

Psychiatry of Intellectual Disability

Newsletter of the Faculty of Psychiatry of Intellectual Disability

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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) for the next issue.

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Comment
and share



Editorial

Editorial



Dr Kathleen Levick

Editor

Welcome to the September 2021 edition of the Faculty Newsletter.

Since the last edition, the pandemic has continued as a background constant, slowly reshaping what every day life and work looks like. We are so lucky to be in a position to have been offered vaccines, and most recently, a third booster dose for a variety of people, front-line health workers amongst them. Let us hope that this additional layer of protection is offered to those most in need, and that this will include many of our patient cohort. I continue to hope that good sense and unity with our fellow humans prevails and that those countries and communities with greater resources continue to ensure that these protections are shared also to those places in the world with less availability.

The first fresh wave of resilience in this pandemic has passed, and whilst some protection has been gained, we are now in the long-haul marathon section of the pandemic, with hopes that this will settle to some manageable background part of life. Of course, as usual, in some ways life continues as normal as we continue to offer support to our patients, whilst also working to make up for the backlog of extra stress and burden that this past 18 months has created.

We have all been touched by the experience of the last 18 months in our own personal ways; you may have noticed, for instance, the longer than usual hiatus since the last edition, as proof! Everyone will have their own stories to tell no doubt, of losses and difficulties, but also, I am sure, of some positives, some joyful experiences that of course prevail despite this strange time. I am thankful for how often these come to me via patients and their families or carers.

As many will already know, we have had a keenly felt loss within our professional community, having sadly lost Dr Gravestock to COVID-19 early this year. I am glad to be able to include a warm and fond tribute to him in this publication, which so vividly brings his nature to life, that even as I felt the sadness, it raised a sincere smile and even a chuckle in remembrance.

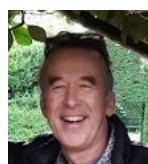
As ever, I have again been overwhelmed with the number of offerings which have been sent for submission. Myself and the editorial team, Geoff, Jen and Jozsef, have been kept busy and

full of admiration for the quality of the articles we share with you here.

We are grateful for the usual regular slots, keeping us up to date with goings-on in the Faculty, with the Special Advisory Committee, and with the latest research. The now no-longer-so-new reps, Amina and Dan, have filled us in with their work behind the scenes, especially important as we continue to miss more frequent face to face contact. We have a lovely film review of an excellent film; I myself can strongly recommend 'The Peanut Butter Falcon', and you can read about it herein. We have, inevitably, a couple of reflections and analyses of the newly common manner of interaction, via video and telephone consultations: one showcasing the service user viewpoint, with the other exploring the more psychological or psychoanalytic perspective. We have a fascinating article exploring the theme of the Next Big Thing in psychiatry research, as well as an article looking into the patterns of referrals seen in a CMHT over the last year. One of the most heart warming and thought-provoking pieces that I have really enjoyed this year is the Joan Bicknell medical student prize-winning essay; it is full of such insightful reflections that it reminds me at once how glad I am to be working in this rich and fascinating field, whilst also giving such hope for the future of this specialty, with such inspiring colleagues-to-be already taking an interest.

I will leave you to read at your leisure, and I will finish with an invitation, as ever: please, don't hesitate to be in touch, tell us what you want to read, send us what you want to read and to see in here! As you will have noted on the cover, we have decided to use this forum to showcase the artistic talents, not only of our colleagues, but I hope, also of our service users! I hope this will offer much more exciting fare than I can manage with my meagre IT talents and copyright free images. Of course, all work will be suitably credited, and an opportunity to share with the readership across the four nations.

We plan the next edition to have a theme of 'Broadening Horizons', whatever you take that to mean, whether it is experience of our specialty in another country, the experience of International Medical Graduates here, or any other new perspective, either written or artistically represented. Until the next time; I am excited to see what will come our way!



Kathleen Levick
September 2021

Co-Editors:

Geoff Marston, Jennifer Mutch, Jozsef Szavuj

View from the Chair



Dr Ken Courtenay

Chair of Faculty

of Psychiatry of ID

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The second year of the pandemic continues to be so much part of our lives, affecting patients and how we deliver services. As a specialty, we have been touched by it too with the loss of our colleague, Dr. Shaun Gravestock, who died from complications of COVID-19 infection in January 2021. I was touched by the responses I received from members across the UK and Ireland, many of whom knew Shaun from his ebullient presence at Faculty conferences, sharing his accurate and thought-provoking insights with us that often challenged our perspectives. We paid tribute to Shaun at the Faculty Spring Conference on 7 May 2021, hearing from Tom Berney, Ian Hall, Andrew Flynn and Karen Bretherton, close colleagues of Shaun over the years.

In England and Wales, the review of the Mental Health Act is underway. The Faculty has been busy gaining the views of colleagues to the proposed changes to legislation, specifically on the issues of intellectual disability and autism in the Act. We convened a series of virtual focus groups that were hugely valuable in gaining a sense of members' views to shape the Faculty response.

I presented evidence to the Health and Social Care Committee in April on the care of people with intellectual disabilities. The report published in July reflected in its recommendations that more support for community services for children and adults with intellectual disabilities is essential if in-patient services are to be used for people who require treatment and not as fixes for deficits in social care provision. I was pleased the report supported our work on developing the intellectual disability physician role.

The Faculty continues to lead on expanding knowledge and practice with the publication of CR230 on ADHD in people with intellectual disability. The College Report grew out of the work of the ADHD-ID Special Interest Group (@Adhd-Sig) led by Dr. Bhathika Perera. Thanks to the dedicated efforts of the SIG, we now have the first authoritative guide to practice on ADHD in ID.

Maintaining contact with colleagues in services across the country is a challenge to the Faculty since many of you are busy delivering services. Over the years, the links with CAIDPN (@CAIDPN1) led by Dr. Mark Lovell have been essential in keeping the Faculty informed about issues affecting CAMHS-ID services. In March, the Clinical Network for Adult Inpatient Services led by Dr. Mahesh Odiyoor met, with the aim of connecting directly with colleagues in inpatient services across the UK to learn about the challenges you face in NHS and Independent Sector services. Similarly, the Forensic-ID group, led by Dr. Harm Boer, informs the Faculty on issues affecting colleagues working in offender services. Contact Kitty Kottasz (kitti.kottasz@rcpsych.ac.uk) for more information.

As Chair of the Faculty, I have learnt how much the College and external agencies turn to us for advice and insights on mental health in intellectual disabilities. It emphasises for me how we as psychiatrists lead on shaping clinical practice and policy. Such leadership originates in our role as clinical leaders, highlighting for me the important leadership role that we provide in our organisations. We should not underestimate how our actions should be a force for good in services. True leadership is evidenced by our actively engaging with colleagues and systems to enhance care and challenge practice where necessary. This is especially true as we follow the principles of 'Building the Right Support' to support people to live fulfilling lives and to help them and their families to deal with the systemic barriers they face.

