ROYAL COLLEGE OF PSYCHIATRISTS

Psychiatry of **Intellectual Disability**

Newsletter of the Faculty of Psychiatry of Intellectual Disability APRIL 2019 Vol 21, Issue 1

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TRANSFORMED?

12/12—03/19….and beyond

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Submitting articles: This is the Faculty members' newsletter and we encourage anyone to submit articles. The shorter the article and the more straightforward its language and style, the more likely it is to be read. We welcome thought-provoking and controversial material which might get a constructive response from readers. The Editor reserves the right to edit contributions as deemed necessary. Copyright of submissions are retained by its author, but the College reserves the right to reproduce the article on the Faculty website pages.

Please email articles to either the **Editors** (psychidnewsletter@gmail.com) or **Kitti Kottasz**, Faculty Committee Manager (intellectualdisability@rcpsych.ac.uk).

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Editorial

Giri Madhavan

Editor

Care Transformed?

Welcome to the April 2019 edition of the Faculty Newsletter. Tom, Elizabeth and I are delighted to welcome Sujeet, Geoff and Indermeet to the editorial group. We do hope you enjoy this issue which has been a labour of love for us all. None of this would be possible without all of our contributors. I'm pleased that in addition to our regular columns, our ID SAC chair, Mary Barrett, is starting her regular report from this issue on.

Many thanks to those who responded to the feedback request in the previous issue. Whilst the responses were positive, which is great to hear, we also noted that there was appetite for more controversial topics. We would certainly welcome these and encourage our members not to hold back. Opinion pieces would definitely be considered.

In preparation for this issue, there were notable deadlines looming beyond producing the newsletter. Brexit and Transforming Care had planned endings in March 2019. Harinder Bains provides an overview of history of Transforming Care as well as insights into how this is shaping the future. It would be amiss of me not to refer to the some of the controversies raised. These include last week's news report on NHS England *"committing to halving the number of people with ID in hospital but achieving only 19%", the BBC File on 4 "Transforming Care– Is it Working?" as well as a recent BJPsych Bulletin publication by John L. Taylor "Delivering the Transforming Care programme: a case of smoke and mirrors?".*

Rachel Steele gives us a research round-up as well as a focus on the important issue of transition from child to adult services. Geoff Marston and Jan Birtle provide a brief overview of mentoring /coaching and its potential benefits with signposting to being a mentee or becoming a mentor. Indermeet Sawhney and Asif Zia highlight the importance of keeping in mind that for incapacitated patients, detention should not become a default position as a consequence of their inability to challenge their detention.

Richard Burrows expands on the recent Supreme Court Judgement of two cases that you may recall he discussed at the 2018 Faculty Annual Residential. Laura Korb shares her experience of attending a Faculty Executive meeting and her QI project that won the Alec Shapiro 2018 prize which focussed on developing a Baseline Clinic for people with Down Syndrome. Rory Sheehan, Gregory O'Brien Prizewinner, shares his experiencing of ID research in the Netherlands and France. Jaleel Khaja shares his personal thoughts on the decisions that brought him into ID training.

David Clarke, well known to Faculty members from his work in the field over the decades, kindly agreed to being interviewed. It was great to hear that he didn't pursue becoming a record producer and the field of ID is all the better as a result. Fionnuala Williams, our outgoing National Trainee co-representative, reports on the recent trainee conference in Edinburgh. And finally, Oliver Duprez and Tawakalitu Kehinde report on the East of England Annual conference.

As always, we welcome articles of interest to Faculty members. We look forward to seeing many of you at the Spring Conference in April #PsychID2019 .

Giri Madhavan, April 2019

Co-Editors:

Tom Berney, Sujeet Jaydeokar, Geoff Marston,

Elizabeth O'Rourke, Indermeet Sawnhey

View from the Chair

Dr Ken Courtenay

Chair of Faculty of Psychiatry of ID

@KenCourtenay

April is a good time of year to mark the changing of the seasons and a time to look forward. The Faculty Spring Conference will take place on 26 April in the College and I am delighted that our President, Wendy Burn, will join us. It will be her first engagement with the Faculty since taking up office. I have had the pleasure of getting to know Wendy and how supportive she is towards us in the Faculty.

The Faculty Executive Committee will meet this month with a lot of business to deal with not least the future of Transforming Care in England. We are keen to learn about the implementation plan promised in the NHS Plan at the next meeting on 2 May 2019. It will be a good opportunity to make progress on the gains from TCP embedding them in to practice. Some would argue that it has not achieved what it intended but we should acknowledge the successes. I see them in my own practice where people who have spent over 20 years in hospital are living well in the community with the right support. Full-scale system change is hard to achieve but through our clinical leadership we can make the difference in local services.

You will learn from Mary Barrett in this issue that recruitment to the specialty is a challenge. The Faculty is embarking on efforts to ensure that we enhance the appeal of the specialty to junior doctors. I am very pleased that our current trainees are engaged with our efforts to promote what we do and the essence of our work. However, it will be down to all of us working together in local services to reverse the current trend on recruitment to the specialty.

I had the pleasure of meeting Dr. Arun Subramanian in Northern Ireland and his colleagues this month. It was interesting to learn how health and social care are delivered in the province. I am keen to meet with colleagues around the country and will visit colleagues in the West Midlands in June. Be sure to get in touch with me to arrange dates in the diary.

And finally, I am very much looking forward to the Annual Residential Meeting in the Hilton Hotel in Leeds on 26/27 September. The meeting is always the highlight of the Faculty year and thanks to our academic secretary, Rohit Shankar, promises to be a good one.

Ken Courtenay (ChairFacultyPID@rcpsych.ac.uk)

Chair, Faculty of Psychiatry of Intellectual Disability

Royal College of Psychiatrists UK

April 2019

View from the ID Specialty Advisory Committee

Dr Mary Barrett

SAC Chair

To introduce myself to those whom I haven't yet met, I am Regional Training Programme Director for Higher Specialty Training in ID across the East Midlands. I joined the SAC on it's inception in 2017 and was appointed to the role of Chair in July 2018, further to John Russell taking on the role of Associate Dean for Curriculum. On behalf of the Committee I would like to thank John for his hard work and excellent leadership over its first formative year. It is excellent to have John leading on Curricula redevelopment at College level, and we look forward to continuing to work with him on this. The SAC has continued to be busy and productive - here are some of the headlines I would like to share with you:

Curriculum Rewrite

At our meetings in November 2018 and February 2019 we have started to work on the ID Higher Curriculum rewrite. Our timeline for this is set by the GMC and also has to link in with the equivalent work going on in other Psychiatric subspecialties. Key dates to note are **September 2019** when we have to submit our ID Purpose Statement and Higher Learning Outcomes (HLOs) – if these are accepted by the GMC, then **May 2020** is when we will submit our full curriculum.

For this first stage, it is vital that we produce a strong Purpose Statement and clearly differentiated HLOs. The GMC Curriculum Oversight Group (The body responsible for reviewing the first stage of applications) had requested the Royal College to consider one single 'generalist' CCT plus several credentials, so providing clear evidence for the need for a three-year higher training programme for ID is going to be crucial. We have a further two SAC meetings booked in March and June to pull this work together.

My thanks to those who have volunteered their time, knowledge and skills to the SAC to support this important work – it has been really encouraging to see the enthusiasm and intellectual effort that is present in the Faculty members who have engaged with us. Particular mention at this stage goes to Sonika Bhasin, Jennifer Dolman, Mark Scheepers, Harriet Slater and Ross Spackman who have joined the committee to support the full rewrite process.

Alongside the SAC's work, I also attend the College-wide Curriculum Revision Working Group, representing ID in the Core Curriculum rewrite process. My fellow SAC Chairs also attend which helps good communication and dialogue between the Psychiatric subspecialties as well as the opportunity to 'sense check' what we are developing in our individual committees. This dialogue will be particularly important when we then move on to start to look at shared capabilities across the Higher Curricula.

Those of us involved in rewrite process are aware that it is a challenging one and a major responsibility in helping ensure the future of our Specialty as a distinct training path. Alongside this, however, is a sense of shared purpose and excitement in the group and the chance to make a real difference to training for years to come. If you feel you have a particular area of interest or expertise that you would like to contribute to the process, please get in touch with me.

Credentialing

In the last few months the GMC had circulated a draft framework for Credentialing, for comment. Credentialing is now expected to become a reality from Summer 2019, and not some time in the 2020s as previously expected. This is due to the decision to include credentials not on the specialist register, which would require a change in British law, but instead on the list of registered practitioners, which does not. I am frequently asked whether an ID Credential will be developed. The picture is developing as we speak, however from the feedback we have to date there is nothing imminent and it would be hard to see how a three-year training programme could be condensed into a 1 year credential.

CESR

As SAC Chair, I have been receiving an increasing number of enquiries from Consultants working in ID Services who have a CCT in another specialty, for example CAMHS or Forensic Psychiatry, and who want to achieve accreditation for their ID work. Nandini Chakraborty, Associate Dean for Equity at the Royal College of Psychiatrists, is championing the use of the CESR for this purpose; in particular she is working to make the process less complex and cumbersome. Interested persons should contact her on nandini-chakraborty@doctors.org.uk ; there is also a training day for CESR applicants on 10 May at the College, bookable through CALC.

Recruitment

The National Recruitment Interview Process has undergone some changes, with enhancement of the Portfolio Station, removal of the Leadership and Audit Station and extension of the Interview Station to include viva questions.

Recruitment rates remain a matter of concern to the SAC, with just **16% of trainee vacancies filled at the last round of recruitment**. The SAC is keen to promote development of FY3 ID posts, in order to help promote recruitment into the specialty. The SAC is also keen to support the Faculty Recruitment Strategy being developed by Ken Courtenay. A number of SAC members attending the recent successful Working Group; following on from this I have been asked to join the Recruitment Strategy Steering Group and three other SAC members (Gill Bell, Ian Hall and Niraj Singh) have put themselves forward to focus on Recruitment across the four Nations.

Trainer/Trainee Survey

The first round of the inaugural ID trainer/trainee survey has just taken place, to help the SAC and Faculty better gauge the state of ID training 'on the ground'. It has been particularly pleasing to support close working between trainers and trainees on this project – something I think we should encourage. Simon Bonnell took the lead on the trainer side, supported by myself, with Catherine Walton and Fionnuala Williams leading on the trainee side – thanks to them all for their hard work. We surveyed all TPDs and Regional Trainee Reps and covered a range of topics that have arisen out of the 2018 TPD Survey and 2018 GMC Survey Specialty-Specific Questions. The response rate was excellent, so thank you to all those who took the time to complete it. The results are currently being analysed and we will be presenting the key findings at the Faculty Spring Meeting. From feedback so far, they will make interesting reading so please come and listen.

Key Points for the Management of ID and ASD

The SAC has been developing guidance on the management of ID and ASD out of hours for ST trainees from other psychiatric subspecialties. This work has been requested by the College Curriculum and Assessment Committee, in recognition of the move towards cross-specialty on-call rotas. It is expected that the revised Subspecialty Curricula will incorporate the necessary knowledge and skills into shared capabilities, however this does not meet the immediate need for trainees currently working 'on the coalface'. Draft versions of these documents have been circulated to Psychiatric Trainees Committee and positively received; the feedback received has been incorporated and the final versions will be ready shortly. My thanks go to John Russell, Eileen McNamara and Fionnuala Williams who have worked closely with me to develop them.

