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Editorial Board

Angela Hassiotis (Editor)

Asit Biswas (asitbiswas@yahoo.co.uk)

Helen Miller (Helen.Miller@swlstg-tr.nhs.uk)

Bala Raju (balarajuuk@yahoo.com)

Roger Banks (Roger.Banks@cd-tr.wales.nhs.uk)

View from the Chair

Sabyasachi Bhaumik

bhaumikuk@yahoo.co.uk



Dear Colleagues,

Welcome to the second issue of the 2009 Learning Disability Faculty newsletter. Since the beginning of this year, the Faculty has continued to make significant strides in many areas, while facing substantial challenges. Among the achievements, we have now moved into the stage of publication of the guidance on the assessment, diagnosis, treatment and support of people with learning disabilities who develop dementia, developed jointly with the British Psychological Society.

We have also started the pilot self-assessment of quality standards for in-patient units for adults with learning disability through the College Research and Training Unit and we anticipate to have completed by October 2009 the policy document on the future role of psychiatrists working in learning disability. Significant progress has already been made in producing an information bank for users and carers, and the working party is pressing ahead with putting together a good practice guideline for people with learning disabilities from Black and minority ethnic groups.

Nationally, annual health checks are now a reality in most places and our Faculty Executive colleagues are maintaining close contact with the Royal College of General Practitioners in addressing the health inequalities experienced by people with learning disabilities.

Among the challenges, there are continuing concerns about training. Dr Jo Jones is working hard with the College Dean in ensuring that the competency

framework for neurodevelopmental psychiatry becomes a cornerstone for all trainees in psychiatry, including those who are undergoing core and higher psychiatric training. The College is trying to address the issues about services for people with autism-spectrum disorder and is in the process of developing a policy document which will cover all the interface areas. Dr Tom Berney has taken an active role in this regard. The Faculty is also actively looking at the strategies to improve recruitment in our specialty by influencing career choice from school to college level. In order to help recruitment, we need to actively work with our Deaneries to create foundation-year training posts in the specialty, for which additional funding is being made available nationally.

The economic downturn is going to cause a major problem in relation to the commissioning of our services in the next 2 to 3 years. Thus, we

wish to develop a support mechanism for our services by working with Dr Roger Banks who is the College lead for the commissioning of mental health services.

In this light, we are also keen on carrying on with the revision of the College Report CR115 on access to generic mental health services for people with learning disabilities.

The Executive Committee is actively debating the issue of expanding our role in neurodevelopmental psychiatry encompassing the wider areas of Asperger syndrome, attention-deficit hyperactivity disorder and other developmental disorders. A further debate regarding this will take place at the Faculty annual residential conference in October.

We have now set our next year's strategic plan and we wish to address some key themes including development of care pathways and outcomes in people with learning disabilities and mental health problems. We have also requested Dr Helen Miller to chair a working group on the Good Practice

Guideline for people with learning disabilities and sensory impairment. Dr Glyn Jones has raised the important concept of our role in liaison services and I will be discussing this with the chair of the liaison section.

The Faculty Executive Committee is actively involved in ensuring the preservation of the terms 'mental retardation' and 'intellectual disability' within the ICD-11 categories. We are in dialogue with our European counterparts in this regard.

We are also very keen to establish a clinical leadership forum for our Faculty and plan to explore this further at the annual meeting.

Finally, I wish to express my sincere thanks and gratitude to all of you for continuing to raise the profile of the psychiatry of learning disability through your local, regional, national and international work. I wish to meet as many of you as possible in Barcelona for our annual residential conference in October. ■

Letter from the Editor

Angela Hassiotis

Dear Colleagues,

I am very pleased to present the new issue of our newsletter. I am thrilled that colleagues, both trainees and consultants, have come forward to submit their work, which is of a high standard. Because of the limited number of pages we have available each time, I have made a choice about splitting the material between this and the next issue. I hope that you all find something of interest in the work presented here, which covers several topics. There are two items of personal relevance in this issue: the closure of Spencer



Close, the base of my first consultant appointment, and the obituary of Jack Piachaud, not only my consultant during specialist training but also a friend.

I would like to thank all contributors and ask our readers to consider submitting an article or comments on published articles. Please email a.hassiotis@ucl.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.

Is it time to change the Faculty name?

