figures for this sector.

In 2008/9, the Faculty carried out a national survey of learning disability psychiatrists through a postal questionnaire, supplemented by information from the regional representatives. This focused on NHS provision and complemented the College's annual census. Although not all regions were able to submit information, a detailed local picture is now available for many regions. This is illustrated in Table 1 for the Eastern and West Midlands regions. More detail broken down by area is available from the authors.

An attitudinal survey of specialty trainees was conducted in 2008/9. Out of 74 national trainees, 65 specialist registrars' and ST4–6s' replies, by Deanery, were: London 6, Oxford 4, Eastern 7, West Midlands 10, East Midlands 4, Yorkshire 1, North West 2, Northern 7, Wales 4, West Scotland 6, South East Scotland 5. More details are available from the authors.

In 2009/10, a national picture of specialist forensic and in-patient learning disability hospital provision was mapped out. Within the 10 strategic health authorities in England, the best estimate figure was 48 high secure, 414 medium secure, 1356 low secure and 2300 assessment and treatment hospital beds. Further details about individual units are available from the authors. This information needs to be developed further to map workforce requirements within this area.

A core aim of all this work was for the Faculty workforce representative to contribute meaningfully, through the College, to the deliberations of the Workforce Review Team (WRT), soon to merge into the Centre for Workforce Intelligence, an arm's length body linked to the Department

Table 1 Psychiatrists in learning disability working in Eastern and West Midlands regions

Area	FTE allocated consultant time, demand	FTE substantive consultants in post (head count) i.e. supply	Participation rate (FTE in post ÷ head count)	FTE locum consultants in post (head count)	Consultant vacancy	SAS (head count)	SAS vacancy	ST1–3	ST4–6
Eastern region	36.6	33.6 (36)	0.93	3 (3)	0	17 (17)	0	10	9
West Midlands	42.3	33.1 (38)	0.87	5.7 (6)	3.5	21.9 (23)	1	14	11

FTE, full-time equivalent; SAS, staff grade and associate specialist.

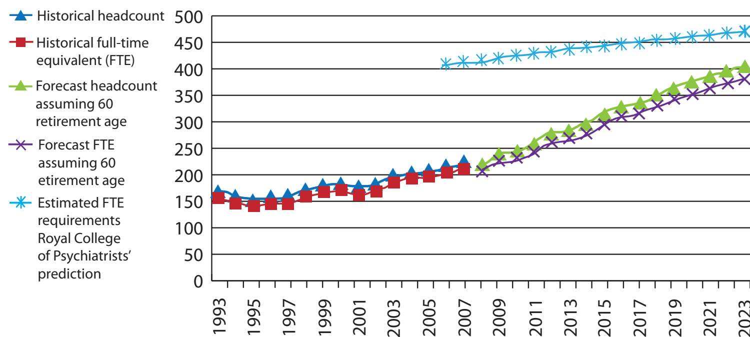

Fig. 1 Forecast and historical supply of trained psychiatry of learning disabilities specialists (NHS Workforce Review Team, 2009*a*).

of Health. It models future workforce requirements for all medical specialties in the country.

The latest WRT modelling report published in 2009 (NHS Workforce Review Team 2009*a*,*b*) suggested that the supply will not reach the estimated future requirement of consultants in psychiatry of learning disability in the foreseeable future (Fig. 1). In a finding that is helpful for our Faculty's future growth, the WRT recommended that more training posts were indicated in psychiatry of learning disability. They commented on the limited training capacity and called for more innovative methods of funding. The challenge for the Faculty is in demonstrating to policy makers the added value that psychiatrists in learning disability bring in improving treatment outcomes for our patients.

Historically, one argument raised about not transferring funds to increase training posts in the specialty was that consultant recruitment was difficult. However, that very clearly is not the case now as evidenced by competitive interviews for all advertised consultant posts in the past 2 years.

Increasing emphasis on equity of access for people with learning disability in mainstream mental health services should be matched by a commitment for equity in treatment outcome. With their training and expertise, psychiatrists in learning disability play a crucial role in achieving this. The WRT recommendation that it is important that strategic health authorities consider transferring funds into psychiatry of learning disability training and look at new innovative models of training to increase capacity is very welcome. It remains vital that the College continues its rigorous monitoring of this training to ensure that prescribed standards are maintained. This monitoring of training standards by an independent academic body like the College is ultimately one of the best safeguards for patient interests.