Any finally…..

It is not possible to cover all aspects of the Committee's work here, or to mention everyone who has attended and contributed. If you would like any further information on what we do or any aspect of the work described above, please do get in touch with me.

Mary Barrett

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In case you missed it: Social Media

Harriet and Catherine representing ID psychiatry and the PTC at the National Student Psychiatry conference @RCPsychTrainees @psychiatryofid @idtraineesuk #NSPC19

Dr Catherine Walton @trotters_r_us

Research Roundup

Rachel Steele

Clinical Librarian with Tees, Esk and Wear Valleys NHS Foundation Trust.

@TEWV_library

Rachel Steele, Clinical Librarian with Tees Esk and Wear Valleys NHS Foundation Trust, begins the I-Spy Research Series with a focus on transitioning from child, to adult, services with a round-up of the latest Intellectual Disability research available.

Transitioning from child, to adult, services in people with learning disabilities

It is generally accepted that transitions from child, to adult, services are a time of vulnerability, both for people with learning disabilities and the general population (Young et al., 2011). There are currently two main models of transition between CAMHS and AMH in the UK – using a dedicated "transition team" to bridge the gap between child and adult services or using shared care protocols during which CAMHS and AMH work closely together and facilitate a gradual transfer of care (Young et al., 2011). It has been argued that the "transition team" model is similar to the idea of implementing early intervention in psychosis teams but that the disadvantage to this approach is the introduction of additional divides within the system (Young et al., 2011).

It has also been argued that transition should be considered a process rather than an event (Munoz-Solomando et al., 2010). A frequent theme which recurs in policy documents is the importance of young people having autonomy in the transitions process. It has, however, been argued that young people who have mental health conditions may have more difficulty in achieving autonomy than their counterparts in the general population (Munoz-Solomando et al., 2010). The same could be said for people with intellectual disabilities (ID).

Indeed the transition to adulthood for young people with ID is difficult (Jacobs et al., 2018). A qualitative systematic review identified that the transition process was perceived as stressful with barriers being identified relating to people with profound ID and their parents (Jacobs et al., 2018). The majority of research participants in this systematic review were parents but the needs of young people and their parents were found to be highly interdependent (Jacobs et al. 2018).

An earlier study explored the perspectives of people with ID who were approaching transition from school or college. Family and school were highly important to these young people and the absence of engagement in leisure activities and work was also a significant theme (Small, 2014). It is therefore argued that transition planning should begin with mapping the system in which individuals live and that areas of strength should be supported, while aspects of the system which are not helpful should be prioritised for intervention (Small, 2014). Another study confirmed that people with ID transitioning to adulthood require information about getting a job and going to college, as well as the transition process more globally (Tarleton, 2005).

I-Spy Round-Up

Health promotion is an important priority for people with ID. Accordingly a systematic review of RCTs investigated the effectiveness of lifestyle change interventions. Only interventions for waist circumference were statistically significant so current lifestyle interventions may need to be more effectively targeted to people with ID (Willems et al., 2018).

A study of the grieving process in people with ID found that the IGCS-ID scale has sufficient reliability. The level of ID, the time elapsed since the loss and the residential setting accounted for different experiences amongst participants (Rodriquez et al., 2018).

Fidelity to guideline recommendations on antipsychotics in ID is problematic. A qualitative study identified that barriers in adhering to recommendations were insufficient collaboration between disciplines and limited enforcement of monitoring of side- and treatment effects (Ramerman et al., 2018).

Feeling that you 'belong' is important to people with ID as well as the general population. An Australian qualitative study found that four themes were important: belonging in relation to place, being part of a community, having relationships and identity (Strnadova et al., 2018).

Increasing attention is being paid to loneliness in society in the general population. A systematic review of five studies reported a prevalence rating of loneliness of 44.74% in people with ID and further research is needed (Alexandra et al., 2018).

A narrative review identified that people with mild to moderate ID may experience problems with both internal, and external, shame which appear to correlate with increased psychological distress and that these feelings may impact on areas of self-worth and emotional well-being (Clapton et al., 2018).

Research from the general population has identified peer relationships and parental overprotection as factors involved in the development of social anxiety. A comparative study of a sample of young people with, and without, ID found that aspects of general, and social, anxiety were significantly greater in the ID group. No significant differences in parental overprotection were found but qualitative data uncovered differences in experiences of social anxiety and parental overprotection (Hemm et al., 2018).

A study explored the relationships between sport involvement in youth with ASD and ID. No significant effects of ASD status were found for frequency or diversity of sport participation but young people with ID alone had higher indicators for positive social experiences than youth with both ASD and ID (Ryan et al., 2018).

Poorer levels of oral health are one of a number of health inequalities between people with ID and the general population. A study identified a number of factors at the individual, social and environmental levels which influence oral care and recommends collaboration between dental, and ID services (Chadwick et al., 2018).

A qualitative study investigated the role played by adult siblings of those with severe ID. Several roles were identified including caregiver, friend (social partner), advocate, legal representative, sibling (teacher/role model), leisure coordinator and informal service coordinator (Hall and Rossetti, 2018).

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Strnadova et al. (2018) ‘“but if you’re afraid of things, how are you meant to belong?” What belonging means to people with intellectual disabilities’, Journal of Applied Research in Intellectual Disabilities, 31: 1091-1102.

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Willems et al. (2018) ‘Effects of lifestyle change interventions for people with intellectual disabilities: Systematic review and meta-analysis of randomized controlled trials’, Journal of Applied Research in Intellectual Disabilities, 31: 949-961.

Young et al. (2011) ‘Avoiding the “twilight zone”: Recommendations for the transition of services from adolescent to adulthood for young people with ADHD’, BMC Psychiatry, 11: 174.

In case you missed it: Social Media

#NHSLongTermPlan contains good plans on its Clinical Priority of Learning Disability and Autism. @wendyburn @psychjoh @NHSEngland @BPSFacID @leder_team @LdSenate

Psychiatry of ID @psychiatryofid

RCPsych Mentoring

Dr Geoff Marston

Consultant Psychiatrist

Dr Jan Birtle

Medical psychotherapist and Associate Medical Director, Worcestershire Health and Care NHS Trust

National Mentoring and Coaching lead for the Royal College of Psychiatrists

Dr Geoff Marston

Consultant psychiatrist, Coventry and Warwickshire Partnership NHS Trust

West Midlands Mentoring and Coaching lead for the Royal College of Psychiatrists

In the following article we provide a brief overview of mentoring /coaching and its potential benefits, along with some signposting to further information about resources and opportunities available to psychiatrists from within the College and elsewhere.

What is coaching and Mentoring?

Contrary to some myths, mentoring is not just for doctors needing 'remedial support', nor is it just having a "cosy chat" and being offered advice by a senior colleague. It is an active, shared process that has the potential to nurture and encourage a person, supporting them to achieve their aspirations and to find positive ways in which to overcome potential challenges they may face at crucial stages of a career. All College members should consider the potential benefits of coaching and mentoring. For many it could prove an extremely rewarding and beneficial process.

Both coaching and mentoring are "***learning relationships which help people to take charge of their own development, to release their potential and achieve results which they value***" (Mary Connor and Julia Pokora) [1]. Other definitions of mentoring include: '***Guiding another individual in the development and re-examination of their own ideas, learning and personal and professional development***' (SCOPME, 1998)[2]. Egan's view (1998)[3] includes "***Helping people to manage their problems in living more effectively and develop unused opportunities more fully…. help people become better at helping themselves in their everyday lives***"

Mentoring and coaching are often used synonymously by organisations, and the two roles share a lot of similarities. At the ends of the coaching / mentoring spectrum some differences may emerge but in practice overlap is very common. Zeus and Skiffington [4] highlight some of these areas.

Similarities include:

- Ability to generate trust ,support commitment , generate new actions through listening and speaking skills
- Aim to improve a person's performance and production
- Facilitate learning and developing skills and competencies
- Providing support without removing responsibility
- Stimulating personal growth
- The skill sets of an ideal coach or mentor are shared, including well developed interpersonal skills and require some organisational know how.

Differences between the two include:

- Coaches tend to focus on setting goals over a shorter time frame with regular sessions. Mentors generally offer sessions over a longer period with more flexibility, sessions taking place as and when needed.
- Coaching sessions are more structured, focusing on specific developmental areas whereas mentoring sessions may be more informal.
- Mentors may be seen as 'wise owls', usually with a lot of experience in their mentees field, whereas coaches need not have direct experience of their clients occupation.

- Coaching focus is generally on development and specific, short term, issues at work, whilst mentoring looks at longer term career and personal development.
- Coaching aims to help a person challenge assumptions and identify their strengths to achieve specific, immediate goals. Mentoring may occasionally include the offering of direct advice, guidance and pastoral support.

There are a number of key principles that underpin the process.

At the heart of any coaching and mentoring relationship are learning, change and transformation. The client is *resourceful* and sets the agenda to meetings with the mentor offering support and challenge to facilitate learning and development. The approach / model used by the mentor will provide a map for the journey and enables movement and direction towards the client's key goals. A mentors qualities and skills will affirm, sustain and enable the client to develop insight, release potential and to progress. The relationship is further enhanced by taking place within a confidential and safe space, with agreed boundaries and clear ethical framework (Diagram 1)

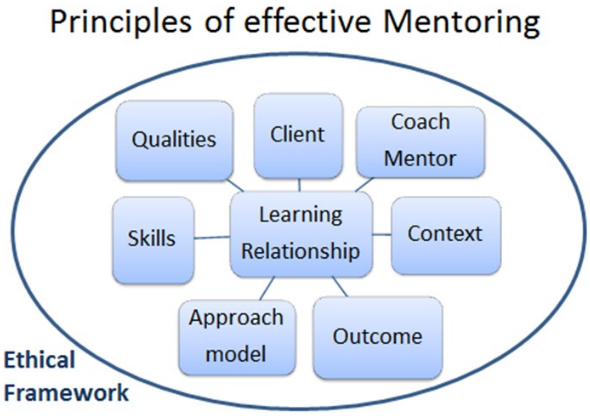

Diagram 1: Principles of effective mentoring (Connor and Pokora)[1]

What are the benefits?

Coaching and mentoring can contribute at all stages of a medical career, especially at times of transition such as planning for and becoming a Consultant for the first time, changing job or retiring. It could be a useful time to reflect on the challenges of taking on new roles such as management, coping with organisational or service change and internal redeployment. Certain groups of doctors may also benefit including those working flexibly, long term locums, Refugee doctors and International Medical Graduates (IMG). It can help when coping with other work stressors like whistle blowing and traumatic events e.g: bullying, serious incident investigations, Coroner's court involvement after homicide/suicide, personal assault; Likewise, in developing confidence, which might include insight about personal development needs.

As well as bringing benefits in the professional role of a psychiatrist mentoring and coaching can also be enriching and nurturing in the personal arena (diagram 2).

Diagram 2: Mentoring for doctors: perceived benefits for the personal and professional (Oxley and Fleming 2008)[5]

Taking a mentoring and coaching approach can also be helpful in a number of areas outside the direct mentoring/coaching relationships. Examples include enhancing appraisal skills, improving teaching and educational interactions with trainees, working within teams, supporting patients to engage positively with their recovery and overcoming inequality within the context of Differential Attainment[6].