Tom Berney (t.p.berney@ncl.ac.uk)

Semantics

Changing attitudes and ideas are often reflected in changing names as their meaning changes or becomes pejorative. We cycled through 'mental deficiency', 'mental retardation', 'mental subnormality' and 'mental handicap' before the Department of Health adopted 'learning disability' in 1992, selected for its consistency with other labels, notably 'physical disability'. The Faculty held a ballot and, by a small margin, decided to fall into line and rename itself accordingly. However, the label has never been really satisfactory.

The term was already in use in the USA to identify 'specific learning disabilities' and they, along with the rest of the international community, are moving to 'intellectual disability' in place of 'mental retardation.' 'Learning difficulties' was used by the Department of Education to identify children with special educational needs and, although it appeared to use the same grades as adopted by ICD-10 for disability ('moderate' and 'severe'), in reality they differed in the degree of severity described. The confusion was increased because a number of services used 'disabilities' and 'difficulties' interchangeably so that, to this day, I cannot be sure what is meant when a child is reported as having a 'moderate learning disability' unless it comes with descriptive detail.

'Developmental disability' embraces a wide variety of innate disorders whose manifestations are dependant on age, including, for example, epilepsy and cerebral palsy as well as autism (pervasive developmental disorder) and dyslexia (a specific learning disability). It is a broad term, the more so as it might be argued that most psychiatric disorders, including the personality disorders and psychoses, would qualify as 'developmental disorders'.

DSM-V (expected in 2012) is using the term 'neurodevelopmental disorder' to describe a narrower group of childhood disorders, such as autism-spectrum disorder, attention-deficit hyperactivity disorder, dyspraxia, and generalised learning disability, which show in early development and are based in cerebral dysfunction. Often attenuated by age and masked by overarching disability, it is only recently that we are beginning to recognise their extent in adulthood.

This is complicated further by our different usage of 'disorder' both to describe a syndrome that has acquired the accoutrements of cause, treatment and outcome, and

a condition that is sufficiently severe to limit the functioning of the person and/or those around (as, for example, we distinguish a personality disorder from a personality type).

Service provision

Child psychiatry recognises the neurodevelopmental disorders as part of its remit, taking part in the multiagency approach to their identification and management. There has not been an equivalent acknowledgement by adult mental health services which are reluctant to take on unfamiliar disorder, particularly in the absence of resources equivalent to special education and developmental paediatrics. The result has been that adults, of overall normal intellectual ability, have found themselves without a service; even when they do have a recognised mental illness, an underlying neurodevelopmental disorder is rarely taken into account. Estimates suggest that about 1% of the general population is affected, a figure that is likely to be higher in clinic populations.

A number of pressures encourage a change in approach to these disorders:

- a rising tide of undiagnosed cases which includes not only those who have been diagnosed and require ongoing clinical management but those for whom the development of a comorbid disorder has destabilised their subclinical state
- a major political initiative in the form of the Autism Bill
- the promise of cost-effectiveness inherent in New Ways of Working which will be reinforced by the looming NHS economies
- the reconfiguration of many adult mental health services, with the development of teams that address a variety of functions ranging from early intervention to psychosis.

Our faculty

Since its establishment, the Faculty has identified itself with statutory service provision, working with the population defined by the Department of Health as having a learning disability. Originally a lifespan service, the bulk of the work was with children and adolescents and included a substantial amount of genetics and developmental paediatrics. Increased life expectancy and the growth of other specialties (particularly child and adolescent psychiatry) resulted in shift of focus towards adults with learning disability. The development of subspecialties working with young people or on forensic cases, sometimes with

multiple accreditation, has led the Faculty to include a wider variety of specialist groups and skills while retaining its core expertise in chronic disability.

Recruitment is an issue, with the worry that many perceive learning disability psychiatry as a marginal specialty and, fearing professional rustication, avoid it as their first choice of career.

New name

I propose that the Faculty should change its name to the Faculty of Neurodevelopmental Psychiatry to reflect its members' expertise in a group of disorders, rather than a service alliance. Such a change would not mean that the psychiatrist should automatically provide a service for, say, adults with Asperger syndrome; simply that, given the resources and interest, they would be eligible to join or develop such a service. Nor does it mean that the service should change its remit or its name; the psychiatrist might well continue to work in a 'learning disability' or 'learning difficulties' team. It is important to recognise that the College defines psychiatrists' training and expertise and that it is the service (and the contract) that defines the nature of their practice, what they actually do (as, for example, a child and adolescent psychiatrist who may be employed in a service restricted to work with adolescents).

Advantages

Services are evolving differently across different parts of the country and their various jurisdictions. Separation of specialty title from local labels would indicate that our members have the flexibility to respond to these developments.