Our annual conference will take place on 7-8 October 2021 as a virtual event. Dr. Indermeet Sawhney has put together an excellent and innovative programme for us. It will be good to re-connect with colleagues and I hope in time that we will meet again in-person but until then I encourage you all to remain safe.

Ken Courtenay

**Chair, Faculty of Psychiatry of Intellectual Disability
Royal College of Psychiatrists UK**

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View from the ID Specialty Advisory Committee

Dr Mary Barrett
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SAC Chair



September 2021

I am pleased to be able to write and share highlights from the world of Psychiatry training. Key topics remain the curriculum rewrite and expanding training pathway opportunities; in addition the new ID Psych Star has been appointed and is getting underway with his work!

ID Curriculum Rewrite

I am pleased to report that significant progress has been made with the curriculum rewrite. The GMC has now approved – and commended - using interactive PDPs to demonstrate training progress, with ID providing the sample documentation on behalf of all subspecialties, for this.

The College have now submitted a further revision of all curriculum documentation to the GMC, based on the PDP model and on feedback from the recent curriculum consultation round and an approval decision is awaited. If approval is granted, the timeline for implementation of the new curriculum is for a pilot to take place in February 2022, followed by full implementation in August 2022. The SAC will have a key role in the roll-out process, both in working to develop all the necessary PDP examples and also in providing support and training around the implementation process.

In preparation for this, we convened earlier this month to begin work on PDP examples for different placement types and a further meeting is due in November, to bring this work together.

Dual Training

The GMC curriculum submission for CAMHS/ID dual training (The only current approved combination) has been made alongside the single CCT ID application. We are also moving forward with the application for dual training with Forensic Psychiatry, which will be submitted once the respective single CCT applications have received approval. Thirdly, we will then progress dual training with Adult Psychiatry.

ID Psych Star

At the request of Dr Ken Courtenay, I led on the development and selection of the new ID Psych Star. Dr Rebecca Brown, ST4 trainee, also supported the development and awareness-raising process. The ID Psych Star has been funded by the Faculty to help raise awareness and interest in ID Psychiatry among medical students. The successful applicant is provided with a mentor and wide range of opportunities to develop their interest in ID, as well as acting as an ambassador for the Specialty.

RCPsych received 20 applications for the ID Psych Star, with many high-quality candidates which made it difficult to pick just one person, however we agreed that Ratnu Vaidya, a Medical Student from the North East was the overall winner. The scheme runs from September, however we have already been working with Ratnu on a number of projects, including supporting him to develop a survey on medical student experiences around ID Psychiatry. We look forward to a productive partnership over the coming year and you can read more from him in future newsletters.

There is a lot more I could write, but I hope the above gives a flavour of the key strands of work taking place at the moment. Hopefully for the next edition I will have further positive news about the curriculum approval, amongst other matters, but do please get in touch with me in the meantime if you want to know more.





View from the National Trainee Representatives

Dr Amina Rawat

Dr Daniel Wilkes

AR: ST5, CNWL, London Deanery

DW: ST5, State Hospital and NHS Grampian, Scotland

National RCPsych ID Faculty

Higher Trainee Co-Representatives



It was 10 months ago, November 2020, that Daniel and I were introduced and welcomed as the new National ID Trainee Reps of the RCPsych Faculty of ID. We both felt privileged to be handed over this role from our predecessors Kat and Reena. We were excited to see what we could contribute to the Faculty having ideas flowing out like a gushing tap and looking forward to getting acquainted with our fellow Higher Trainees in ID.

However, these past months seem like a blur and our perception of time passing by has been accelerated such that it seems very little has been achieved. Personally, I blame COVID and the increase reliance on technology coupled with the lack of human contact for this. After all, were we not created to be social animals by evolution or by divine creation – you choose your pick of the two? Or has there been some kind of hybrid evolutionary-divine process going on? Sorry, I'm digressing. Whatever one believes in, I think we can all agree that human contact grounds us, gives us a sense of purpose, a sense of time which is more fulfilling with memories that form part of our existence and which take us into the future.

We have been deceived. On further reflection, behind the façade of screens, and of course in front of them, more has been achieved than one could have imagined. This time thanks to COVID and the increased use of technology; yes, a double-edged sword. Take the Pan-London Higher Trainees Psychiatry of ID Conference in March of this year. There were over 90 attendees, many from outside London, from medical students to Professors, who had the pleasure of being intrigued by 6 keynote speakers and 4 workshops. The theme was about our fascinating and diverse careers in Intellectual Disability with speakers talking about their personal career paths, academia in ID, leadership opportunities

in our field, forensic aspects of ID including stalking and Out Of Programme opportunities for Higher Trainees. We also had the joy to listen to journalist Saba Salman in conversation with Shaun Webster, MBE. Saba is a human rights campaigner who has edited and presented her book, *'Made Possible: stories of success by people with intellectual disabilities; in their own words'*. Speakers were able to donate an hour or so out of their ever demanding lives to enlighten others due to the virtual nature of the conference. Let's also not forget the conference organisers, higher trainees, who were able to meet with ease on a regular basis due to the screens in front of them and who then behind their screens (well actually, still in front of them) diligently got on with their tasks to make the conference the success it was.

The *'Meet the College ID Faculty Chair and Reps'* event in April 2021 attracted Higher Trainees attending from a variety of places, including London, Wales, East of England and Scotland, again *grâce à toi, notre ami*, the computer. A variety of issues of importance to the specialty were discussed; mental health act changes, availability of special interest sessions or subspecialty experience in CAMHS/ Forensic-ID, dual training schemes and preparation for consultancy. Very positive feedback was received from trainees who attended and the level of the discussions gave a really optimistic view that these trainees represented the future of our specialty. There will be another one coming up this autumn, so watch out for the invites by the College, by email of course!

With national recruitment numbers in Psychiatry of ID being short, technology has contributed to an increase drive in initiatives to challenge the misperceptions of a career in psychiatry of ID and showcase our speciality to many more people. We have been able to attend careers fairs, undergraduate conferences, Foundation Year and Core Trainee teaching sessions, and IMG (International Medical Graduates) training events around the country. Not only that, collaboration via technology has led to an increase in the number of medical student electives and FY posts in the field, and the creation of a PsychStar role in Psychiatry of ID, which this year attracted a high number of applicants, and of a high calibre. The winner, Ratnu Vaidya from Newcastle University, will in turn be using technology to gauge and challenge the perceptions of medical students' perspectives towards Psychiatry of ID. Needless to say, COVID and the increase reliance on technology have enabled greater participation in the Faculty's Recruitment Management Steering Group meetings!