The time spent delivering and in personal development around mentoring and coaching can reflected in your CPD and set against a variety of GMC good medical practice domains (Table 1)

Table 1: Mentoring and coaching in relation to GMC good medical practice domains

Domain 1: Knowledge, skills and performance
Mentorship practice,
Mentorship induction training
Mentorship updates – e.g. through mentorship
CPD
Wider issues and changes
Enhance leadership impact
Developing resilience
2 – way learning/life- long learning
Coaching approach to management and leadership

Domain 2: Safety and quality
Protect public and patient safety
Consultation
Supervision
Reflective practice
Network – peer support and challenge
Feedback
Reflective writing
Self awareness

Domain 3: Communication, partnership and teamwork
Accept, listening
Gathering
Feedback (anonymised or not?)
Communication skills training is central to mentorship
Support and challenge
Engagement,
Nurturing talent

Domain 4: Maintaining trust
Agreement/contract
Boundaries
Confidentiality
Role modelling
Aware of personal limitations

What resources are there in the College?

Mentoring and coaching initiatives play an important role in the college strategy to ensure psychiatrists are well supported in their work and throughout their careers.

Historically the college has focused a lot of its support to new consultants, in their first few years after training, offering mentoring and coaching for psychiatrists by psychiatrists. However, more recently the scheme is looking to involve other groups including career grade doctors and trainees. The hope is that by providing support throughout the career cycle it may help with retention and recruitment, along with having some impact on equalising the Differential Attainment[6] experienced by some groups such as BME and IMG doctors.

Jan Birtle is the national lead for the mentoring and coaching network, support by Rosetta Wotton (Psychiatrists' Support & Remediation Services Manager). Each Division has its own mentoring lead (table 2) and within many divisions there are a number of psychiatrists (mainly senior consultants) who have offered their support in mentoring colleagues. Further information about local mentors can be found on the Divisional sites, within the member's only area of the College website.

Division/ Specialty Group	Lead
South East	Dr Hasanen Al-Taiar
Northern and Yorkshire	Dr Nicola Baylis
Trent	Dr Mohan Chawla
North West	Dr Vicky Cleak
West Midlands	Dr Geoff Marston
London	Dr Ros Ramsay
South West	Dr Ian Rodin
Wales	Dr Pritpal Singh
Eastern	Dr Rakesh Magon
Scotland	Dr Sarah Beesley
Northern Ireland	Dr Julie Anderson
PCT Reps	Natalie Ashburner and Abigail Swerdlow
SAS Doctors	Dr Monique Schelhase
Psychiatrists' Support & Remediation Services Manager	Rosetta Wotton

Table 2: Mentoring Network leads

Between 2016-2018 the College held a number of national training events, most recently targeting SAS and International Medical Graduates, supporting over 130 psychiatrists to develop their understanding and skills around mentoring and coaching. Within the regions, a number of Divisions have held local training events, encouraging would be and existing mentors to develop their skills. These events offer a basic introduction to mentoring and coaching, information around developing a mentoring relationships-including setting boundaries and contracting; introducing some basic coaching/mentoring models to use such as GROW; as well as practising basic coaching skills like active listening and asking powerful questions.

In some regions (eg West Midlands) there are regular support and development groups, where local psychiatric mentors can meet and discuss, in a safe and confidential space, any issues or concerns they may have. Meetings may also include sharing of mentoring / coaching skills to further encourage learning and development.

Developing awareness of and access to Coaching and mentoring links into a number of College wellbeing initiatives including StartΨell (soon to include SAS grades) and supported and valued as well as improving retention and recruitment. A number of regional and national wellbeing events have been supported by mentoring and coaching network leads delivering workshops or presentations.

In various regions (including the West Midlands and London) there have been coaching and mentoring initiatives for Psychiatric trainees, some of whom have gone on to set up 'cascaded' mentoring/coaching support for junior colleagues. The hope is that by introducing psychiatrist led mentoring/ coaching at the earliest stages of a medical/psychiatric career resilience as well as recruitment and retention will be positively impacted.

The College's Psychiatrist's Support Service [7] where appropriate offers signposting to mentoring and coaching for members at times of difficulty.

The mentoring and coaching website [8] also has links to useful resources and offers more information about this important area.

What other resources are available?

The BMA website has a helpful section on mentoring

Health Education England (HEE) periodically offers free regional coaching/mentoring training through their "Leadership Academies", of which there are 10 in the UK. Training opportunities vary in length and intensity from half day courses to longer certifications.

2 such courses periodically offered by the Academy are the ILM 5 and ILM 7 certificates in coaching and mentoring. These involve attending a number of training days over a 6-8 month period, writing three dissertations, along with reflecting on 12 -20 hours of coaching experience (with supervision provided within the course). These courses would make an ideal specialist interest opportunity for any higher trainee and would enhance any CV.

HEE also offer direct mentoring and coaching within the regions, which is accessible to all those working within the NHS free of charge. Experienced educationalist coaches/mentors have also offered themselves as "associates", to support the development of coaching and mentoring training within regions. For a reasonable fee (subsidised from those normally charged) trusts and organisations could access their skills to set up training and development opportunities for staff.

E-learning for healthcare has an introductory online module covering the basics of coaching and mentoring. Two x 1 hour sessions give you a basic overview of what mentoring and coaching is/isn't and introduces the learner to basic models of coaching such as GROW. I would highly recommend all trainees look at these modules as part of their leadership skills training, likewise consultants and all other grades psychiatrist would find this a helpful and interesting two hours of CPD within their personal development plan.

The Faculty of Medical Coaches , for a fee, provide mentoring and coaching to individuals/groups as well as training.

A number of Trusts offer in house training opportunities to managers and doctors interested in developing coaching and mentoring skills. Some will have their own bank of coaches/ mentors and may run regular support groups for those actively coaching/mentoring others. Coventry and Warwickshire Partnership Trust is one such example.

Top tips to promote mentoring?

- If you are mentoring or being mentored, next time you are having an appraisal or job planning review make sure it is recognised and given appropriate time.
- At service meetings remind your managers how mentoring can help to develop doctors and boost effectiveness, not to mention its potential impact on recruitment /retention and differential attainment.
- Next time you are on an interview panel or writing a job description, make sure Startwell and mentoring support are mentioned and remind the successful candidate about the benefits and availability of mentoring.
- Suggest mentoring / coaching training as part of your local academic programme.
- Put down a few CPD hours around mentoring / coaching within your personal Development plan. Visit e-learning for healthcare to do an introductory 2 hour online module
- If you are inspired to become a mentor or would like to be mentored get in contact with your regional College Network lead via the divisional office, or visit the college website
- Join or set up a peer group for mentoring and coaching (either in your Trust or through the college). These groups are a good learning opportunity and way to support good practice, by sharing skills and experience. Link this in with your own personal development and CPD needs.

Don't hold back. The GMC recognises mentoring and coaching as an important role for all psychiatrists. Most likely, you have been doing it already, so embrace it and where needed take advantage of the support available to you

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8 RCPsych mentoring site: https://www.rcpsych.ac.uk/members/supporting-you/mentoring-and-coaching?searchTerms=mentoring

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Let’s just do it: Tribunal referral for incapacitated patients

Dr Indermeet Sawhney

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Dr Asif Zia, Executive Director for Quality and Medical Leadership HPFT

The Mental Health Tribunal is a long established safeguard for patients detained under the Mental Health Act. This gives such patients an effective appeal mechanism to ensure legal protection of their liberty. The right to apply to the tribunal against such detention is underpinned by the right to liberty under Article 5 of the European Convention of Human Rights (ECHR). Article 5 (4) states; ’Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by Court and his release ordered if the detention is not lawful’.

A part II patient may apply to the Tribunal, or their case may be referred to the Tribunal. An application can be made to the Tribunal by a patient or his nearest relative under Section 66 of the MHA. The only way a patient detained under Section 2 can have access to the Tribunal is by a direct referral made by the patient, with in the first fourteen days of detention with no provision for relatives to apply to the Tribunal. There is no provision for a managers hearing for a Section 2 patient. Essentially, an incapacitated patient can be detained without any safeguard and mechanism to review the detention for 28 days. For patients detained under Section 3, there is a provision for relatives to apply to a tribunal in the first six months of detention. However an incapacitated patient who does not have any family member involved in their care will have no recourse to the tribunal for this period of detention.

We need to be mindful that patients who lack capacity in reality are unable to challenge their detention and these safeguards can be tokenistic. Perhaps unsurprisingly, a study revealed that patients who do not appeal under Section 2 have greater difficulty in understanding their rights under the Act (Bradley, Marshall and Gath, 1995). Studies that have looked into the association between capacity to request a tribunal and frequency of completed tribunal hearings found that patients with capacity received more completed hearings per year than those without, both overall, and by patient application (Galappathie, et al. 2013).

In the case of “MH v UK”, the European Court of Human Rights held that MH’s Article 5(4) rights were violated in relation to the initial 28 days of detention. MH was a woman with Downs Syndrome who lacked capacity to apply to a Tribunal and was admitted to hospital under Section 2 of the Mental Health Act. The Court held that “special safeguards” need to be in place in order to protect the rights of persons who lack capacity to challenge the lawfulness of their detention under the Mental Health Act. The judgement is significant, and ensures equality of access of safeguards for patients who are deemed to be incapacitated and puts their rights at par with those with capacity. It has reiterated the obligation of the State to place patients without capacity to consent in the same place as those patients with capacity; thus protecting their rights under Article 5 (4).

How does the current statute lend itself to address the violation identified in the judgment? To protect persons lacking capacity, the Government has made amendments to the statutory guidance in the revised Code of Practice which came into force in April 2015. The role of an Independent Mental Health Advocate (IMHA) was established to help patients understand the legal provisions to which they are subject under the MHA (MHA, 1983), and the rights and safeguards to which they are entitled. The IMHA will assist patients to exercise their rights by helping them to make applications to the tribunal. However, for the cohort of patients with moderate and severe learning disabilities who cannot appreciate that they are being detained, might ‘slip through the net’, and miss a crucial opportunity to access the tribunal.

Additionally, the Revised Code of Practice (Para 37.45) states: ‘Hospital Managers should consider asking the Secretary of State to make a reference in respect of any patients whose rights under the Article 5 (4) of the ECHR might otherwise be at risk of being violated because they are unable (for whatever reason) to have their cases considered by the Tribunal speedily following their initial detention or at reasonable intervals thereafter’. Any departure from this should be well documented and included stating the reasons for the same. The Code of Practice also dictates that this reference should be normally be sought in any case where the patient lacks capacity to request a reference (Para 37.46). Section 67 of the MHA enables the Secretary of State to refer a patient to the Tribunal.

An audit of our services was undertaken to ascertain if detained patients without capacity admitted to our Assessment and Treatment unit, were referred by the Secretary of State to the Tribunal. The data was collected for a year between August 2015 to August 2016. Out of the six admissions, five were deemed not to have capacity to apply to a tribunal at the time of admission and a referral to the Tribunal was not done for any of the five patients.