The name will tell our colleagues about a range of expertise that goes beyond the IQ cut-off. It is not a bid for exclusivity but merely an indication that we can overlap with other psychiatric specialties to provide a service based on the patients' need in that particular locality. A comparison can be made with the way that College's reviews of services for young people with a learning disability have avoided assigning this either to child psychiatry or to learning disability psychiatry but have left it open for both specialties to provide the service that best fits local circumstances.

This move would broaden our advertised remit in line with our curricula (past as well as present) which cover the knowledge and skills necessary to manage long-term disability. We are well used to working with the other agencies that provide teaching, training and supported living for people with limited survival skills. At the same time, we cannot be compelled to accept new responsibilities without

the resources to fulfil them, including both sufficient clinical time and adequate further training.

Taking a more adventurous line, putting the emphasis on a form of medicine rather than on a circumscribed service group, is likely to attract a wider range of potential recruits.

Drawbacks

Any change involves bureaucracy which must make us ask whether it is worthwhile.

The remit of learning disability psychiatrists was largely coterminous with that of the clinical teams in which they were embedded. This move would mean that a number will find themselves effectively in split posts; either working on their own, in a liaison role, or with other teams, should they take on a new group of patients. The more diffuse boundaries will mean that referral pathways, once sharply defined by IQ score, move even further towards individual negotiation.

Although a doctor's service obligations are defined by contract, there is often an escape clause that allows them to be directed to other duties as their managers see fit. Broadening the specialty remit might open the door to such redirection and raise the anxiety that it would be taking us beyond our competence, promising more than we can deliver, and thereby setting the stage for accusations of incompetence

Conclusions

Widespread review of a variety of psychiatric services makes this the time to discuss whether we should seize the opportunity to change our name and identity, to separate clinical expertise from service commitments, and to advertise our particular expertise in psychiatry. ■

Closure of Spencer Close assessment and treatment unit: Armageddon at the door?

Edward da Costa (dcedwa@aol.com),
Mary McLaughlin, Elinore Percy
and Abir Mukhopadhyay

Dr Fitzgerald's account of possible renewal following the trials and tribulations contending the learning disability villas at Chase Farm Hospital, Enfield (Fitzgerald, 2008) was read with avid interest, as it evoked many similarities with the experience of staff at Spencer Close, which is a learning disability assessment and treatment unit. Commissioners had informed the staff that they would be presiding over its demise imminently by the end of March 2009, citing various developments locally, such as home assessment and treatment services and the availability of another in-patient unit in the trust's catchment area reducing the requirement for in-patient beds, besides staff recruitment difficulties, purported bed blocking and lack of turnover of patients. Staff felt that by unearthing, unravelling and objectively appraising the available evidence in this context themselves, they would be in a better position to judge whether closure was indeed appropriate and inevitable, and if this was not the case, they would attempt to persuade commissioners otherwise. The following is a narrative of this venture and its eventual culmination.

Background

Spencer Close was established in 1987 as a 15-bed learning disability assessment and treatment unit for individuals with psychiatric disorder, including challenging behaviour. It served the catchment areas of Epping Forest, Harlow and Uttlesford, on the same site as the local National Health Service (NHS) hospital, St Margaret's. As was the case in Enfield, the buildings were new, shiny and forward-looking, and the unit symbolically bore its name from the late Princess Diana, who presided over the inauguration. The unit had a day hospital and a wealth of multidisciplinary expertise that heralded new approaches to care, avoiding the pitfalls of institutional care. At its conception, it was complemented by a social care-based unit, Ferguson Close, of approximately double the bed numbers, which catered to individuals with less complex needs, but not as yet capable of living in the community.

Changes in the service

We reviewed the last 10 years' admission and discharge figures for Spencer Close, which showed that between the years 1995 and 2000 there was a consistent throughput of service users, of around ten per year. In 2001, however, a number of service-related changes took place, which inadvertently led to 'bed blocking' that persisted subsequently. First, a change from permanent to locum consultant psychiatrist left the service without a consistent clinical lead. A strategic change in the service model also took place, with the remit of the service altering to provide intensive support beds and medium-term rehabilitation to service users with highly complex and challenging needs. This resulted in a mix of clients, with some highly vulnerable service users living alongside service users with a forensic history, making the development of a coherent service model very difficult.