The shift from classroom, or lecture hall based learning, for those of us who are more academically inclined, to online learning has meant we have access to a plethora of resources. I myself have witnessed the sudden surge in attendance to the College's ADHD in ID Peer group meetings. The learning opportunities these meetings provide through case discussions and presentations are exceptional and are now available to all, nationwide. By contrast, before COVID decided to pay us a visit, it was rare to have an attendee outside of the parameters of the M25.

In a similar way, we have been able to achieve much more in our clinical care, as virtual assessments have enabled us to see more patients. This is particularly noticeable in the community where the travel time between seeing patients has reduced to seconds and involving only the movement of our extraocular and forearm muscles. From the patient's perspective, and especially pertaining to those with learning disabilities, access to clinical care and resources has increased and become easier.

In between these countless virtual meetings and assessments, and with less interference by human contact, we have also become very efficient in using technology to churn out work, almost robot-like. Just like violence begets violence, reliance on technology begets reliance on technology. And here lies the problem; the lack of human contact hinders the building of positive relationships, it hinders greater understanding and empathy towards our patients. The discomfort of never having seen a person for whom we are prescribing questions our integrity as doctors, particularly as trainee psychiatrists. More so still, working with people with intellectual disabilities where we may not even be able to speak with them directly! We cannot get a good enough sense of their disabilities or their carer's difficulties, neither can we accurately judge their abilities. I remember the sense of relief I felt after visiting a family who the whole team were concerned about, particularly as they were refusing support. There was talk of raising a safeguarding concern due to their refusal. But sitting in their home, a relaxed and pleasant environment, feeling the positive ambience, and observing the tenderness between the patient and her carer, I was reassured that despite their difficulties, they were doing ok.

In the same way, the lack of human contact has also hampered our understanding and empathy towards colleagues. We have all experienced increase challenges in COVID times with increase rates of morbidity and mortality of our patients, our colleagues and our loved ones. The stress has been intensified in trying to balance the newly ubiquitous 'work from home' with childcare, and of course for many key workers (as with many around the world), there has been an increase in financial pressures. With all the applause by management circles and by government personnel for our hard work and resilience, it seems we have risen to the challenge.

But have we? Has the applause pacified us, preventing us challenging management and government? Has it given us a false sense of being resilient and powerful making us just get on with whatever is thrown at us? Has it prevented us admitting our struggles to our colleagues? Perhaps this explains the lack of response from trainees to emails Daniel and I have sent requesting feedback of their training experiences in COVID times. I guess the impersonal nature of such requests by emails does not help either! We really would like to know. Please somebody talk to us!

The increase reliance on technology has the potential to also make our support structures less personal. The HEE London School of Psychiatry have recently proposed to move away from small Trust based programmes into larger regional programmes supported by a realignment of TPD sessions. Yes, there are advantages of this but also disadvantages, as a trainee fed back to me (woohoo I got a response!) "...at the moment we receive excellent, personalised input from our TPDs .. I would be concerned that the changes may result in a reduction in the quality of support which we currently receive."

More importantly, perhaps the problem is admitting our struggles to ourselves in the first instance. We all know the drill of acknowledging or accepting a problem before change can be made, we say it all the time to our patients and help them gain insight to support recovery. But do we do the same to ourselves?

At a more personal level, I have a particular angst. I have been in my higher training post for 18 months, enough time to build friendships among peers, but I have had no face-to-face contact with them, not even in a professional capacity, never mind at any social events. I remember our Faculty Chair, Ken Courtenay, telling me the importance of such relationships as these will be the people who you'll be working with for the rest of your career life. With the increase in COVID rates again, potentially further, more vigorous and lengthy lockdowns, I wonder if I'll ever make any meaningful relationships with my peers in the course of my higher training? I'm banking on the National Trainees Conference, to be hosted by West Midlands this November, being a non-virtual one!

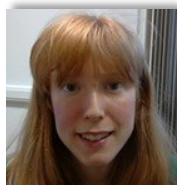




Research Roundup

Rachel Steele

*Clinical Librarian with Tees, Esk
and Wear Valleys NHS Founda-
tion Trust.*



[@TEWV library](#)

Down syndrome (DS) is linked to intellectual disability (ID), pervasive developmental disorders and Alzheimer's dementia (DS). A recent paper (Anderson et al., 2020) considers the evidence regarding the relationship between dementia in people with DS and the severity of ID and the presence of pervasive developmental disorders. The paper identified a pressing need for longitudinal studies concerning the presentation, development and progression of dementia in people with DS to ensure that the severity of ID and comorbid pervasive developmental conditions are captured regularly to study their influence on the causes and outcomes of dementia.

A recent study compared the knowledge of GPs and psychiatrists in Cornwall towards antidepressant withdrawal symptoms. Psychiatrists thought that withdrawal symptoms were more severe than GPs did, with 35% of respondents saying that they inform patients of withdrawal symptoms, however patient surveys indicate only 1% of patients are actually informed (McCabe et al., 2020).

A review discussed factors influencing discharge of people with ID from institutional/hospital settings to community settings. It found that factors linked to a successful transition were suitable standards of housing, staff support/training and health-care access (Lennard et al., 2020).

The ADAPT instrument was developed to assess adaptive skills in people with ID. 2,081 ADAPTs from people with suspected ID and 129 ADAPTs from the general population were administered and results indicated that the ADAPT is a valid tool for assessing adaptive skills in people with ID (Jonker et al., 2021).

People with ID are more vulnerable to trauma than the general population. A recent scoping review identified areas for further research and concluded that aggressive behaviours can be symptoms of trauma, there are appropriate assessment tools for trauma's impact, evidence-based interventions for trauma may be effective and factors linked

to disability can be experienced as traumatic (McNally et al., 2021).

A qualitative study explored the perspectives of parents who had adult offspring with ID. It found that recurring feelings of loss experienced by parents regarding their child's ID diagnosis persist over time and that specialised emotional interventions are required to help parents alleviate the intensity of their feelings of grief (Fernandez-Avalos et al., 2021).

A qualitative study investigated the attitudes of staff in community residential homes for people with ID regarding their opportunities to promote a healthy diet in the residents. The four most important themes encapsulating their views were, "attitudes", "facilitating a healthy diet", "practical cooking skills" and "applied dietary knowledge" (Rostad-Tollefsen et al., 2021).

A recent study focused on a nationally representative longitudinal study of older adults with ID (aged over 40) in Ireland. 92.4% of the sample had friends, with just over half having a best friend (52%). Co-resident friends (71.8%) were more common than non-resident friends (62%) and staff friendships (62.5%) were important. Challenging behaviour and communication problems were linked to reduced likelihood of having a best friend (McCausland et al., 2021).

A recent study adapted a group CBT programme designed for youth with ASD anxiety to the needs of people with ASD and ID. The adapted treatment was feasible and acceptable to the sample and anxiety improved, but the findings need to be replicated in a larger sample with a control group (Blakeley-Smith et al., 2021).

An RCT also adapted DBT for people with mild-to-moderate ID and comorbid mental health conditions. The adapted treatment proved to be feasible and beneficial for this group (Jones et al., 2021).