Since this audit a process has been set up to change practise in this context in our local service whereby, every patient is assessed by the Responsible Clinician(RC) for their the capacity to apply to a tribunal at the outset of admission. The hospital managers are alerted for patients who lack capacity by the RC and a referral is triggered to the Secretary of State requesting for a tribunal.

We need to be mindful that for incapacitated patients, detention does not become a default position as a consequence of their inability to challenge their detention. Any departure from the guidance in the Code of Practice is not justified. There may be exceptional circumstances in clinical practice that need careful consideration with legal advice. Needless to say, routine procedures will have cost and resource implications but this should not be a deterrent to deny these patients of their basic human rights. It is ironic that the most vulnerable and marginalised patients, who need maximum protection of their rights are unable to exercise the same. As psychiatrists we need to champion and advocate for the rights of this vulnerable cohort of patient to ensure that they get a timely hearing. If we don't who will? So, let's just do it!

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In case you missed it: Social Media

The award for Psychiatrist of the Year goes to @DrHeatherHanna, Clinical Lead for N Ireland's first and only fully integrated CAMH Service for children and young people with Intellectual Disability. Judges praised her 'impressive energy and drive' @SouthernHSCT #RCPsychAwards

Royal College of Psychiatrists @rcpsych

TRANSFORMING CARE: Past, Present and Future

Dr Harinder Bains

(MB BS FRCPsych LL.M)

Clinical Director Elysium Healthcare

'The Better services for the mentally handicapped' white paper was published by the Department of Health in June 1971 and outlined a desire to move away from caring for people with 'mental handicap' in institutional settings, and to increase the provision of local community care. The white paper set out the government's plans for improving services, including increased investment in residential facilities. This was essentially the beginning of what came to be called the 'deinstitutionalisation' of care.

By 1987, there were still more than 30000 people with some form of learning disability (also known as "Intellectual disability") (The Royal College of Psychiatrists) in institutional care. By 1993, following the publication of the *Mansell report* (Department of Health, 1993) there continued to be significant focus on 'deinstitutionalisation' and moving people out of big hospital settings into communities. The Disability Discrimination Act 1995 and the *Valuing People* white paper (Department of Health, 2001) further propelled the movement of people from institutional type settings into community settings. By the time of the revised *Mansell report* (Department of Health, 2007) there were less than 5000 people in institutional settings.

The shocking footage of the BBC Panorama programme on abuse of people with learning disabilities at Winterbourne View hospital brought into focus the need to protect this vulnerable group. The Department of Health's response to the abuse and the criminal behaviour of staff at Winterbourne View led to the *Transforming Care programme* (Department of Health, 2012). This sharply re-focussed the move towards rapid reduction in bed based provisions and discharge of people into community based care, closer to their families.

The review led by Sir Stephen Bubb (Winterbourne View – Time for Change, 2014) focussed on, amongst other things, commissioning of community based services to prevent admissions and focus on discharge of people from inpatient settings. The report also brought into focus overprescribing of medication, an agenda that was later taken up by NHS England and the Royal College of Psychiatrists through the Stopping Overmedication of People with a Learning Disability, Autism or both (STOMP) programme. (STOMP was a call to increase awareness and bring about change in the practice of prescribing psychotropic medication for people with intellectual disabilities and/or autism). The government responded to the recommendations from Sir Bubb's review through *Transforming Care for People with Learning Disabilities – Next Steps.*

Sir Stephen Bubb's subsequent review in the form of *Winterbourne View- Time is running out* in 2015 continued to focus on need to make community services more robust to avoid admission to inpatient services. Recommendations included continuation of the programme to close hospital based facilities and the review was critical of the failure and delay in closing down beds, with continued focus on the commissioning of appropriate services.

The Learning disabilities census was principally commissioned to deliver and monitor action number 17 of the *Transforming Care* programme which stated that; "The Department of Health will commission an audit of current services for people with challenging behaviour to take a snapshot of provision, numbers of out of area placements and lengths of stay". The census data showed that the inpatient occupancy for three consecutive years from 2013 to 2015 had stagnated around the 3000 mark.

Building the right support in October 2015 maintained the commitment of closing down beds but also focussed on streamlining and closing outmoded inpatient services, and developing community based services which meet people's needs. Whilst the report remained focussed on reduction of bed capacity, there was appreciation for the need for specialist services. The scope of the *Transforming care* programme had over the years also widened to include people with autism spectrum disorders who did not have a learning disability: a population group whose specialist needs were distinct from the learning disabilities population.

The report provided an estimate of how many inpatient beds were needed and recommended a reduction to 1300 to 1700 beds across the country. The aim outlined in this report was

45-65% reduction in Clinical Commissioning Group (CCG) commissioned beds and 20-40% reduction in specialist NHS England commissioned beds. The CCG commissioned beds were mainly assessment and treatment, and locked rehabilitation services. The specialist NHS England commissioned beds were primarily within secure forensic services.

There was regional variation in the required reduction with an aimed 70% reduction in bed capacity in the north of the country and a 20% reduction in the south. This was because the majority of inpatient services were in the midlands and the north of the country. The recommendation in the report was to eventually have 10-15 CCG commissioned beds per million population and 20-25 specialist NHS England commissioned beds per million population.

The difference in regional focus meant that whilst the north of the country focused on reduction of bed numbers, in the south there has been a need to develop specialist services to support the repatriation of patients closer to their 'home' areas. This has meant that there has been opportunity to develop more specialist *niche* provisions to meet specific needs of people, for example specialist autism services. Although this appears to be paradoxical to the direction of bed reduction outlined by The *Transforming care* programme, the development of specialist capacity has been supported by closure of beds in other regions of the country and repatriation of people closer to their home areas.

There are essentially two distinct inpatient care pathways for patients with learning disabilities and autism. This broadly mirrors the commissioning streams through CCGs and NHSE. The first pathway which is CCG commissioned (hereafter referred to as the 'community pathway') is a community based pathway which provides inpatient care in assessment and treatment, and locked rehabilitation services. These services which are usually called 'non secure services' provide admission facilities to manage exacerbation in behaviours that challenge for people who are in community based care. People admitted to these services will usually be under the care of community mental health or learning disabilities services.

The second pathway is the NHS England commissioned (otherwise known as 'specialist commissioning') beds which are in secure forensic services (hereafter referred to as 'the secure pathway'). People admitted into these services may be offenders admitted through Courts or the Criminal justice system but does occasionally include people who have become difficult to manage in the community pathway described above.

The clinical characteristics of the patient in the two pathways described above tend to be different. The CCG commissioned community pathway tends to have people with more severe intellectual disabilities or autism and more likely to present with day to day behaviours that challenge. The secure pathway tends to have people with milder intellectual disabilities/ or no intellectual disability and those less disabled by their autistic spectrum conditions, but are more likely to have an offending or forensic history.

The closure of inpatient beds and movement of people into the community has been supported by establishment of Intensive Community Support Teams (ICSTs) in some areas. A number of NHS Trusts have moved resources from closure of inpatient services and redirected these into ICSTs. In regions where ICSTs have been established, there has been reduction in admissions to inpatient care. However this is primarily in the community pathway described above, as the patients needing a secure pathway need admission to an inpatient facility, which is usually secure and under provisions of the Mental Health Act. Similarly ICSTs have not been involved in case management of out of area patients in secure services either because of the design of the service or because they do not have the time and resources to do this in addition to their community based role. The effect of ICSTs has therefore been primarily reduction in use of assessment and treatment, and locked rehabilitation beds.

Specialist forensic community teams have developed in certain regions of the country. These services and care pathways have been set up thorough local initiatives (Devapriam and Alexander, 2012). A national model for outreach forensic services for people with learning disabilities has been proposed (NHS England-Community Forensic Support for people with a learning disability and or autism -a national perspective, 2017). There are considerable resources for therapeutic management of high risk patients in inpatient settings, provision of such services in the community has been dependent on local innovation and limited by resources, and clinical expertise in the community. There needs to be a focus on 'bridging the gap' between therapeutic risk management in inpatient and community setting with a focus on joint working, information and resource sharing, and more supportive approach to the transition from secure to community care. This usually involves working across different organisations which are sometimes geographically separate. Hence there is need for formal management of such care pathways with oversight from commissioning bodies. It makes sense to manage these pathways by bolstering and enhancing the existing Care Programme Approach (CPA) arrangements by encouraging increased participation and joint working.

The *Transforming care* programme has maintained focus on improved commissioning of resources and capacity in the community to facilitate bed closures. For the secure pathway a commissioning challenge has been the transfer of funding between NHS specialist commissioning and CCGs.

Further bed closure initiatives need to be supported by effective discharge planning by tackling not only financial resource barriers but also commissioning, clinical, therapeutic and risk management resources. Whilst there may be a minority of people who need longer term inpatient care either due to the nature of risk or offending, it should be possible that the majority of people in inpatient facilities can be discharged and rehabilitated if there are suitable facilities and resources available in the community to meet their needs.

Another consideration is the legal hurdles which affect discharge of people on the secure pathway. There is no formal mechanism of joint working on *Transforming care* agenda between the Ministry of Justice (MoJ) and NHS England commissioning, to tackle the issue of discharge of people who have restriction orders under the Mental Health Act. An example of this is that when independent Care and Treatment Reviews (CTRs) consider discharge of patients, this may not be possible due to no formal mechanism of passing these recommendations to the MoJ (CTRs are part of NHS England's commitment to transforming services by reviewing the quality of care for people with learning disabilities, autism or both. CTRs aim to reduce admission and encourage discharge of people from inpatient services).

Recent Case law has also led to challenges with discharge of people. In recent cases of *MM and PJ*, the 2017 Court of Appeal decisions *(Secretary of State for Justice v MM; Welsh Ministers v PJ* [2017] EWCA Civ 194*)* has led to issues with discharge of patients in inpatient settings. The decision in the case of *MM* has meant that First Tier Mental Health Review Tribunals are now not able to recommend conditional discharge of people who are restricted under the Mental Health Act when conditions in the community placement amount to deprivation of liberty and the person has capacity to consent to such conditions. The case of *PJ* limited the First Tier Mental Health Review Tribunal's powers of discharge under provisions of a Community Treatment Order (CTO) if the conditions of discharge amount to deprivation of liberty. The Ministry of Justice has recently released guidance for their case workers where patients satisfy the above conditions.

The overall effect has been that the legal landscape has not been conducive to discharge of people into community settings particularly when they are detained under restriction orders of the Mental Health Act.

March 2019 is the deadline for delivering the model defined by the *Building the right support* document. With this date rapidly approaching, it is clear that the direction that has been defined by the *Transforming Care* programmes and process will need to be carried into the future. The NHS long term plan lists autism and learning disabilities as priorities and also recommends more investment into community care and joint working. It therefore remains to be seen how the *Transforming care* initiatives are translated into future plans under this longer term NHS plan.

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In case you missed it: Social Media

We are delighted to announce that SUDEP Action and its amazing partnership of researchers & clinicians, have been shortlisted for the 'Education Team of the Year' at this year's #thebmjawards 2019. @bmj_latest Read more about why, in our news item - http://ow.ly/yb3T30nIgQ2

SUDEP Action @SudepAction

Supreme Court Judgment

Dr Richard Burrows

ST5 in Forensic Psychiatry

West Midlands

Firstly, on 17th of December 2018 the Supreme Court gave its judgement on whether community treatment order (CTO) conditions, under the Mental Health Act 1983 (amended 2007) (MHA), could amount to a deprivation of liberty (1).