Recruitment and other issues

An intensive support (admission) service was then set up in Colchester, following which Spencer Close reverted back to an assessment and treatment unit; however, it took a number of years to move on those service users with the most complex and challenging needs and it was difficult to gain support from Social Services to do so. As a result, the momentum of assessment and treatment was lost and has never been regained. Part of the reason for this was the struggle to recruit skilled nursing and support staff, given the nature of the service and its location on the fringe of London. The lack of nurses meant that the service could not admit service users detained under the Mental Health Act 1983, and in 2004 conflict between existing service users and the need to act under the vulnerable adults framework (Department of Health, 2009) led to the service developing a number of single units for certain clients. In accordance with the government directive for the re-provision of 'NHS campus patients' into the community by the year 2010, nine of the ten in-patients were deemed appropriate to be re-provided in community settings. Staff felt that the re-provision of this existing service offered an opportunity for a new service to be developed to serve the needs of the local population with learning disability.

Policy guidelines

The need for specialist beds has been unequivocally mentioned in national policy on service provision (Scottish Executive, 2000), estimating that about four beds per 100 000 population will be required. Service users needing admission to hospital should be treated as close to home as possible. The *Valuing People* strategy (Department of

Health, 2001) specifies that at a local level there should be representation from learning disability service providers on National Service Framework for Mental Health implementation groups to ensure that people with learning disabilities benefit from this initiative (Department of Health, 2004).

Staff proposed that the new service would have a clear assessment and treatment/crisis admission bed model of care, which dovetails with the existing in-patient services based in Colchester and meets local need in conjunction with community-based services. By the end of 2005, the multidisciplinary team had a substantive consultant psychiatrist and consultant psychologist besides other multidisciplinary team members, who were committed to working with the stable team of nursing and support staff that had been in post for a few years.

Current service status

The service at Spencer Close is presently part of North Essex learning disability services, which has a 6-bed assessment and treatment unit for a population of approximately 900 000, admitting patients for a maximum of 6 months, and an adjacent 8-bed intensive therapy unit for patients requiring longer-term rehabilitation. An audit of the six-bed unit revealed 21 admissions in 1 year (2005/2006), with an average stay of 140 days. Since the inception of the intensive therapy unit, there had been 19 admissions in 7 years until 2006. During 2006, six patients were admitted to the private sector and four in other 'out-of-area' NHS facilities from the entire trust catchment area, which reflected the pattern in previous years. During this period, five patients from the Spencer Close catchment area were admitted to the respective general psychiatry wards with concerns raised about the appropriateness of this move in at least three individuals. It was therefore clear that despite the existence of the home assessment and treatment service, there was a trend towards out-of-area, independent sector and general psychiatry admissions at defined periods of time.

Lyll & Kelly (2007) had shown that a reduction in their assessment and treatment beds in Lothian had resulted in a similar increase in the use of general psychiatric beds.

Conclusions of the review

The staff therefore felt that the evolution of events in the life of the Spencer Close unit self-indicated that it did fulfil its role well before falling victim to idiosyncratic policy-making and expediency on the part of commissioners and managers, rather than manifesting significant intrinsic deficits. Evidence from policies on service provision as well as the pattern of in-patient service use locally was sufficient to confirm that the unit still had a viable and important role.

However, all our efforts to convince the commissioners to change their recommendations in this context have proved futile, leaving many staff and service users bewildered.

What next?

Should we conclude that Armageddon is increasingly at the door of locally based learning disability assessment and treatment units in the current market-driven philosophy of care? Such services may be perceived as an expensive investment and a luxury when mainstream units could be the significantly less expensive default option that also provides for the same need. However, there is considerable debate as to how well they do so. Does quality of care still have primacy over best value and is there an objective way to draw the line to balance these priorities? Were we just unlucky in being subjected to commissioning idiosyncrasies confined to the local area where running an in-patient unit is perceived to be fraught with difficulties and at high risk of failure and hence not worth the gamble, or is there a wider trend in this context? Were our commissioners indeed justified in their appraisal of the evidence? Were there other reasons to consider? Our staff and service users would like you to be the judge. ■

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A workshop to help trainees in learning disability psychiatry prepare for the transition to consultant

Iain Jolley (iain.jolley@ridgeway.nhs.uk),
Raj Attavar, Peter Cutajar and
Tonye Sikabofori

The step up from trainee to consultant can be quite challenging. We held a workshop for specialist registrars (SpR) in learning disability psychiatry to help them prepare for this transition. We focused, in particular, on issues to do with getting the right management experience, finding jobs, succeeding at interview and coping with stress, and looked at mentoring for new consultants. The workshop was well-received and the trainees found it helpful and supportive. We suggest similar workshops be made available for all trainees towards the end of their higher specialist training.