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The next big thing in psychiatry research.

Dr Jalil-Ahmad Sharif

ST5 and Chief Resident,

Solent NHS Trust



Article originally published as Duncan MacMillan Prize winner, 2nd place, for The Institute Of Mental Health

<https://www.institutemh.org.uk/about/awards/907-2020-duncan-macmillan-essay-prize-competition-winners-announced>

The human genome was mapped successfully in 2003 using Omic technologies. Since then, new waves of sequencing technology, allowed scientists to correlate the impact of genes on diseases, while simultaneously kick-starting a new branch of medicine called 'personalised medicine'. 1

Oncology is at the forefront of harnessing personalised medicine. It is gradually permeating to other specialties, and it's impacts on psychiatry will be ground breaking.

Current challenges in psychiatry are the symptom-based diagnosis to provide caseness for patients; limitations are the inadequate response of psychotropic medications to their respective psychiatric disease. Taking aripiprazole as an example, only one in five patients responds to treatment.1

The RDOC framework developed by the US-based NIMH is an outstanding tool in neuroscience research to overcome this challenge. 2–4 It takes the bio-psycho-social model into account to integrate psychiatric diseases with neuroscience to research pathogenesis to establish a newer system of nosology. RDOCs framework biological model aims to research dysfunctional genetic, transcriptional, translational, cellular and biochemical processes, namely:

- genomics (DNA sequences)
- transcriptomics (RNA transcription)
- proteomics (protein translation)
- metabolomics (metabolites). 3,5

It focuses on individual and combined biological processes and integrates them systematically to establish causes for psychiatric illnesses. Studying the impact of psycho-social stressors using the RDOC framework is vital.

Intellectual disability (ID) and autism have multiple pathogenic genes. The dysfunctional SHANK3-gene, for example, implicated in autism and Phelan-McDermid syndrome, is potentially pathogenic in schizophrenia and other neuropsychiatric conditions. 6

In the UK, the STOMP initiative has improved prescribing for patients with ID. It aims to reduce the harm caused by polypharmacy - closely considering risk vs benefit, especially when prescribing off-licence. 7 The combining of Omics with the RDOC framework will further direct treatments to specific psychiatric diseases and reduce polypharmacy. Appropriate rationalisation of psychotropic medications is essential in minimising patients' exposure to unnecessary drugs using outdated prescribing practices. Targeted medication reviews

are critical in reducing the unwarranted impact of the multi-factorial side-effects of psychotropic drugs.

Targeting rare genetic causes of ID, where patients are more susceptible to psychiatric diseases such as schizophrenia allows their analysis in genome-wide association studies. Subsequently, stratifying these genes into polygenic risk scores will enable clinicians to develop improved diagnostic tools taking genes as well as symptoms into account. Improving psychiatric diagnosis, caseness and treatment, taking current prescribing practises to another level. 8–10

An example of how this can be achieved is the breakthrough technology of induced pluripotent stem-cells (iPSC) alongside genomics, it enabled the culturing of human neuronal organoids. These "mini-brains" utilised in research are the closest to human in-vivo testing to study aberrant neuronal functioning and morphology, an excellent tool for psychiatric personalised medicine. 11–15 Suppose genes show statistically significant pathogenic potential, splicing this distinct pathogenic gene into human iPSCs allows research of neurodevelopment and drug response to psychotropic medications.

It is evident that utilising this research methodology will enable a better understanding of the biochemical changes to inter-cellular and intra-cellular processes when modulating neurotransmission and neurotransmitters by psychotropic medications. Subsequently, this will enhance the targeting of psychotropic medications to the patient, called pharmacogenomics, thus offering personalised medicine. Pharmacogenomics will also help in repurposing the side-effects of drugs used for other conditions as a potential treatment option in psychiatric diseases. 16

Another layer of research in Omics is the study of epigenetics, exploring if specific genes are switched on or off. This regulatory mechanism impacts on protein synthesis, metabolism and signalling. 11,17 As epigenetics elucidates expression of distinct genes, it is vital in understanding the reverse effect of psychotropic drugs on the gene, proteins, and metabolism in the neurons but also other cells in the body. Interestingly, psycho-social factors reflexively modulate genes epigenetic properties. Research of psycho-social factors leading to diseases are priorities of the RDOC framework, as mentioned earlier.

For example, epigenetic research has challenged some firm-held beliefs of pathophysiology in dopaminergic and glutaminergic signalling in schizophrenia. A study by Skene et al. 2018 in mice focused on pathological messenger RNA

transcription processes impacting on protein metabolism, highlighting an increased association of schizophrenia in the abnormal development of medium spiny neurons, pyramidal cells, and interneurons. Conversely, it did not find any association with dopaminergic neurons or glutaminergic communication pathways. 18

Current challenges of genomic research are the underrepresentation of ethnic minority participants and researchers. The genetic reference genome for cross-referencing genetic variants comes from a White-American cohort. It undermines population-based genetic research from non-white ethnic backgrounds, potentially misattributing ethnic-specific genetic variants as pathogenic—reducing utility in these population cohorts. 19 The East London Genes and Health dataset is a step in the right direction as it uses genetic data from south Asian participants reducing reference genome bias, enriching genomic research by generating ethnic-specific variants. 20 Interestingly, the datasets may highlight founder effects and the impact of cultural practices on the prevalence of diseases, such as consanguineous marriages. In such population cohorts prevalence of disorders may be higher as genes are either recessive or knocked-out, highly advantageous for studying rare diseases. 21

Currently, second-generation or next-generation sequencing technology analyse smaller fragments of the genetic code to provide a better understanding of the overall intronic or exonic regions. Despite being very sensitive and specific with a low error-rate, the bottleneck to Omics research is the cost and computational resources required. 22,23

The third generation of sequencing technology aims to overcome some challenges by being able to capture longer sequences of patients genetic and epigenetic profile in parallel; however, it retains the financial and computational challenges. 24 Proof-of-concept fourth generation sequencing goes further by visualising real-time protein synthesis in cells in-situ, vital in studying the effect of psychotropic drugs on cells. 25

In summary, Omic technologies will undoubtedly allow us to delve further into the potential risks or biological causes of developing psychiatric diseases by pathogenic genes. Harnessing stem cells for pharmacogenomic testing will enable better targeting of medication to patients. In turn, this will reduce polypharmacy. Combining pharmacogenomics and the RDOC framework will enhance patient care by genetic- and symptom-based nosology enhancing psychiatric Personalised Medicine.

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Film Review - The Peanut Butter Falcon

Dr Alistair Farquharson

ST5, West of Scotland



“The Peanut Butter Falcon” tells the story of Zak - a young man with Down’s syndrome who escapes from an oppressive care home to pursue his dream of becoming a professional wrestler. Zak soon finds himself in the company of Tyler, whose background as a free-spirited, independent and lawless crab fisherman is in sharp contrast to his own restricted and stifled upbringing.