The case initially pertained to the situations of a 47 year old man, PJ, with mild to borderline intellectual disability with co-morbid “difficulties which fall within the autistic spectrum” “accompanied by abnormally aggressive and seriously irresponsible behaviour consisting of violent and sexual offending” (1). In 2011 he was discharged to a care home on a CTO (1). The conditions imposed were argued to be a deprivation of liberty (1). Aside from the mandatory conditions (of making himself available for examination) there were conditions effectively meaning “his alcohol use was limited to four units per week”; “was breathalysed to secure compliance; any alcohol reading after home leave or contact with his brother would result in immediate suspension of home leave”; his “whereabouts were monitored at all times within the unit, with 15-minute observations” and he was escorted by staff on community outings unless agreed otherwise by the RC and social supervisor (1).

With development of the case the court proceedings came to focus on whether it was legal to deprive someone of the liberty under a CTO. Initially the court of appeal had concluded that the conditions of a CTO could amount to a deprivation of liberty (1). However, the case was then brought to the Supreme Court, “the final court of appeal for all United Kingdom civil cases, and criminal cases from England, Wales and Northern Ireland”, which concluded that this was not the case, being the decision we are left with now (1)(3). To many this is probably what they would expect, as it is what is stated in the MHA code of practice (1). However, it is striking that the court of appeal initially judged otherwise and just highlights the complexities of working with the MHA (1).

Secondly, on the 28th of November 2018 the Supreme Court gave its judgement on whether the conditions imposed on a patient who is conditionally discharged can amount to a deprivation of liberty (2). This judgement is of particular relevance to secure intellectual disability services. However, it is also of general interest in terms of the ethical and legal aspects considered.

I am aware that the conditional discharge of patients does not form all psychiatrists’ day to day work and as such I will start with a description of this. A UK court can deal with a criminal case where mental health issues are prominent by means of imposing a hospital order with restrictions, otherwise known as Sections 37/41 of the MHA. This can be utilised instead of a prison sentence where the offending is a result of mental illness to a significant degree and the treatment of this remains appropriate. The Section 37 or “hospital order” part, once imposed, functions much in the same way as the more familiar Section 3 of the MHA and can be utilised without the Section 41 part. The Section 41 part, the restriction order, however, is quite different. This part essentially takes the final decision making power over discharge and leave away from the responsible clinician and gives it to the Ministry of Justice (MoJ) and the Tribunal. This can be seen as providing an additional safeguard for patients that pose a particular risk to others.

Another peculiar aspect to the hospital order with restrictions is that the patient may be “conditionally discharged”. This can be thought of analogous to (but not the same as) a CTO. One of the main differences is that, again, oversight is taken by the MoJ who require regular reports from the clinical and social supervisors and can recall a patient to hospital based on concerns raised. As such, known breaking of the patients “conditions” would be expected to be reported to the MoJ and may result in recall to hospital by the MoJ. Additionally, as per Section 3 of the MHA, for the patient to remain in hospital the patient would have to be deemed to be suffering from a mental disorder to a nature or degree to warrant them to remain in hospital for management.

The patient concerned in this case, MM, was a 35 year old man with diagnoses of mild learning disability, autistic spectrum disorder, and pathological fire setting (2). When he was aged 17, he was convicted of arson, being reckless as to whether life would be endangered (2). He was considered to “represent a serious risk of fire setting and of behaving in a sexually inappropriate way towards women” (2). Opinions were given that he could be safely conditionally discharged under conditions that amounted to a deprivation of his liberty (2). It was, furthermore, noted that he was prepared to consent to such conditions and was felt to have capacity to do so (2).

Eventually his case was brought before the Supreme Court (2).

In the judgement the issue of consent was raised where it was cited that the “patient could withdraw his consent to the deprivation at any time and demand to be released” making the practicality of discharge a patient under such circumstances questionable (2). Case law was examined with the conclusions that “to deprive a person of his liberty is by definition an interference with his fundamental right to liberty” and that fundamental “rights cannot be overridden by general or ambiguous words” and the relevant wording was found to be “as general as it is possible to be” (2). Furthermore, the frequency of applications allowed to the tribunal were also considered, where they are less for a conditionally discharged patient compared to a patient otherwise detained under the MHA in hospital, thought to be indicative that when the MHA was drawn up that such a discharge, under conditions amounting to a deprivation of liberty, was not considered (2).

It was concluded that “conditions amounting to detention or a deprivation of liberty upon a conditionally discharged restricted patient” is not permitted under the MHA (2). This was the view of Lady Hale to which three off the other Justices agreed and one dissented, meaning the view of Lady Hale was the final judgment (2).

Practically both of these judgements might be seen as prolonging the detention of such patients in hospital and restrictions persisting for longer than if the judgements had gone the other way. Appropriate use of deprivation of liberty safeguards may, to some extent, enable safe discharge of some patients. At the least, however, when conditionally discharging patients and making CTOs, attention must now be paid as to whether the proposed conditions will amount to a deprivation of liberty.

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In case you missed it: Social Media

#PsychID2018 so proud of all our trainee presenters today morning & yesterday at Spotlight..the future of ID psychiatry is in good hands..high quality research coming through..keep it up folk!

Dr Rohit Shankar @haritsa1

Improving the Dementia Pathway in Camden Learning Disability Service

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AH- Consultant in Psychiatry of ID

Aim: To apply QI methodology to improve the Dementia Pathway within Camden Learning Disability Service (CLDS).

The first QI project within the development of the pathway was focussed on developing a Baseline Clinic for people with Down Syndrome

Background:

People with intellectual disability (ID), particularly those with Down Syndrome have a higher prevalence and earlier age of onset of dementia than the general population. Due to advances in medicine, people with Down Syndrome are living for longer and therefore we can expect that there will be increasing numbers of people diagnosed with dementia within community learning disability teams. Earlier identification and interventions for people with dementia can improve quality of life (BMJ 2015).

Whilst the Camden Learning Disability Service (CLDS) were amongst the first to run memory clinics for people with ID, current understanding of improving patient outcomes and the publication of national guidelines necessitated the update of the CLDS dementia pathway. Important recommendations from guidance produced by the Royal College of Psychiatrists and the British Psychological society (2015) include, for example, the completion of a baseline cognitive assessment of all people with Down Syndrome by the age of 30. These baseline assessments can be used to compare cognitive functioning longitudinally aiding diagnosis and establishing prompt treatment response.

A NICE produced guideline (2018) also recommended assessing older individuals with ID to plan for their future needs within services.

Methods:

<u>Dementia pathway – Process mapping</u>

We used QI methodology to implement changes at each stage of the pathway. As a multidisciplinary team we met regularly to discuss the development of the pathway including the baseline clinic, assessment, diagnosis, interventions and linking with the palliative care pathway from an early stage.

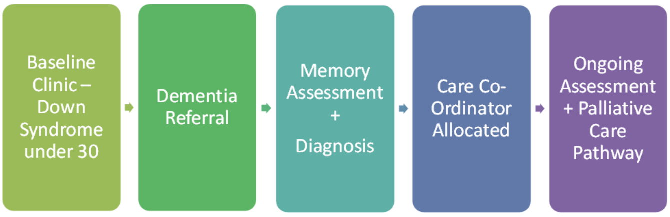
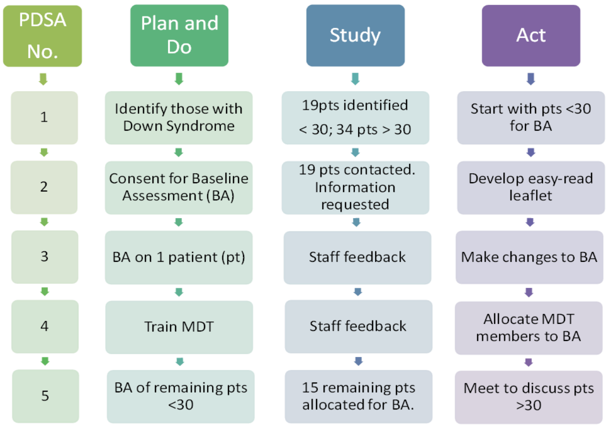


Figure 1: Process Mapping

Our first QI project was to introduce a Baseline Clinic for people with Down Syndrome under 30 years old. We identified 19 eligible service users and our measurement was the number of completed assessments by December 2018. We used PDSA (plan, do, study and act) cycles. Examples of completed PDSA cycles include:

1. Production of Easy Read materials about the clinic
2. Identification and testing of a cognitive assessment tool
3. Development of competencies and involvement of Allied Health Professionals (AHP) in completing the assessments.
4. Feasibility by carrying out 2 assessments by trained AHP
5. Allocation of the remaining service users to AHP
6. Moving forward in the QIP ladder with regular meetings of all involved and beginning Re-assessments of adults with DS and of other individuals referred with ID referred for cognitive problems.



PDSA No.	Plan and Do	Study	Act
1	Identify those with Down Syndrome	19pts identified < 30; 34 pts > 30	Start with pts <30 for BA
2	Consent for Baseline Assessment (BA)	19 pts contacted. Information requested	Develop easy-read leaflet
3	BA on 1 patient (pt)	Staff feedback	Make changes to BA
4	Train MDT	Staff feedback	Allocate MDT members to BA
5	BA of remaining pts <30	15 remaining pts allocated for BA.	Meet to discuss pts >30

Figure 2: PDSA cycles

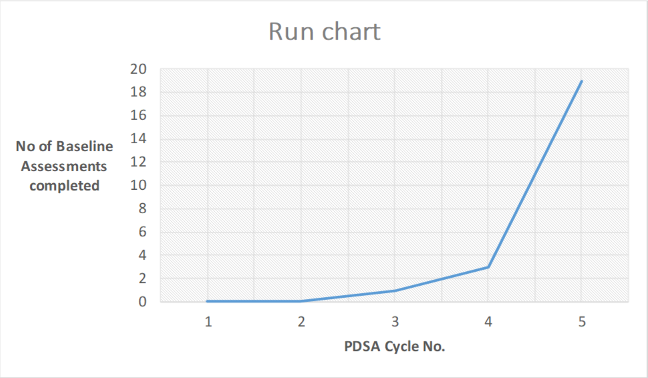


Figure 3: Number of baseline assessments completed for each PDSA cycle

Discussion and lessons learned:

- The single most affective intervention was allocating assessments to different members of the multi-disciplinary team.
- The health team managers needed to be fully invested in the project so that the members of the MDT could be trained.
- The biggest challenge was to get people with busy schedules to meet regularly and have all the disciplines working towards a common goal.
- Involving the MDT made the project sustainable despite changes in staff

MDT:

The QI was led by Dr Laura Korb (ST6 Psychiatry of ID) pictured receiving the Alec Shapiro Prize at the Annual ID Conference) and supervised by Professor Hassiotis. Dr Patsie Leaning (lead psychologist) is now co-leading the project. The dementia QIP members included: Doctors (Professor Angela Hassiotis, ST6 Dr Korb and CT3 Dr Hughes), Community lead Nurse (Lynette Kennedy), Psychologists (Dr Patsie Leaning), OT (Rebecca Mason), SLT (Elyse Luxon), Accessible Information (Richard Lohan) and Specialist Support Workers (Salome Bryant)

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In case you missed it: Social Media

Great day @rcpsych planning our #Recruitment strategy in #PsychiatryofID. Psychiatrists passionate about high-quality training and care in #MHID services. @KenCourtenay @IanHallPsych @AsitBiswas7 @regalexa @Roy1Ashok @Bexcouper @wendyburn

Psychiatry of ID @psychiatryofid

Gregory O’Brien Prizewinner

Dr Rory Sheehan

@dr_rorysheehan

NIHR Doctoral Fellow

University College London

Approaching the end of my clinical training and while studying for a PhD, I felt that this year was a good time to expand my horizons. In May I visited the Netherlands and France with the Gregory O’Brien Travelling Fellowship, awarded biennially by the Faculty. The aims of my trip were twofold; to further my research in psychotropic medication use in people with intellectual disability by making links with European researchers; and to consider more broadly the approaches to assessment and management of mental illness and challenging behaviour in people with ID in different healthcare settings and systems.