We co-facilitated a workshop titled 'Transition from SpR to consultant – prepare yourself for a smooth landing' at the Learning Disability Faculty annual conference in Manchester, October 2008. About 20 people attended and the feedback was very positive.

Brief presentations by, and reflections of, the conveners' own experiences gave the participants the opportunity to hear some views from an experienced consultant, a recently appointed consultant in his first post, and a trainee. A discussion followed.

Challenges

Dr Sikabofori (SpR) talked about some of the challenges faced by trainees in learning disability psychiatry. He discussed the need to strike a balance between service provision and training, and reflected on the importance of keeping up to date with clinical evidence and changes in the NHS. He mentioned the difficulties some trainees encounter in getting involved in research and having work accepted for publication. He then spoke about the process of mental preparation required to make the transition from SpR to consultant, and talked very frankly and honestly about some of his own concerns. Additional concerns were raised, such as the training implications of a diminishing study leave budget and an apparent lack of knowledge about precise training requirements among some educational supervisors. There was an opportunity to celebrate success too,

and we heard from some members of the group about a range of very positive training experiences.

Management experience

Dr Attavar introduced a number of issues to do with trainees getting the right sort of management experience. The group agreed that management experience is absolutely essential, and should be considered a core part of training. We acknowledged the existence of a variety of opportunities through everyday clinical work, but stressed the need to seek out more specific management training and experience. We agreed that, although there is something to be gained from shadowing a manager, a trainee is much more likely to learn by taking the lead on a range of management tasks under expert supervision.

Finding the right post and preparing for interview

Drs Attavar and Cutajar, both consultant psychiatrists, raised a number of points to do with finding the right consultant post and preparing for consultant interviews. The group agreed it is generally necessary to consult a range of paper and online publications, such as *BMJ Careers* and www.jobs.nhs.uk, when looking for a consultant job. We emphasised the need to be proactive, to 'network', 'ring around' and so on, and talked about the risk of losing out to more assertive candidates by waiting for posts to be advertised before expressing an interest. Some of the issues to do with long-term vacancies and unadvertised posts were also discussed. We agreed that the regular publication of a list of current vacancies by a coordinating body, such as the College, would be extremely helpful. We discussed the need to consider all the most obvious practical aspects of any consultant post (like the location, clinical setting, pattern of work and on-call commitment) when thinking about making an application. We stressed the need to do some extra work to find out as much as possible about other, less immediately obvious, factors (such as the management structure, nature of the multidisciplinary team, financial state and vision of the trust, and general sense of morale among staff).

We agreed it would be unwise to base a decision about the suitability of a post on the advertisement or job description alone. We talked about the value of finding out as much as possible about the members of the interview panel too. We reflected on the importance of first impressions, and reminded ourselves that the panel will be looking to appoint someone prepared to function at consultant level from day one. We recognised the need to be both confident and ready to articulate how one might aim to contribute to the

success of the organisation in the future. Some of these issues are addressed in more detail in Brammar (2008) and McKenzie *et al* (2000).

Rewards

Dr Cutajar talked about some of the rewards and challenges associated with working as a consultant in learning disability psychiatry, for example, the personal and professional satisfaction to be derived from working in the field. He commented on the opportunities for professional autonomy, flexible working and the development of close working relationships with colleagues from a range of backgrounds. He acknowledged the potential for a heavy workload too, and spoke about the possibility of a sense of professional isolation at times. He reflected on the need to cope with inevitable incidents of conflict within the multidisciplinary team, and advocated taking responsibility and dealing with complaints. He talked about a range of coping strategies, but highlighted, in particular, the importance of learning to say 'no', being prepared to delegate, and developing strong working relationships with other senior members of the team as well as keeping in regular touch with other medical colleagues. This led to a discussion about mentoring for new consultants.

Mentoring

Dr Attavar then talked about his own very positive experience of having had a mentor in his early days of working as a consultant. We agreed a mentor should be someone who is available and prepared to act as a 'sounding board'; someone willing to offer confidential advice and support, share coping skills, and relieve some of the sense of isolation a new consultant is bound to feel. We clarified that most trusts now publish a list of people (usually, but not always, doctors) prepared to act as mentors, and agreed that most trainees would be very interested in linking up with a mentor when they first begin to work as a consultant. The College has issued guidance on this subject (Royal College of Psychiatrists, 2008).

Final considerations

We took some time to think about the session after the event and tried to clarify what we considered the most important learning points. We felt the workshop had been a great success. A few people noted a degree of overlap between the three talks, and said they would have liked more detailed information about certain topics, but the feedback was otherwise overwhelmingly positive. Members of the group seemed comfortable with the format. The

atmosphere was non-judgemental, and participants proved willing to share some of their concerns in a very frank and honest way.