After discovering Zak stowed away on his boat, Tyler reluctantly agrees to help him make a start on his adventure, but as their journey progresses the two begin to form a close bond. Tyler takes on the role of an older brother, showing Zak encouragement and no small measure of tough love.

The unlikely pair are tracked and eventually found by Eleanor, a caring support worker who recognises the inappropriateness of Zak’s care home placement, but is desperately worried about the risks he faces. She is unable to convince Zak to return, and eventually the three of them continue together. I’ll leave my plot summary there - hopefully I have given the gist of the film without any major spoilers!

I watched this film on a Monday off, following a weekend on-call. Usually, I’m quite keen to avoid watching programmes about work in my free time, and I think I was drawn to this film because of my odd fascination with the rural American South in which it is set, and not the link to Intellectual Disability Psychiatry. But I’m very glad I watched it, as I found it moving and thought-provoking, and actually hugely relevant to my clinical practice.

As ID psychiatrists we are placed in positions of great power. We have the ability to dictate medical management plans and prescribe potentially life-changing treatments, but we are also often heavily involved in making decisions that affect our patient’s freedoms in trying to find a balance between encouraging their autonomy and protecting them from harm. I find making these decisions inherently uncomfortable, because by its nature the “right” answer will lie somewhere on a spectrum between two forms of harm, if a “right” answer exists at all.

“The Peanut Butter Falcon” demonstrates an extreme example of this dilemma. The care home and it’s uncaring and image-conscious manager exist at the anti-risk extreme of the spectrum, while the fairly feral Tyler sits firmly at the pro-freedom end. Eleanor comes the closest to representing the balanced view of a clinician who has to weigh up not only Zak’s safety and his independence but also the limitations of the available resources. Of course, Zak’s own perspective in this is not forgotten either, but he clearly has limited insight into the potential risks he faces, and naturally he craves autonomy.

Overall, I thought that “The Peanut Butter Falcon” was a moving and entertaining film, that captured this fundamental dance between freedom and protection in a compelling, if not particularly nuanced, way. It also happened to beautifully shot, and it featured fantastic performances from Shia LaBeouf (Tyler) and Zach Gottsagen (Zak).





Patterns of referrals to the Moray Community Learning Disability Team during the COVID-19 Pandemic.

Dr Miriam Brown, ST6

Dr Niamh Fingleton, Trainee Clinical Psychologist



Key Findings

Referrals in the summer of 2020 increased by 45% compared to the same time period the year before.

This increase was due to the same patient requiring multi-disciplinary input, rather than an increase in the number of people who were referred.

41% of referrals during the first wave of the Covid-19 pandemic were related to Covid-19.

20.8% of 2020 referrals were due to a Covid-19 related change in support hours or structure.

Those with profound learning disabilities were most likely to have referrals relating to Covid-19, and those with moderate learning disabilities least likely.

Introduction

People with learning disabilities are known to suffer health inequalities. These inequalities have been amplified by the Covid-19 pandemic, and there has recently been a wealth of literature documenting this. People with learning disabilities have seen cuts in their care packages, and disproportionately high morbidity and mortality rates in relation to the general population.⁽¹⁻⁴⁾

A service review was undertaken looking at how Covid-19 had affected the lives of those on the caseload of a rural community learning disability team during the first wave of the pandemic. This review compared the pattern of referrals in summer of 2020 with that of 2019.

The aims of this project were:

To look at how the pattern of referrals differed between the two years

To see what proportion of referrals were a result of Covid-19

To link these with the level of learning disability the patient had.

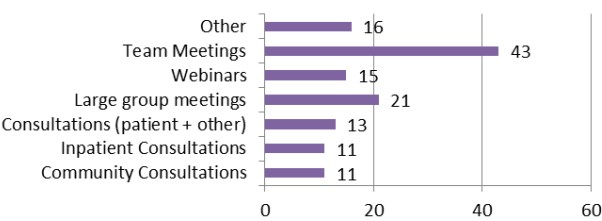
Methodology

The time period 26th March to 26th July was selected for analysis and all referrals received within this time period for both years (i.e. 2019 and 2020) were included.

Information regarding referrals was collated from the minutes of the team meetings, and referral forms themselves. Information regarding the level of learning disability was established from review of clinic letters, and in discussion with professionals who knew the patient. Demographic details which were not included in referral forms/minutes of team meetings was collected from medical records. This information was entered into an excel spreadsheet.

Referrals were categorised using an iterative process, and in consultation with professionals to whom the referrals had been made. Basic descriptive statistics were used to analyse the data.

Figure 1. Number of respondents using video technology by activity (Total n=51)



Results

Overview and Demographics

The number of patients referred in both years was roughly the same (92 in 2019 and 83 in 2020), but the number of separate referrals in 2020 (173) was much greater than 2019 (119), representing a 45% increase. The demographics of the patients (sex, age range, level of intellectual disability) was broadly similar. Referrals from within the team were fairly static (44 in 2019, 45 in 2020); however, there was a 71% increase in referrals received from people outside of the multidisciplinary team (75 in 2019, 128 in 2020).

Referral Patterns

The most common reason for referral in both years was a change in support hours or structure (11.5% in 2019, 21.2% in 2020). Other common reasons included physical health support (7.5% in 2019, 12.7% in 2020), mental health difficulties (11.8% in 2019, 9.2% in 2020), care support and treatment plan review (15.1% in 2019, 3.4% in 2020), mobility/musculoskeletal pain (8.4% in 2019, 1.7% in 2020), communication assessment/dysphagia (5% in 2019, 5.6% in 2020), and Adult Support and Protection (ASP) Concerns (2.5% in 2019, 5.6% in 2020). Other referral categories were: Adults with Incapacity Act, behaviour, dietary modification, environmental adaptations, finances, housing, relationship with support staff, assessment for intellectual disability, medication management, occupational or sensory assessment, social difficulties and staff training.

COVID-19

In 2020, 41% of referrals were Covid-19 related. The most common reason by far for this was a change in support hours or structure (20.8% of the referrals in 2020 were due to a Covid-19 related change in support). Only 2 referrals in this category in 2020 were not related to Covid-19. The next most common Covid-19 related reason was that of patients having difficulty understanding or following Covid-19 restrictions, this accounted for 6.3% of the 2020 referrals. Other referrals which came about as a result of Covid-19 included: mental health (3.5%), physical health support (2.8%), ASP Concerns, behavioural issues (both 2.3%), issues with relationships with support staff (1.1%), social difficulties, staff training, and care support and treatment plan reviews (all 0.5%). Proportionally, referrals of those with moderate intellectual disabilities were least likely to be related to Covid-19 (only 35%), and referrals of those with profound learning disabilities were most likely (67%).