Dr Gerda de Kuijper is a psychiatrist at the Centr Verstandelijke Beperking en Psychiatrie (CVBP), an assessment and treatment unit in Assen in the north-east of the Netherlands. CVPB is a relatively small and modern unit which provides care for people with ID who are experiencing major mental illness and/or severe challenging behaviour. As well as ward accommodation there are semi-independent flats for further functional assessment/training intended to promote smooth transition back to the community. Patients may be under a hospital order or admitted on a voluntary basis and tend to stay for around six months.

The ‘CVBP’ in

Assen

Concerns about over-use of psychotropic medication are as prominent in the Netherlands as they are here in the UK and the CVBP has invested heavily in psychotherapeutic and occupational treatments. In addition to standard group and individual therapies, many patients join ‘psychomotor (or movement) therapy’, a treatment located somewhere between physical activity and traditional talking therapies that can be adapted and used in a variety of presenting problems.[1] The therapy employs a varied set of gentle exercises, games, and body movements as a tool for expressing oneself and stimulating reflection on internal processes, with physical fitness being improved as a by-product. The modality is popular in Continental Europe but never really been adopted in the UK.[2]

Eye movement desensitization and reprocessing (EMDR) also has a central role in CVBP treatment for many people with challenging behaviour, on the basis that much is underpinned by past trauma and ongoing anxiety. I saw several adaptations made to the therapy, for example, changing the presentation of the bilateral stimulus from eye-tracking to tapping the hands or presenting sounds to alternate ears using headphones. Although the therapists reported good results of EMDR, I could find few formal studies (limited to case series) that have evaluated the treatment specifically for people with ID.[3,4] If the treatment paradigm is to be shifted away from a reliance on psychotropic drugs, further evidence to support alternative treatments, including potential for adverse effects and economic analysis, is needed.

Alongside the CVBP are several houses which provide long-stay care for people who have more severe-profound intellectual disability and often other co-morbidities. The model is of a relatively self-contained campus with most facilities (including a GP practice, sports centre, swimming pool) and opportunities for sheltered work (e.g. in the cafe or garden centre) provided on-site. The success of this model, and the high costs, have been questioned and an ongoing process of ‘reverse integration’ is underway as an attempt to open up the community with homes for public rent or sale within the grounds. As might be expected, a relatively high proportion of residents of the houses (roughly ⅓) are prescribed antipsychotic drugs and Dr de Kuijper’s recent research has focused on deprescribing in this group. Findings suggest that antipsychotics used in this context can, in some cases, be discontinued without behavioural worsening and with the potential for improvement in adverse side-effects.[5,6] However qualitative work has highlighted some of the complex practical barriers to drug discontinuation, including resistance from staff or patient advocates,[7] sometimes borne out of unrealistic expectations of medication efficacy,[8] and various obstacles to implementing best practice guidelines in real-world settings.[9]

Carpentry workshop – part of the occupational therapy department of the CVBP

Although psychiatry of ID is not a formal sub-specialty in the Netherlands, many psychiatrists pursue an interest in *licht verstandelijke beperking* (literally translated as *light mental retardation*) which includes people with borderline to mild intellectual disability. Following closure of most of the traditional ward-based institutions towards the end of the last century, the country established an 'ID physician' specialty, community doctors who receive a general training in neurology, genetics, psychiatry, and paediatrics as applied to people with ID. This model was interesting to me as a way of improving access to healthcare. Indeed, this is one of the ideas that has been floated as a way to reduce health inequities but I believe shouldn't be at the expense of equipping all professionals with a good working knowledge of ID and ability to respond to the needs of this group.

ID physicians and psychiatrists converged at the Kajak national annual conference in Utrecht. I had been invited to run a workshop about health services for people with ID in the UK and noticed that many of the themes that arose at the conference – adapted psychological therapies, diagnostic overshadowing, training (or lack of) for staff, and involving families – were common to the challenges we experience in the UK. There were also some common political issues; although funding of the health service in Netherlands is a mandatory insurance system (with concessions for those who are unable to pay), clinicians and people with ID often find themselves in the centre of "care vs cure" boundary disputes, with a distinction drawn between what is classed as 'cure' (a misnomer, as a medical intervention in this context is most often not curative) funded by the insurance company, and longer-term social 'care' funded by the state. This emphasised to me that such rigid distinctions are rarely helpful when assessing the needs of people with ID as social and environmental conditions so fundamentally influence physical and psychological health.

Kajak conference – workshop held at the historic Royal Dutch Mint in Utrecht

On to Paris and the Institut Lejeune. Named after Jérôme Lejeune who discovered the chromosomal basis of Down syndrome in 1958, this unique facility specialises in the assessment and management of people with intellectual disability with genetic origin. The centre offers comprehensive, multidisciplinary annual assessments to people with Down syndrome and 250 other, less common genetic conditions (e.g. William's, Parder-Willi) across the lifespan. In view of the premature ageing associated with some of these conditions and the high degree of medical co-morbidities, the geriatrician in the team begins seeing people at the age of 35. Suggestions for treatment are sent to the patient's local hospital, however the gold standard recommended interventions may not always be available.

Most of the clinicians at Institut Lejeune are active in research and all patients are routinely offered the chance to participate in studies. Several multi-centre clinical trials are co-ordinated from the Institut; current RCTs include EGCG (a molecule derived from green tea) to improve the cognitive and adaptive function of children with Down syndrome, and a trial of bumetanide for autism in Down syndrome.

The Institut holds a biobank of over 6,000 biological samples with a linked database of anonymised clinical information, often from detailed sequential assessments conducted over several years. These samples are available to researchers worldwide and much in demand. As an academic trainee it was encouraging to see the seamless integration of clinical and research work and witness the positive impact that this has for patients and doctors alike.

It's not always easy to agree or measure outcomes in the field of ID or to directly compare the success of varying service models. However, despite some differences in organisation and delivery of care across the Nethelands, France and the UK, the fundamentals challenges that people with ID and clinicians face were instantly recognisable. This reinforced the importance of working together to reach solutions and share best practice ideas. These visits gave me insight and inspiration and for this I would very much like to thank my hosts and the Faculty for making the trips possible.

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Institut Lejeune in the Montparnasse district of Paris

In case you missed it: Social Media

Fascinating lecture on sleep disorders in ID given by Dr O'Regan - advised not to give promethazine for insomnia. Consider low dose doxepin (1-6mg). @psychiatryofid @KenCourtenay @bathika @idtraineesuk #insomnia #sleepmedicine

Dr Laura Korb @Laurakorb

Life before becoming a psychiatrist

Dr Jaleel Khaja

ST6 Psychiatrist

HPFT

Itchy eyes due to formalin and trying very hard not to drop the pretence that the demonstrator of anatomical dissections had my undivided attention remains an abiding memory of my early days at medical school in Srinagar. It was a time of a telling mismatch between expectation and reality – a time when I contemplated giving up the idea of becoming a doctor. I did persevere and remain hopeful that things will change. Indeed, they did. The year-3 clinical training brought me face to face with patients and my enthusiasm returned to its rightful place. Nonetheless, a vexation remained. The Medical Science, as it was being taught to us, seemed a bit too mechanistic and I found myself unwilling to accept that we humans were just an ensemble of tissues and organs. Lo and behold! I had my first taste of psychiatry in the latter part of the medical training and I knew, almost instantly, that this was my calling.

I was very excited as I joined the basic psychiatric training in the UK in 2003. However, far from being prescient, I did not have the slightest inkling that what was to follow was not an entirely seamless process of learning but a journey as much filled with waylaying misconceptions as indeed with useful knowledge. I remember in the heady days just after joining the rotation I was very keen to fit every clinical presentation into ICD-10 or DSM-IV diagnostic criteria, never doubting for a moment the validity of the two. Every indisposition or reaction to stress was a mental disorder and every psychotropic a panacea. Rather ironically, I found myself following a 'model' akin to what, years earlier, had made me want to drop out of the medical training. Fortunately, the 'spell' did not last and once again I was able to see patients for who they were i.e., individuals with unique stories that carried meaning far and beyond what a notion of 'a disorder in brain' could possibly capture. As much as I remained persuaded that medications etc. have a role to play I recognised the centrality of a patient in the process of his or her own recovery. Things, I realised, only made sense when viewed in the explicating context of a dynamic totality of an individual's life rather than as meaningless fragments. A lesson was learnt for life.

In the autumn of 2006 I passed MRCPsych exams and decided to apply for higher training. However, the following year proved to be *annus horibilis* for many trainees. I was one of them. My application was not successful and I, like many others, blamed MTAS (Medical Training Application Service) and felt vindicated as the protestations calling it a "fiasco" got noisier. But a decade on I look back and wonder what might have been if I had simply worked harder than I did and made my application a bit better. Anyway, in 2008, in a rather indignant frame of mind I took up locum work as a speciality doctor which, against all the prevailing wisdom, proved to be a positive experience – well, on the whole. Initially, I had thought I would do it for a year or two but did it for nearly nine. It was an interesting time not least because of the changing financial landscape of the NHS which as an 'outsider' caused me less frustration than to my permanently employed colleagues who quite often would be genuinely outraged over endlessly repeated euphemisms like 'restructuring', 'reorganising', 'consolidating' etc. Curiously, I could and I did almost all the locum work in just one NHS trust, albeit across two specialities – Forensic and Learning Disability. This, when viewed against the backdrop of resignations, redundancies, re-deployments, and ward closures affecting staff in substantive posts of all grades, was difficult to comprehend. I could only surmise that in some situations a locum was probably preferred to permanent staff, as having temporary staff provided employers the latitude needed in making radical changes to the posts or, more drastically, doing away with them altogether. I hasten to add that I would not exactly rub my hands in glee as the employers took time to deliberate or were being sluggish to make job descriptions more attractive to people seeking substantive posts but I must admit I would be quietly pleased over the delays in replacing me. Luckily for me, I have had enough time in every post to gain a broad range of experience in both the specialities.