The discussion was mostly focused on a range of practical issues to do with getting a consultant job and coping with all the challenges associated with starting out as a consultant. Participants wished to think about how best to cope with the anticipated initial sense of isolation and step-up in responsibility, and wanted some guidance on how to deal with much more unfamiliar issues such as management and service development. They appeared particularly keen to learn more about mentoring for new consultants and seemed to take comfort from the fact that they should not have to feel totally alone when it comes to taking up their first post.

We all agreed we would be very keen to run the workshop again and would be interested in facilitating separate sessions to cover some of the topics in more detail.

For further reading, we suggest trainees consult the excellent online information guide published by the Psychiatrists' Support Service which covers many of the topics discussed here (Psychiatrists' Support Service, 2008). ■

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Regional representatives for the Faculty of the Psychiatry of Learning Disability

Geoff Marston (geoff.marston@cov-warkpt.nhs.uk) and Richard Welfare

What are regional representatives and what is their role?

Each division of the College has a post of specialty regional representative for each faculty/section. This is an internal College appointment, with the main duties specified as:

- to provide specialist advice to the regional advisor on job descriptions for consultants, specialist registrars (SpR) and staff and associate specialist (SAS) doctors
- to support the deputy regional advisor and faculty/section in collecting accurate census/workforce planning data
- to offer advice to chairs of divisions/faculties/sections on nominations for fellowship and distinction awards
- to bring any local issues of concern to the attention of the regional division executive and faculty/section
- to offer advice on other salient aspects of services and implementation of College policy, including mentoring arrangements
- regional representatives may be asked to sit on advisory appointment committees for consultants, SpRs and SAS doctors (except in Scotland).

Within the Faculty of the Psychiatry of Learning Disability these duties have been further defined as: to try and improve communication between faculty members and the executive; to provide more detailed and up-to-date workforce surveys; and to promote awareness of the type and number of jobs being approved or advertised in each region by regular audit.

How are regional representatives appointed?

Local arrangements may vary slightly, but in general an interested local consultant will put their name forward, with a proposer, to the regional consultant group. If there is more than one candidate, a vote or secret ballot (up to local discretion) may be needed.

Once a nominee is agreed, they need to forward their CV to the chair of the national faculty/section executive. Their appointment will then be discussed at the next executive

meeting and acceptance confirmation will be sent by the faculty chair. At the same time, the local divisional chair and regional advisor are also notified. The application is forwarded to the Education, Training and Standards Committee for final approval. The position is for 5 years, although it can be extended if agreed locally.

What are the commitments?

The regional representative needs to respond promptly to requests from the regional advisor to assess new job descriptions. They are expected to attend two learning disability regional representatives meeting a year, at the spring (April) and residential (October) meetings, and the strategy meeting of the faculty executive (June). Most will attend their divisional executive meeting (usually four per year), though in some areas, such as London, only one agreed regional representative will be invited. Those learning disability regional representatives attending divisional executive meetings are also encouraged to attend all of the Faculty of the Psychiatry of Learning Disability executive meetings (four per year).

It is hoped that from 2009 all learning disability regional representatives will provide regular reports to the executive committee about:

- local issues of concern
- local job descriptions (audit tool in use)
- local appointments and vacancies
- local learning disability psychiatrists with specialist interests, who would like to support the faculty from time to time (e.g. reviewing policy etc.) as part of a 'think tank'.

They will also be expected to disseminate the main issues of concern to the faculty with local members and to encourage local consultant/SAS groups and learning disability mentoring if they are not available.

Where do I find out who is my regional representative?

The faculty area on the College website has a list of regional representatives (<http://www.rcpsych.ac.uk/college/faculties/learningdisability/aboutthefaculty/regionalreps.aspx>). This is regularly updated, but sometimes information can be out of date. If there is any confusion, please contact Kitti Kottasz, committee manager, at: kkottasz@rcpsych.ac.uk.

The current chair of the learning disability regional representatives is Dr Richard Welfare (Trent; richard.welfare@nottshc.nhs.uk) and the secretary is Dr Geoff Marston (West Midlands).

Regional representatives are appointed to be of service to local members, to communicate their opinions and concerns, and identify key local issues so that the executive can pick up national trends and represent members in the best way possible.

Please get to know and support your local regional representative, or consider offering your services if there is no one appointed.