Discussion

The results of this project are consistent with recently published literature describing the effects of Covid-19 on people with learning disabilities.⁽¹⁻⁴⁾

The high proportion of Covid-19 related referrals which documented a change in support hours or structure echoes findings by a recent Mencap social care survey. These results have significant implications due to the knock-on effect for the families and carers of those they pertained to. Relatives were required to provide more care due to closure of day services etc. This had consequences for their own lives (e.g. mental and physical health, finances when they could not work). Relatives who are subject to these demands cannot simply have a day off sick and rely on another to fill their slot as someone who is employed as a carer might. The relentlessness of this can compromise relationships between people with learning disabilities requiring care and their relatives, and lead to crisis situations resulting in illness, injury and preventable admissions.⁽¹⁾

The second most common reason, (difficulty in understanding lockdown restrictions), is consistent with other studies looking at the experience of the lives of people with learning disabilities during the pandemic.⁽²⁾

The jump in referrals from people outside of the multidisciplinary team between the two years is thought, in part, to reflect the problem-solving needed to adapt to these new circumstances which care teams did not have adaptable protocols for. Services have now found new ways of working which sit within the evolving parameters, and have developed skills in changing care plans to suit those they care for and whatever restrictions are currently at play. A re-evaluation of the same time period in 2021 is being considered, to see if this assumption is borne out.

Conclusion and Next Steps

The results of this service review are in keeping with current literature regarding the experiences of people with learning disabilities during Covid-19. They highlight increased needs of this population which has been met with reduced service provision. The consequences of this are increased mortality and morbidity from Covid-19 of those with learning disabilities which is out of proportion to their non learning disabled peers.

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Tribute and fond memories of Dr Shaun Gravestock

Dr Karen Bretherton, Consultant Psychiatrist

Shaun was born on the 13th of May 1962. His early life was in County Durham, attending the Durham Johnston Grammar School. Shaun undertook his medical training at Newcastle University, graduating in 1985. He completed his pre-registration house officer jobs in Durham.

Shaun was accepted onto the St Georges psychiatry rotation in London, gaining his membership in 1989, then starting his senior registrar training in the Psychiatry of Intellectual Disability, working with many doctors who had inspired him in this speciality. On completing training his first post was as a locum consultant in Enfield. Shaun wanted his first substantive post as a consultant to be back in the North East of England and he was appointment consultant psychiatrist for people with intellectual disabilities in the Northgate and Prudhoe Trust in 1993, looking after patients in Northumberland, and inpatient units in Northgate Hospital. He moved back to London in 1997 to be a consultant psychiatrist in Greenwich for the Oxleas NHS Trust where he worked for 11 years. He then moved to consultant posts at the Maudsley Hospital, then North East London and finally the East London and City Trust as a consultant forensic intellectual disability psychiatrist.

Shaun enjoyed the academic roles within his work. He authored many papers and book chapters on his speciality areas such as eating disorders in intellectual disabilities, low secure services, group therapy and service redesign. He regularly presented lectures and workshops at intellectual disability conferences and was known by all in the speciality.

Shaun was an inspirational teacher and trainer who inspired many trainees to join the speciality due to his enthusiasm, commitment and desire to improve the mental health and lives of people with intellectual disabilities in his care. He led by example with his detailed assessments, management plans; always ensuring time for the person, their family and carers. Shaun was the reason I joined the speciality. I am very grateful for the teaching, encouragement and support he gave me throughout my training.

All who knew Shaun appreciate how much he would enliven a conference. I would look for Shaun, and if not visible immediately it would not be long before you could hear

where he was. He would sit writing copious illegible notes, nodding enthusiastically, always asking interesting and insightful questions however esoteric the lecture. He would enjoy the social side of the conferences, entertaining all late into the night with his stories and, at times, outrageous comments! Anyone who travelled a long way with Shaun on a train, knew that he would not only entertain you, but also the whole carriage for the length of the journey. Working on the train was never achieved!

Shaun was a great advocate for patient's, colleagues and services. He never tired of making his point when he knew he was right, trying to ensure the best outcome for all. He showed such commitment and remained determined to do his best for all, despite lack resources and time. Shaun embraced life, family, work and friendship with great warmth and enthusiasm.

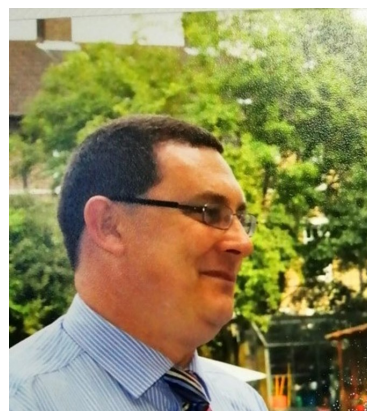
Shaun retired in March 2020 and was looking forward to a change of pace in life and new challenges. He was undertaking training in group analysis, assessments regarding eating disorders and had joined the Child and Adolescent Intellectual Disability Psychiatry Network. In his retirement he had managed to complete the revisions for his MD titled '*Eating Disorders in Adults with Learning Disabilities: prevalence, types and aetiological associations*'.

Shaun was a devoted husband to Darren (whom he met in 1988) and father to Patrick. Shaun was looking forward to the time he could take exciting retirement holidays with Darren, postponed due to the pandemic, and spend more time with his family.

Shaun contracted Covid 19 and became acutely unwell with pneumonia passing away on the 9th January 2021.

He was awarded his MD aegrotat on the 12th of February 2021.

He will be sadly missed by all who knew him and he is a great loss to our faculty.





Effectiveness of remote consultations in people with intellectual disabilities: service user perspective

Dr Vibha Shah, CT3, Redbridge CLDT

Dr Bini Thomas, Consultant Psychiatrist, Havering CLDT



Background: Current challenges faced by people with intellectual disabilities in light of COVID-19 and the impact on service delivery

The unprecedented COVID-19 pandemic has created a global health crisis with far-reaching consequences. People with intellectual disabilities (ID) are especially vulnerable due to inequalities in healthcare provision and marked co-morbidity (Alexander et al., 2020).

Recent literature has confirmed that people with ID have a higher prevalence of comorbid risk factors (i.e. hypertension, heart disease, respiratory disease, and diabetes), which puts this population at a higher risk of poorer and more severe COVID-19 outcomes (Turk et al., 2020). Therefore, people with ID have been advised to follow strict social distancing. This includes avoiding public transport and remaining at home. For those who are judged to be at very high risk of illness, shielding measures must be adopted (Alexander et al., 2020).

As a result, community intellectual disability teams have endorsed the use of telephone and videoconferencing tools to contact carers, family members and people with ID where possible. If a visit is necessary, appropriate guidance is followed to minimise risk, which may include wearing PPE during the visit.

It is evident that information technologies, including internet and telephone-based resources, are becoming integral in healthcare settings, serving as an alternative and supporting method of providing many forms of services (Downes et al., 2017). Especially in primary healthcare, consultations on telephone are ever increasing and providing a promising alternative and supporting service to face-to-face consultations (Khan, 2013).