I was posted on medium secure units twice. Both units had a predominantly rehabilitative focus with 'recovery model' being the mantra which was reflected in almost every treatment programme run on the wards. But quite often the intractability of conflicts of narratives of the patients and those of the care teams would stall the progress of therapeutic work. Sometimes 'excessive circumspection' would get in the way. That said, there were quite a few successful discharges from the units even though there were many cases of protracted admissions. For my part, I quite enjoyed the whole experience of working on the wards, doing assessments for suitability of transfers from prisons and a high secure unit, and attending a parole boarding hearing on behalf of a consultant on leave and securing a patient's release on a life license etc. in addition to doing a more quotidian work of writing reports. It was a thoroughly positive experience but I could not envisage a long term career in forensic psychiatry. My heart was somewhere else.

I felt drawn to the psychiatry of learning disability during my six month posting as a senior house officer in the speciality in 2006. A further nearly five years of working as a locum in the specialty only increased my ardour for it. I have always felt there is, if you like, a 'known unknown' that influences our career choice but when finally in 2016 I joined the higher training in learning disability I had two very clear reasons for it. Firstly, I find the specialty as very broad in its remit in that it deals with almost every mental health condition one comes across in other psychiatric specialities in addition to concerning itself with a range of clinical presentations which are distinctively unique to it. Secondly, the multi-agency working is more than just a soundbite in this specialty. It is right at the heart of it. Truth be told I would have probably carried on with locum work despite the nagging thought of having a 'dormant' MRCPsych under my belt and the incessant pressure from friends and relatives to become a consultant. What tipped the balance eventually was one of my most recent locum jobs where I, like never before, felt a hankering to be free to express opinion and not be constrained by someone else's rigid, bordering on stubborn, way of working. I must add that I am glad I did this job. It was here, more than anywhere else, I learnt 'what not to do' and without the 'push factor' it provided I probably would have gone on to do locum work for longer than I did.

So far, the training has been a much better experience than I had expected, not least because of the support I have received from the trainers who have not only taken interest in my development as a trainee but have very much been instrumental in forging an attitude of a life-long learner. Also, I think it is an exciting time to be trainee when initiatives like Transforming Care are in full swing and Mental Health, Learning Disability and Autism are deservedly prioritised in 10 Year Plan. I look forward to the remaining few months of training and beyond.

In case you missed it: Social Media

Calling all providers of care and treatment for people with a learning disability or autistic people. Here's a booklet to help you understand your important role in relation to C(E)TRs . https://www.england.nhs.uk/wp-content/uploads/2018/09/cetr-booklet-health-social-care-providers.pdf … @Sally_Brown1962 @SteveHardyLDN @carterjenny16 @NHSAbility @marybusk

Anne Webster @AWebster67

My experience attending the Faculty Executive Committee

Dr Laura Korb

LK- ST6 Psychiatry of ID

What does Faculty of Psychiatry of Intellectual Disability do for me? My experience attending the Faculty Executive Committee

I have been a member of the Royal College of Psychiatrists 2015. Like many others, I worked hard to gain the professional qualification to progress in my career in Psychiatry. I attended exam courses, I paid the fees, and even I travelled to Sheffield! I am not sure I really understood what the College meant for psychiatrists working in clinical services. I followed the path recommended by my tutors that included becoming a member of the Royal College. I had a very basic understanding of the College. I understood there were various faculties and that my specialty had its own which ran conferences a few times a year. I knew I paid money to attend conferences and money to maintain my annual membership. I also knew they had a shiny new building with a very nice café. That was the limit of my knowledge of the College.

I have been working with Ken Courtenay, Chair of the Faculty of Psychiatry ID, since 2018. He suggested I attend a meeting of the Executive Committee as part of my training in the profession to learn more about the function of the Faculty and the College. So there I was, on a Wednesday afternoon in January heading to Aldgate in East London not knowing what I would experience at the meeting. I have to admit to being a little apprehensive about who I might meet there.

The meeting was well attended by elected members from around the UK and others who were co-opted for specific roles. I was really pleased to meet three trainees representing the ID Trainees group and the Psychiatric Trainees Committee. The business of the meeting ranged from plans for recruitment into the specialty, Faculty finances, future business plans, position statements on relevant issues, information from the Specialist Advisory Committee, and finally feedback from Regional and Trainee representatives. I knew few people on the Committee but through the agenda I learned about their role on the Executive Committee and the work they have been doing as a member. They were warm and friendly towards me and made me feel at ease as an observer. Although there was a clear structure to the meeting, everyone was able to express their views including the trainee representatives. I was pleased to observe dedicated and passionate individuals trying to make a difference to future of our speciality.

This opportunity is open to one person not elected to the executive per meeting. I highly recommend attendance for those people interested in seeing how the future of our specialty is evolving and how issues are being addressed.

In case you missed it: Social Media

Feeling proud to present in away day as an LD Psychiatrist higher trainee representing the whole Penine in PENINE LD AWAY DAY @idtraineesuk @psychiatryofid @KenCourtenay @DrKateLovett @wendyburn

Dr Syeda Asma Hasan @SyedaHasan16

Interview: David Clarke

Dr Giri Madhavan

@Dr_GiRi_PsychID

ST6

Psychiatry of Intellectual Disabilities, West Midlands Deanery

About Dr Clarke

Dr Clarke is a Consultant Psychiatrist who has worked in the West Midlands for both adults and children with intellectual disabilities for over 30 years. As well as numerous publications in the field of ID, including a special interest in Prader-Willi syndrome, he has co-authored the book "The Psychiatry of Intellectual Disability" and was a member of the working group for the DC-LD.

Background to the interview

Dr Clarke is a well-known name in the field of intellectual disability and to the College and its members. Many years prior to STOMP, Dr Clarke was authoring studies on the use of medication post discharge as well as reports on medication use for challenging behaviour. As he mentions in this interview, he is more of an introvert, so it is wonderful to share some of his reflections on the field of ID as well as personal insights

What are the key changes you see as having happened in psychiatry services for people with ID?

The move to community-based services must be the biggest. I joke with colleagues that working with me is dangerous because everywhere I work closes (Midland Nerve Hospital, Hollymoor Hospital, All Saints Hospital, Harris House Resource Centre, Monyhull Hospital, Lea Castle Centre). People with ID now have a much better quality of life, but I do worry about the increasing difficulty in arranging decent inpatient treatment for those people who need it - especially those with autism who require a particular kind of environment and pattern of care. Another change has been the attitude of other doctors, including other psychiatrists. I remember being questioned about "why on Earth" I wanted to do psychiatry rather than medicine, and a senior psychiatrist commenting that the prevailing view was that most psychiatrists working with people with a learning disability were themselves disabled or backward.

What do you see as the big priorities in research for people with an ID?

A better understanding of the genetics of the many disorders and diseases that make up "intellectual disability" leading to targeted treatments that may, at some point, even arrest or prevent disability. PKU and Huntington's disease have shown what can become possible once the genetic and metabolic underpinnings of disability are clarified.

If you were not a psychiatrist what other profession would you choose?

For a long time I thought I would have liked to have been a record producer (for the younger generation, records were black vinyl things that came before the CDs that came before downloads). Having struggled with basic multi-track recording at home I now think this may not have been such a good idea. Psychiatry and working with people with ID has been very rewarding.

What was your earliest ambition?

To run a scrap-yard. I really enjoyed trailing my father round the scrap-yards of the early 1960s in Wolverhampton and the surrounding area, especially if the trip back coincided with what was then Banks's brewery discharging the week's hop aroma. As a child all my toy cars had the tyres removed (and anything else that would detach).

What advice would you give to recent new entrants?

It always pays to be the local expert in something

Be careful with your language – most people with ID understand much less than their carers think, and gain a lot of information from context and expression rather than the content of speech

Watch where you sit when visiting patients with hoarding and hygiene problems (washable clothing is a must)

Take no notice of those who say there is no future in LD psychiatry (people were saying that when I was a trainee)

Learn to (politely) say no

Do you see Brexit as impacting ID services

Not other than in the very short-term. My take on Brexit is not very sophisticated – you can have more prosperity (which would be my preference) or more sovereignty, but you can't have both. In the long run other events will have much greater influence and significance – on ID services and on the UK as a whole.

Has Transforming Care been a success?

See "key changes " above (and my dislike of verbosity!)

Which people have influenced you the most?

Very difficult to say – I think I have learned from everyone I trained with, often about style of interaction or how to approach particular problems. I have learned (and continue to learn) a lot from colleagues and, when I had them, trainees. Chuck Berry ("run your own show", "don't let the same dog bite you twice") and Warren Buffet ("you find out who is swimming without pants when the tide goes out" "be greedy when others are fearful, be fearful when others are greedy") also deserve a mention. As does Mark Twain ("a gold mine is a hole in the ground with a liar at the top").

Tell us about either a film or a book that left an impression on you?

There have been many – books usually rather than films. "Brandon Chase" (BB) for its politically incorrect account of three boys running away from their aunt to live in a wood, including the first stirrings of adolescent love. "The Wine Dark Sea" (Robert Aitken) and in particular "The Trains" which manages a very unsettling twist on the "two woman have to take shelter in a creepy house" horror trope, and "The Red Room" (H. G. Wells) which is also an excellent horror story – a ghost story with no ghost.

When not being a psychiatrist what do you enjoy?

Gardening, fishing (especially fly-fishing the river Rea in Shropshire for trout) and spending time in a wood. I am also an incorrigible collector – of suffragette postcards, Roman silver coins, English Trade tokens, Royal Worcester Character Jugs, oil lamps, fountain pens, you name it. In 2015 I dug a large garden pond by hand and it is now stocked with goldfish, tench, rudd and two Koi - the noisiest and greediest feeders I have come across.

Tell us something about you most people don't know?

Three things – for about 12 months I ran (sort of) a commercial fishery in my spare time. I used to keep ferrets. I also restore old oil lamps (Tilley, Coleman, etc) and have a shed devoted to lamp restoration in the garden.

How do you relax?

In the Summer in the garden (or lamp shed) in the wood, or by a river. In the Winter in front of a wide-screen TV - a subject causing some marital friction by being "too" wide-screen, although my daughter is on my side on this one… I also like laying and lighting fires and will happily spend an hour superintending a coal fire by moving coal to the optimal position to take advantage of the kindling wood.

What is your biggest achievement to date - personal or professional?

Getting an MD with Honours was nice, but out-smarting the financial services industry to manage my own investments post-pension has probably been more of an achievement. And digging a garden pond without my back giving way.

What is on your wish-list for the next five years?

Staying alive and in reasonable health (which will probably mean an operation to do something about my lumbar spine) and building a detailed model railway depicting the last days of steam working on British rail (c1963).

What is your pet hate?

Verbosity, written or spoken (especially if accompanied by much gesticulation, a reflection of my being a miserable introvert I suppose). My wife is a hand-waving extrovert and we are incompatible in almost all respects. Having said that I have some respect for Proust despite his page-long sentences. He was probably a lot snappier in the original French.

What is the most important lesson life has taught you?

Value what you have rather than hanker after what you don't have - but plan carefully for the future.

In case you missed it: Social Media

NEW PAPER : We discuss depictions of #ActuallyAutistic females with autism within works of fiction across a range of media, including books, TV, film, theatre and video games. Plz read + RT @VerityChester @PriTharian @NikitaHayden @LPTresearch @lptnhs

Dr Sam Tromans @SamuelJTromans

National Intellectual Disability Trainee Conference 2018 – 30th November 2018, Double Tree Hilton, Edinburgh City Centre.