Current vacancies exist in the following regions:

- Northern and Yorkshire: northern region
- Scotland east (Dundee)
- Scotland north east (Aberdeen)
- Scotland west (Glasgow). ■

Learning disability in Parliament

Ian Hall (Ian.Hall@thpct.nhs.uk) and Neil Balmer

With all the current political turmoil around expenses and the recession one might expect that people with learning disability are not very likely to get a look in at the seat of power. But actually there are signs on several fronts that politicians are taking more notice of learning disability and mental health issues, which will hopefully lead to future service improvements. In this article we discuss how Learning Disability Faculty members can get involved in the political process, but we will start with two success stories.

Working with MPs, Peers and service users

Most people will be familiar with Mencap's *Death by Indifference* report (2007) that describes how six people died because of lack of care for their physical health. Mencap runs the all-party parliamentary group on learning disability, a group of MPs and Peers interested in people with learning disability that meets in Westminster. Other stakeholders are invited, and contribute enthusiastically, including many service user representatives as well as several members of the Faculty. Over the past year, they have used their *Death by Indifference* work, the subsequent independent inquiry in access to health (Michael, 2008) and the *Six Lives* Ombudsman's report (2009) to really raise the profile of the access to health issue in Parliament.

This has had practical application in helping to ensure that the Equality Bill retains the duty of public bodies to make reasonable adjustments for people with learning disability, a duty that has been crucial in promoting the access to health agenda. The use of individual stories, both in the reports and in meetings of the all-party group, has been a very powerful agent of change.

Work on autism

The National Autistic Society runs a similar all-party group on autism (www.autism.org.uk/appga). Their work is also very impressive. They have completed an inquiry into transition to adulthood of young people with autism (Allard, 2009) (to which the College submitted evidence) and have also managed to support a 'private members' Autism Bill. They have used their lobbying and influence (to which the College contributed) to persuade the government to adopt this Bill. Thus, the forthcoming autism strategy for England to be published in December 2009 will have the force of 'statutory guidance', meaning that primary care trusts and local authorities will be subject to judicial review if they do not implement it. Many things are proposed for the strategy (see the Department of Health's consultation document, 2009), but it will certainly aim to improve access to services for people with autism who at present fall between the gap between learning disability and mental health services.

You can get involved

These are two excellent examples of campaigning making a real difference to people with learning disability. The College is keen to address the political agenda by developing its own campaigning skills and those of its members. It launched a 'political pack' at the 2009 Annual Meeting as part of the Fair Deal campaign (available at www.rcpsych.ac.uk/campaigns/fairdeal/fairdealpoliticalpack.aspx).

It is a set of information sheets which can be used as practical tools for College members, service users and carers, and anyone who might want to raise Fair Deal priorities with parliamentarians and with local government. Topics covered include explaining why and how MPs can help resolve local issues, how to get them interested, finding the best person to contact, and suggestions about what exactly you might ask a parliamentarian to do to take the issue further, for example asking parliamentary questions or taking the issue up with the relevant minister. Considering the forthcoming public service spending cuts, we need to be sure people with learning disability are well placed in the 'pecking order', and Faculty members raising issues with politicians is an important way we might achieve this,

particularly where there are service gaps or poor treatment of people with learning disability. Positive examples of how things can be solved or done well are also really helpful.

Users' and carers' voice

Even more powerful than the professional viewpoint is the voice of users and carers. Mencap and the National Autistic Society enable users and carers to lobby politicians, and we should be doing the same. For the first time this year, we will be including mental health service users as part of the College delegation to the Labour Party Conference in the autumn. It would be a great development of the Faculty's work to engage users and carers if we could include service users with learning disabilities in the College delegation to party conferences in future years. ■

References

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- Department of Health (2009) *A Better Future: A Consultation on a Future Strategy for Adults with Autistic Spectrum Conditions*. Department of Health.
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- Mencap (2007) *Death by Indifference*. Mencap.
- Michael, J. (2008) *Healthcare for All: Report of the Independent Inquiry into Access to Healthcare for People with Learning Disabilities*. Department of Health.

Obituary: Michael James Henry (Jack) Piachaud (1948–2009)

Regi Alexander
(regialexander@btinternet.com)

Jack Piachaud was born on 6 June 1948. After graduating in medicine from Oxford University in 1973 and completing his psychiatric training at the Royal Free and Maudsley hospitals, he became a consultant psychiatrist in mental handicap in 1981. Over the next 20-odd years he guided

and shaped service developments in Harperbury, Haringey, Westminster and Hertfordshire, working within both hospital and community settings. A tireless advocate for the rights of people with learning disabilities, his keen intellect and gentle manner made him a much respected clinician and medical manager, who had stints as the clinical director of the Eric Shepherd unit and the medical director of Horizon NHS Trust.