However, for the community intellectual disability services, telephone consulting is a completely new mode of providing services. It is something that teams have had to adapt to very quickly due to the COVID-19 pandemic.

At the onset of the pandemic, the Community ID Teams in North East London Foundation Trust, consisting of those in the London boroughs of Waltham Forest, Redbridge, Barking & Dagenham and Havering, stopped face-to-face consultation and started remote consultation via telephone and video. Face-to-face meetings only took place for urgent cases and those that required depot medication administration. Service users' views of remote consultation were unclear, therefore we conducted a survey to determine patient satisfaction of the remote consultation service provided by the NELFT Community ID Teams.

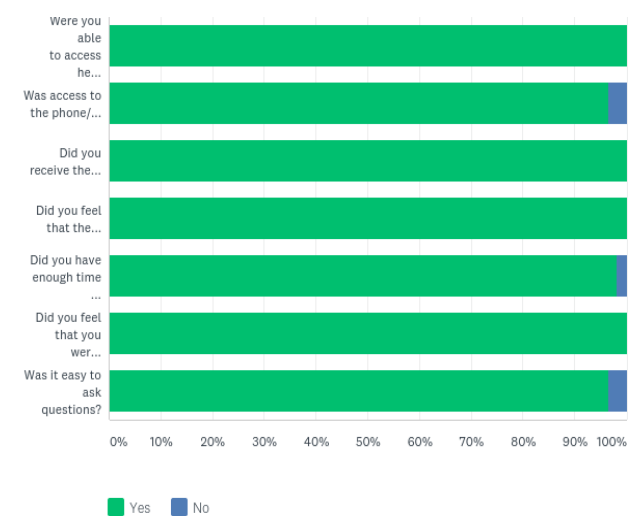
Methods

An online survey created via Survey Monkey was sent out to all professionals, including psychiatrists, nurses, psychologists, occupational therapists, physiotherapists and speech and language therapists, who were providing telephone or video consultations in the NELFT Community ID Teams. The professionals then conducted the survey with the service users or carers with whom they were having a remote consultation. The survey was anonymous and the participants were randomly selected.

The survey opened with a series of 'yes' or 'no' questions about ease of access to mobile devices and help, as well as whether the call was at a suitable time and duration. Questions on whether the professional was able to understand their needs and give them choices as to how they could be supported were also included in this section. This was followed by a group of questions to determine the convenience and communication difference between telephone and face-to-face consultations. The final questions asked how telephone consultations met patients' needs as compared to face-to-face and what modality of appointment they would prefer in the future. The survey closed with the opportunity for service users or carers to provide additional comments.

Numerical data were analysed using simple statistical methods supported by Excel.

Results

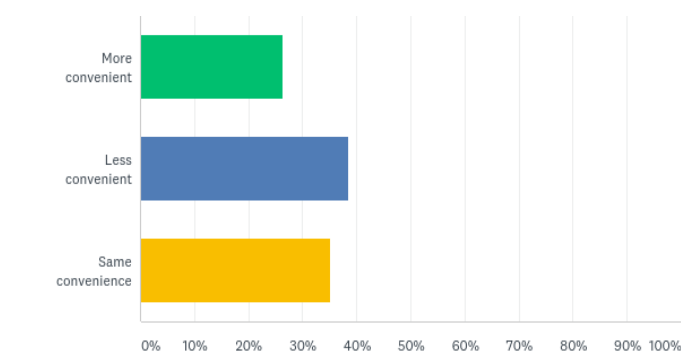


(Figure 1, above)

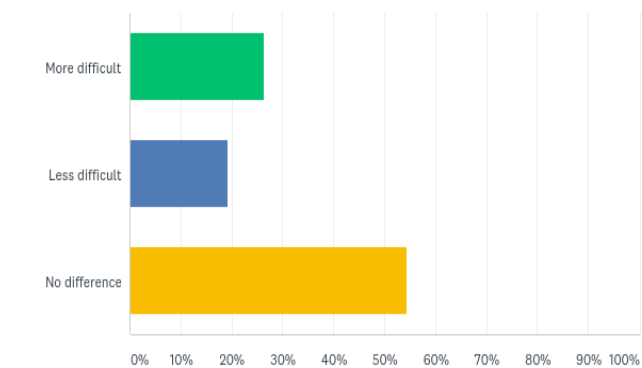
There were a total of 57 responses over 15 days.

100% of service users/carers found that during remote consultations, professionals were able to understand their needs and give them choices as to how they could be supported, and that the consultation was at a suitable time. 100% also reported that they were able to access help when needed. 96% found that access to mobile devices was easy and that it was easy to ask questions. 98% felt that there was enough time to discuss their needs (Figure 1).

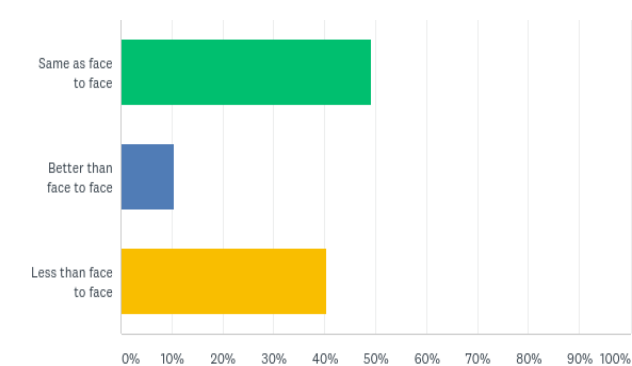
Comparing the convenience of telephone consultation to face-to-face consultation, 26% of responders found telephone consultations more convenient, while 39% found it less convenient and 35% found no difference in convenience (Figure 2, below).



Regarding the ease of communication, 26% of respondents found it more difficult to communicate over the phone than in person, 19% found it less difficult and 54% found no difference in the ease of communication (Figure 3, below).



49% of service users/carers found that telephone consultation was able to meet their needs the same as a face-to-face consultation. However, 40% found that face-to-face was better at meeting their needs and only 11% found that telephone was better than face-to-face at meeting their needs (Figure 4, below).