We hope that your regional representatives will continue to supply data on posts with particular focus on areas where recruitment is difficult. If you have any thoughts about this topic or would like to be more actively involved, please contact us via email.

References

NHS Workforce Review Team (2009*a*) *Learning Disabilities Supply Model*. NHS WRT (http://www.wrt.nhs.uk/index.php/work/specs-profs/55-medical).

NHS Workforce Review Team (2009*b*) *Migration Advisory Committee Shortage Report: Consultants in the Psychiatry of Learning Disabilities*. NHS WRT (http://www.wrt.nhs.uk/index.php/mac/169-september-2009).

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Regional representatives: update and future challenges

Richard Welfare

Richard.Welfare@nottshc.nhs.uk

As chair of the regional representatives for the Faculty, I would like to thank all the representatives who work hard in their local divisions to ensure strong and vibrant communication between the Faculty and its membership; a vital link and one that needs to be nurtured, particularly in the current economic climate.

At the end of April 2010, the Education, Training and Standards Committee approved new job descriptions for regional representatives and deputy regional representatives. This gives more clarity on the appointment process, tenure of office, roles and responsibilities. A key role is to work closely with regional advisers in providing specialist advice in the development and approval of job descriptions, and to be the voice of the Faculty at divisional level. Regional representatives' developing role in workforce issues and membership support is to be welcomed.

Over the next 12 months we are especially keen to focus in more detail on medical workforce issues in learning disability services. Regional representatives' active involvement in approval of all job descriptions gives a potential opportunity to dynamically monitor local recruitment and workforce issues and translate these into the national setting. This is particularly important at the current time, as both the Royal College of Psychiatrists and local services work through their respective responses to the country's economic challenges. Workforce data sources continue to differ in their accuracy and ability to capture live information. We are keen to ensure that the faculty has as full a knowledge of workforce issues as is possible to inform evidence-based service development.

We have already started to get detailed information about posts in various regions (see the preceding article) and are particularly keen to identify long-term vacancies/locums and 'hard-to-recruit posts' as we feel that these may be

vulnerable in the current climate. We also want to be aware of jobs where sessions are cut or modified (e.g. child and adolescent sessions being reduced as services transfer to child and adolescent mental health services (CAMHS)) to ensure that they meet the local needs of people with learning disabilities and remain viable jobs.

We hope to develop a system of notification about vacancies that trainees and others would be able to access. We are also keen to develop robust support systems for people taking up new posts in difficult areas. Regional representatives have an important role in creating and maintaining feedback loops between workforce planning at the College, Faculty and local services. However, without support from local colleagues their role becomes impossible and potentially vital intelligence is lost.

We thank you in anticipation of your support for your regional representatives. Myself and Geoff Marston (Regional Representatives' Secretary and Workforce Lead at the Faculty) are always happy to be made aware of local issues of concern. ■

Word of thanks to Sabyasachi Bhaumik, past Faculty chair

Harm Boer, Ian Hall

harm.boer@covwarkpt.nhs.uk

Sab Bhaumik's term of office as Chair of the Faculty of the Psychiatry of Learning Disability has come to an end. During his 4 years in office (2006–2010) he has led the Faculty with vision, energy and persistence. He has been able to encourage and inspire others. Sab has been instrumental in promoting a large number of projects and initiatives, and has made it a priority to communicate these with Faculty members in meetings, conferences and also in the Newsletter.

One of the first decisions Sab took when he came into office was to invite regional representatives from each English region to attend the Executive, and although the attendance has been patchy, this was illustrative of his wish to involve and communicate with all members of the Faculty.

As member of the Royal College of Psychiatrists' Board of International Affairs Dr Bhaumik has promoted, and been involved, with other members of the Faculty, in developing international links including teaching and other support in various countries (India, Sri Lanka, Pakistan, Egypt and other countries in Africa).

A major theme has been the improvement of services for people with learning disability. As part of this work Sab has been instrumental in or initiated a number of projects ranging from payment by results, dementia and Black and minority ethnic guidelines to quality standards and future roles of learning disability psychiatrists (*4-Year View from the Chair*, pp. 4–5).

Sab has led the Faculty from strength to strength, and has left it a better place. He will be a hard act to follow. ■

Recent Faculty achievements and appointments

Congratulations to all the following members.