As an Honorary Senior Lecturer at St Mary's Hospital and Imperial College London, Jack was involved in some of the pioneering work around training medical students on disability issues. He was a widely published author and an inspirational teacher. Above all, his personal warmth, wisdom and limitless capacity to listen meant that for many junior doctors, particularly those on the St Mary's and Charing Cross psychiatry training schemes, he was a favourite mentor. It was a relationship that many of them were fortunate to carry on having with him till his death.

Jack had an abiding belief in the power of ideas being greater than violence. He has written about the Nobel Laureate, Lord Boyd Orr, himself a doctor and a founder member of the Medical Association for the Prevention of War, who described war as the worst of the psychological diseases of human society and considered its prevention as the most important part of preventive medicine. It was belief in that ideal that informed Jack's lifelong commitment to victims of conflict. In the 1980s, he was an active member of the Medical Association for the Prevention of War and the Medical Campaign against Nuclear Weapons. When these organisations merged to form the charity Medact, Jack became its treasurer, a position he served in till 1998.

In 2001, Jack took early retirement from the NHS to spend more time on his charitable and social welfare activities. He was an active member of the Labour party through good times and bad, chair of governors of the local school, psychiatrist for the Medical Foundation for Victims of Torture, chair of Medact Violence, Conflict and Health group and editor of the journal *Medicine, Conflict and Survival*. Till the later stages of his illness, he continued working on a number of projects that brought together medical students and health professionals to help victims in conflict zones.

Jack Piachaud died of lung cancer on 10 February 2009. He leaves his wife Anne and their three children, Nicholas, Thomas and Sarah. ■

Awards

THE PROFESSOR JOAN BICKNELL MEDICAL STUDENT ESSAY PRIZE 2010

This prize was established by the Faculty of the Psychiatry of Learning Disability to be awarded for an essay written by a medical student about their contact with a person(s) with learning disability during the course of their studies, in collaboration with the person(s). The essay should focus on the ways in which the student's training has been influenced as a result. The award aims to raise the awareness of issues of disability in medical training and to encourage students to pursue further study and professional training in this area.

Prize: £250 **Frequency:** Annually **Eligible:** All clinical medical students in the UK and the Republic of Ireland
Presented at: 2010 Faculty spring meeting (usually held in April)

Closing date: 1 December 2009

Submissions to: Academic Secretary, Faculty of the Psychiatry of Learning Disability, via Kitty Kottasz, committee manager, Tel: 020 7235 2351 ext 299, email: kkottasz@rcpsych.ac.uk

NATALIE COBBING TRAVELLING FELLOWSHIP 2010

The Faculty of the Psychiatry of Learning Disability is pleased to offer a travelling fellowship in the memory of Natalie Cobbing.

Prize: £3000 **Frequency:** Biennially – next award 2010 **Eligible:** Fellows/Members/Affiliates, senior house officers/specialty trainees 1–3, and College staff and officials in the UK and Ireland

Closing date: 28 February 2010 (biannual)

Submissions to: Chair, Faculty of the Psychiatry of Learning Disability, via: Kitty Kottasz, tel: 020 7235 2351 ext 299 email: kkottasz@rcpsych.ac.uk

FACULTY OF THE PSYCHIATRY OF LEARNING DISABILITY EDUCATIONAL BURSARIES

The Faculty has established an educational bursary fund of £2000 per annum. The fund supports:

- specialist registrars/specialty trainees 4–6 and staff grade/associate specialist doctors working in the field of learning disability who have been unable to obtain alternative, or sufficient, funding to attend College meetings and other appropriate educational activities
- learning disability psychiatrists from low-income countries may apply for a bursary of up to £500 to assist in attending either the Faculty's annual spring or residential meeting (April and October) or the College Annual Meeting (June/July). No more than two such grants should be made per year (subject to annual review).

In all cases, the Faculty Chair together with the Honorary Secretary, Academic Secretary and Finance Officer will jointly decide, on behalf of the Faculty, whether a bursary should be granted.

Enquiries to: Finance Officer, Faculty of the Psychiatry of Learning Disability, via Kitty Kottasz, Committee Manager, tel: 020 7235 2351 ext 299, email: kkottasz@rcpsych.ac.uk



Look out for the new learning disability chapter, published in the October and November 2009 issues of *Psychiatry*

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