Dr Fionnuala Williams

ST6 Scotland Deanery

National RCPsych ID Faculty Higher Trainee Co- Representative

On St. Andrew's Day with the gorgeous panoramic view from the Double Tree Hilton in Edinburgh, delegates gathered from all four nations of the United Kingdom for the National Intellectual Disability (ID) Trainee Conference. Our first talk was from Dr John Russell, the College's Associate Dean for Curricula who described to us the upcoming changes afoot in the ID curriculum. For example, it will be easier to adjust the curriculum in future as at present it can take years to make alterations. Also by improving the curriculum, the hope is that this will lead to improved recruitment. Dr Russell compared the development of the curriculum over time to the three Forth bridges, with the aim that, like the Queensferry Crossing, the new curriculum will be a more efficient and less bumpy journey!

We then commenced a series of talks on our main theme of the day: the development of mental health legislation across the UK. Our first speaker was Dr John Crichton, Chair of RCPsych in Scotland and Vice President of the College. Dr Crichton had as a trainee been asked to provide an independent report into the Bournewood Case. He gave an interesting account of the case of HL which gave not only a description of the legislative developments in this case but also a picture of what HL was like as an individual, something often lost in reports of such cases. The presentation also highlighted how optimising relationships with families is essential. In this case, like many other high profile medicolegal cases, there had been a breakdown in relationships between carers/family and professionals. Dr Crichton continues to receive a Christmas card every year from HL's carers updating him on how HL is doing: a reminder of how even as trainees we can have an important impact on patients and their carers. Dr Crichton was followed by Dr Simon Webster, Secretary to the Independent Review of Learning Disability and Autism in Scotland's Mental Health Act. Dr Webster gave us an overview of the review process which is still in its early stages. It was reassuring to hear how comprehensive it will be. It is not merely a matter of reviewing whether these conditions should be considered mental disorders under the Act but also about whether the Act and its provisions meet the needs of people with ID and Autism. Significant efforts have been made to make the review process accessible to service users with easy read versions of the questionnaires and development of Talking Mats. It is clear that both the importance of the review and need to consider carefully any changes or alternatives to current provision have been recognized.

After coffee we headed south of the border to hear updates regarding proposed changes to English legislation from Ken Courtenay, Chair of the ID Faculty. A number of changes are being considered including a review of the definitions of Deprivation of Liberty Safeguards (DoLS), unifying Sections 2 and 3 for a shorter period of detention, reviewing the role of the nearest relative to have a "nominated person," the plan to change the term used under the Act from Learning Disability to Intellectual Disability, and removing "unsound mind" from the Act. We then travelled over the Irish Sea to learn about the new Mental Capacity Act in Northern Ireland from Dr Stephanie Campbell, ST6 in General Adult and Old Age Psychiatry and ADEPT Clinical Fellow in Leadership. This global first in combining mental health and incapacity legislation is yet to "go live" but it was interesting to hear of both the benefits and the potential difficulties with the Act. There are benefits for patients in having an Act that only allows compulsory powers if they have lost capacity, one that provides a framework for treatment in the community, one that has robust safeguards in place, and one that broadens the range of professionals who can do capacity assessments. It was interesting to hear that under this Act the advance directives made when someone has capacity will continue to be binding after the person has lost capacity. It was also noted that children will not be covered by the new Act and will continue to be managed under the old act: the Mental Health Order. Much debate ensued about the pros and cons of this new law.

After lunch, we listened to Dr Susie Gibbs and Dr Adelene Rasalam about CAMHS ID both as a service and a specialty. The closure of the big institutions was essential and the admission of very young children to ID hospitals, for what ended up being decades for some, had to change. However, these changes led to ID psychiatrists in Scotland working primarily with adults and no longer maintaining their expertise in working with children. Children with ID fell in the gap between services but through the hard work and dedication of clinicians with an interest in this area, CAMHS ID psychiatry services in Scotland began to develop again around the start of the 21st century. However, there continue to be some health boards with no dedicated CAMHS ID service, there is no inpatient service for children and young people with ID, and community services require more development. Although the specialty is under resourced, we heard about some of the fascinating cases that are managed in CAMHS ID and about the real differences that clinicians in this area can make with their patients. We then had a brief session from our Faculty trainee representatives, myself and Dr Catherine Walton about what we can do for the trainees. This included a discussion about the current focus on recruitment from the Faculty Executive and how trainees can help.

Anthony Kramers, Regional Leader from L'Arche Uk and Lynn Darke, Community Palliative Care Specialist then presented on the gifts and challenges of supporting people with ID who are coming to the end of life. It was encouraging to hear how with the right setting and support from the multidisciplinary team, people can be supported to have a “good death” at home. The importance of good communication and supporting not only the patient but the carers/staff team around them was highlighted. We then finished the day with a fascinating talk about the Scottish Malawi Mental Health Education project from Dr Lindsay Mizen, ST6 + in Psychiatry of Intellectual Disability. It was thought-provoking to hear about the differences in medical education and services for mental health and how rewarding an experience it can be to take some time out to teach the eager students.

In summary, this was an interesting and diverse programme, and the atmosphere was relaxed enough to allow discussion to flow freely. The Welsh trainees have agreed to take on the baton for next year and we look forward to their conference in Cardiff in 2019!

...like the Queensferry Crossing, the new curriculum will be a more efficient and less bumpy journey!

16th East of England Psychiatry of Intellectual Disability Annual Conference.

Dr Oliver Duprez &

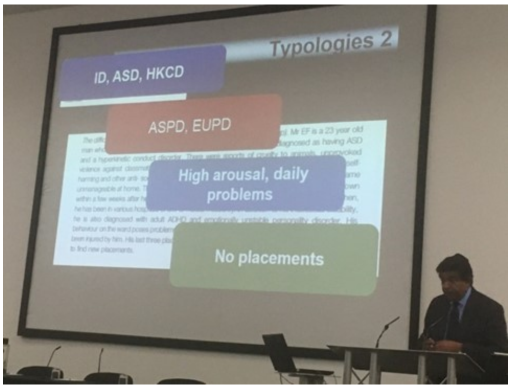
Dr Tawakalitu Kehinde

Consultants in Intellectual Disabilities Psychiatry working in Hertfordshire.

On Friday 8th June 2018, The Fielder Centre in Hatfield welcomed delegates for the annual East of England Intellectual Disabilities conference. The themes were diverse covering leadership and quality in challenging times, epilepsy, autistic typologies, ADHD and performance issues in doctors.

Dr Kamalika Mukherji organised the conference along with Dr Sophie Shardlow, and opened the event with some introductory remarks.

Tom Cahill, Chief Executive of Hertfordshire Partnership NHS Foundation Trust, and HSJ Chief Executive of the Year 2017, gave an inspiring talk on Healthcare Leadership in Challenging Times. He compared the challenges faced by NHS 70 years ago with the current difficulties. Mr Cahill went through the 5 Year Forward View, and highlighted the need for increased integration, the need to move from variation to standardization, and new organisational forms, including Strategic Transformation Partnerships (STP’s), Integrated Care Systems (ICS) and Integrated Care Partnerships (ICP). The new organisational frameworks will give healthcare providers the flexibility to plan and implement services to meet the needs of local populations. He commented “ If we standardised healthcare systems across the country to the median, we would get better outcomes.” Mr Cahill explained why clinical leadership is important to the transformation of NHS. His inaugural address generated a lot of interesting questions and discussions, and will surely be a regular fixture for future conferences.



Dr Regi Alexander then introduced the concept of autistic typologies. He started by going over the core features and co-morbidities of autism, and used a constellation of stars as a powerful metaphor to describe the core features of impaired communication, social impairment and restricted repetitive behaviours and interests and the three brightest central stars, with other surrounding stars (co-morbidities) such as OCD symptoms, tics, catatonic symptoms, ADHD, and epilepsy to name a few. He then outlined some of the current research into the neurobiology of developmental disorders and their associations with psychotic disorders and personality disorders. He then went on to the issues around offending behaviours in people with autism. He emphasised that law breaking rates are similar or less than the general population, but in certain forensic settings, people with autism are over-represented. He postulated reasons for this to include defects in theory of mind, misinterpretation of social cues, lack of empathy and social naivety. Finally, he outlined the different typologies for offending behaviour which can influence treatment outcomes. The full text of this research is available at https://www.emeraldinsight.com/doi/pdfplus/10.1108/AIA-08-2016-0021

Next Dr Rohit Shankar MBE gave a powerful synopsis of the prevalence, diagnosis and management of epilepsy in people with intellectual disabilities. He has recently worked on the Royal College of Psychiatrists report into the Management of Epilepsy in Adults with Intellectual Disability, which proposes a traffic light system of competencies for psychiatrists in the management of epilepsy. Dr Shankar has made an invaluable contribution to the lives of people with epilepsy; his passion for this subject was conveyed to the conference.

Dr Bhathika Perera then gave an overview of his work in developing a new diagnostic tool for ADHD in people with intellectual disabilities, the DIVA-ID, based on the DSM-5 diagnostic criteria. He also updated us on the new NICE guidelines for ADHD.

Prof Asif Zia, Executive Director of Quality and Leadership HPFT, outlined the structures and frameworks involved in investigating psychiatrists when complaints or allegations are made. His talk gave food for thought for the need to balance accountability and fairness for doctors when complaints are made. A healthy debate ensued about some recent high profile cases.

The conference broke into Workshops including a new consultants forum chaired by Dr Daniel Dalton, “how to get published” by Dr Howard Ring and 2sexuality, ID and the law” by Dr Sanjay Nelson. Dr Dalton outlined different leadership styles and change management theories

The conference was well attended and provided thought provoking insights into some of the challenges faced by clinicians in the field of Intellectual Disabilities Psychiatry.

Dr Daniel Dalton and newly qualified consultants.

Upcoming conferences

DATE	TITLE	LOCATION	ORGANISATION
MEETINGS			
26 April 2019	Faculty of Psychiatry of Intellectual Disability Spring Conference	Prescott Street	RCPsych
10th May 2019	Centre for Autism Neuro-Developmental Disorders and Intellectual Disability	Double Tree Hilton Hotel , Chester	CANDIDD
16-17th May 2019	CAIDPN residential meeting	Glasgow	Child and Adolescent Intellectual Disability Psychiatry Network
23 – 25 May 2019	12th European Congress Mental Health in Intellectual Disability	Palau de Congressos Fira de Barcelona	EAMHID
1-4 July 2019	RCPsych International Congress 2019	Excel, London	RCPsych
6-9 August 2019	IASSID World Congress	SEC, Glasgow	IASSID
26-27 September 2019	Faculty of Psychiatry of Intellectual Disability Annual Residential	Hilton Hotel, Leeds	RCPsych

Upcoming prizes

DATE	TITLE	LOCATION	ELIGIBILITY	PRIZE
PRIZES				
30 April 2019	The Brian Oliver prize	Presented at the Faculty annual residential meeting., usually held in Autumn each year	Eligible: Applicants must be in an approved UK training scheme working at CT1-ST6 level or within the first 3 years of a Consultant post.	**Prize**: £500 The prize is awarded for research undertaken in the psychiatry of intellectual disability.