- New regional representatives (approved in 2010):
  - Dr Rajnish Attavar (South East, Oxfordshire region)
  - Dr Yan Kon (North East)
  - Dr Rolf Feller (deputy regional representative for South West)
  - Dr Philip Bennett (Yorkshire)
- Regional representatives awaiting approval
  - Dr Shaun Gravestock (London South East, re-appointment)
  - Dr William Howie (London South West)
  - Dr Sujeet Jaydeokar (London North East)
- Faculty members who were awarded College fellowship in February 2010
  - Dr Tim Andrews
  - Dr Arumainayagam Arulrajan
  - Dr Elizabeth Carmody
  - Dr Shaun Gillespie
  - Dr Ernest Gralton
  - Dr Glyn Jones
  - Dr Winston Lim
  - Dr Tapati Mukherjee
  - Dr Sivaswami Nagraj
  - Dr Saeed Nazir
  - Dr Howard Ring
  - Dr Peter Speight
  - Dr Christopher Speller
  - Dr Raymond Travers
- Faculty members who were awarded Faculty Advisory Committee on Clinical Excellence Awards in 2009
  - Dr Harm Boer (bronze)
  - Dr Karen Bretherton (bronze)
  - Dr Helen Matthews (bronze)
- Faculty Prize winners
  - Dr Tom Selmes – Alec Shapiro Oral Presentation Prize
  - Dr Raj Dheeraj – Alec Shapiro Poster Presentation Prize
  - Ms Tracey Norwich – Professor Joan Bicknell Medical Student Essay Prize

Annual Residential Conference

Dr Regi T. Alexander, Academic Secretary
regialexander@btinternet.com

The programme for the Annual Residential Meeting this year has been revamped with a number of keynote and concurrent sessions, the latter including workshops, master classes and symposia. A substantial part of the programme has been generated through a widely advertised open call for papers. Do try and make it to the Faculty's next Annual Residential Meeting at Oulton Hall, near Leeds, on 7–8 October 2010.

Faculty of Psychiatry of Learning Disability
Annual Residential Conference

7-8 October 2010, De Vere Oulton Hall, Leeds

Conference Theme

Psychiatry of Learning Disability- Improving Patient Care through Evidence Based Practice

1 Great Venue

2 Eventful Days

11 Key-note Lectures

11 Master-Classes or Workshops

14 Oral Presentations & 40 Research Posters

Deadline for submission of abstracts for posters & oral presentations:
16 July 2010

Speakers and presenters include leading academics, health policy makers and clinicians from a range of backgrounds and specialities

Prof Sally-Anne Cooper, Prof Tony Holland, Prof Peter Tyrer, Prof Shoumitro Deb, Prof Robert Snowden, Prof Michael Fitzgerald, Prof Digby Tantam, Prof Sheila Hollins, Prof Antony Sheehan, Prof Nicola Gray, Dr Stuart Cumella, Dr Sab Bhaumik, Dr Tom Berney, Dr Peter Carpenter, Dr Sherva Cooray, Dr Rob Chaplin and many others.

An opportunity to learn, network and have fun. Don't miss it.
Book early to avoid disappointment

For a preliminary programme, registration form and submission details please visit

www.rcpsych.ac.uk/events

Tel: +44 (0)20 72352351 x6129

Email: conference@rcpsych.ac.uk

Mental Health and Illness in Young People: DVD resource for teachers

Dr Lisetta Lovett and Dr Kate Gingell, consultants in child and adolescent psychiatry

This DVD, funded by the Faculty of Child and Adolescent Psychiatry, is 65 minutes' long and divided into a number of sections covering the following topics:

- mental illness and stigma
- normal and abnormal development
- self-harm and coping strategies
- psychosis and cannabis
- depressive disorder and bipolar disorder
- anxiety disorders
- eating disorders
- attention-deficit hyperactivity disorder.

The DVD is based on the experience of running 2-day courses on mental illness in young people for teachers in the West Midlands (part of the Royal College of Psychiatrists' Images of Psychiatry campaign).

The DVD should be shown to small groups of teachers in the presence of a psychiatrist or senior mental health worker (not necessarily expert in child and adolescent psychiatry) able to facilitate discussion and field questions. It is accompanied by worksheets for teachers to fill in as they watch and a questionnaire to photocopy for participants and return to us.

If you have a link with local schools or sixth form colleges, possibly through your children, you can apply for a free copy of this DVD from Dr Lisetta Lovett (Traceyk.Pickering@northstaffs.nhs.uk) with details of where you hope to show it.

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