For future appointments, 44% of service users/carers would prefer mainly face-to-face consultations, 40% had no preference and 16% preferred mainly telephone consultation (Figure 5, below)

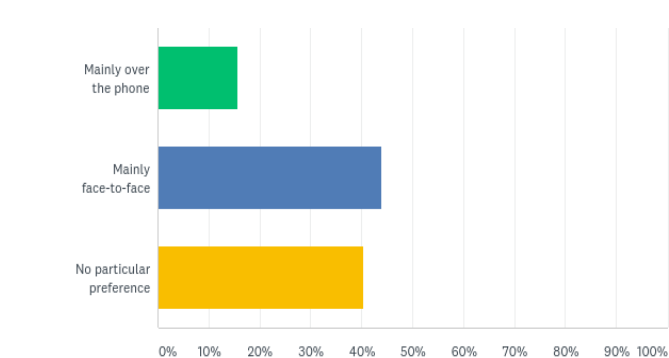


Table 1. Free text quotes from survey responses

<ul style="list-style-type: none">· Phone calls are outstanding 110% and what professionals have been doing over the phone is amazing, but it would be nice to see the professionals in person as they would be able to see patient and observe and see if there is anything wrong.· Contact in normal circumstances would be face to face but in present circumstances telephone contact suffices.· Its more easier to talk over the phone and you feel more freely and more better.· I find it difficult to ask questions over the phone and prefer to draw on paper to help with asking questions and describing how I feel.· Prefer to for my doctor to see me face to face.· Would prefer Zoom to telephone.· Marisa has been a great help to me over the last few weeks but I have really missed our face to face appointments.· The community learning disability nurse has been fantastic. She has been a great support and glad for this support. I am pleased the LD service has stayed open and that someone has been at the end of the phone when I've needed them. Wouldn't have known what to have done if you were not at the end of the phone. Service Users Mum.· It is easier saves her a journey and time.· I like to see my nurse face to face not phone calls. Corona virus has messed things up.

All responders were invited to complete a free text box with additional comments. Comments expressed included the view that service users miss having face-to-face contact with healthcare professionals and that under normal circumstances, face-to-face would be preferred. Some felt that telephone consultations were more convenient in terms of the time saved. Other views were that it was easier to converse via telephone consultation (Table 1, above).

Discussion

The findings from this survey suggest that almost 100% of service users/carers found that the remote consultations were able to provide timely care, which is easily accessible and suitable for the service users’ needs. We found little difference in convenience and communication between telephone and face-to-face consultation. There was a small difference in those that preferred face-to-face and those that had no preference, 44% versus 40% respectively.

The free text responses also underline the importance of face-to-face contact for people with ID. The lack of visual cues and the concept of psychological distance in remote consultations could explain the difference in preference between the two modalities (Borton, 2020). In addition, face-to-face interaction is likely to be more important for people with ID, for whom communication can be more challenging and access to mobile devices and technology more problematic.

Due to limited experience of remote consulting, clinicians within the teams were unsure whether telephone consultation would be able to provide the same level of care as face-to-face, especially within the ID population. This was owing to difficulties in communication, particularly where patients may be non-verbal or not have access to electronic devices, which left clinicians largely dependent on carers for information. Equally, for service users the change in consultation style may result in feelings of dissatisfaction if they were not understood.



Nevertheless, we found that for the majority of service users (49%), telephone appointments met their needs equivalent to face-to-face appointments. It is likely that remote consultations are more convenient and efficient for clinicians and service users alike, as there is no need to set aside time to attend an appointment in person. Furthermore, video consultations in particular may be preferable to telephone, as they can allow relationships to be reinforced or developed and can provide a better sense of satisfaction as patients feel more comfortable discussing personal issues (Giles et al., 2020).

The current environment has accelerated the use of remote working for all sectors. Healthcare has generally been behind the curve in this area, but there is a lot of potential in welcoming the possibilities offered by technology. There is an opportunity to consider providing more routine care via remote consultations and thereby saving face-to-face clinician time for those who require it. This would necessitate ensuring that service users have access to devices, triaging service users, determining their needs and ensuring both service users and clinicians have a safe space and access to appropriate technology. It would also be beneficial for clinicians to have information on background history and safeguarding concerns regarding the service user in preparation for the appointment and have clear pathways outlined for decision making and the outcomes of appointments.

Final comments

The survey was aimed to capture a snapshot of service user experience with remote consultations. Although telephone consultation has the potential to provide safe, timely and quality care, further rigorous evaluation is needed in this area. Particular attention needs to be paid to assessing suitability for the service users given the complex communication profile in people with intellectual disabilities. It may also be useful to seek training relevant to telephone consultation to allow clinicians to provide appropriate support for patients safely and in line with information governance guidelines. We aim to keep developing services based on continual feedback from service users and will recommend further work regarding service user preference and engagement as we continue to use remote assessments in our everyday practice.

Declaration of Interest: None

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Intellectual Disability Psychiatry—My Reflective Essay

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Psychiatry is a specialty that I find particularly interesting and will be considering for my future career. I am especially interested in Intellectual Disability (ID) psychiatry as I have worked in the community as a support worker for adults with intellectual and physical disabilities for the past two years. I felt that prior to my placement, I already had a good insight into the everyday life of adults with ID due to my work experience. However, my placement in ID psychiatry helped to build upon my knowledge and furthered my interest in this field.

As part of my second-year placement, I was assigned to spend one week at Brooklands Hospital. Brooklands Hospital offers both an inpatient and outpatient service for adults and children with ID. ID is defined by three key criteria: lower intellectual ability (usually an IQ <70), significant impairment of social or adaptive functioning and onset in childhood [1]. The degree of ID can vary from mild, moderate, severe, or profound [1]. ID is commonly a component of other conditions e.g. Down's syndrome [2] and people with ID often also have many comorbidities e.g. epilepsy [3].

After an initial research online, I discovered that the inpatient aspect of Brooklands Hospital provided services for individuals with challenging and violent behaviour, this made me a little anxious about attending this placement. I feel that there is a lot of stigma around both mental health and ID and even though I have previously worked with adults with ID, I was still feeling uncertain about the placement. Although I was anxious, I was also eager to learn more about the management of adults with such complex needs.

On the first day of my placement, I attended one of the outpatient clinics. The psychiatric outpatient clinic appointments are considerably lengthier and more in depth than the general practice consultations that I have witnessed previously. I feel that this is essential because many of these patients will present with complex issues and more time is needed to effectively explore these. Devotion of time to

these patients allows psychiatrists to get to know them as individuals and understand what is going on in their lives. This results in positive outcomes for not only themselves, but also their family members and wider support system. Psychiatrists often see the same patients for years and are therefore able to watch their patients grow and develop over time. It is extremely rewarding to be a part of a patient's journey, support them and witness their progress.

Many of the patients that I saw were accompanied to the clinic by a caregiver, this was often a family member or support worker. I discovered the importance of creating a balanced, inclusive consultation that allows both the patient and caregivers time to speak. Often caregivers can provide vital information and are able to work collaboratively with healthcare professionals (HCPs) to provide support with management mechanisms. However, the focus of the consultation should be on the patient and HCPs should not be relying solely on a collateral history. For some patients that were not able to easily communicate, even with supportive measures in place, a collateral history was useful. I also learned about the importance of addressing and managing the concerns of caregivers but not letting these overtake the consultation.

I met a patient with DiGeorge Syndrome and a mild ID in the outpatient clinic. As well as addressing this patient's anxiety disorder, the psychiatrist also enquired about their previous hearing problems and recurrent ear infections. I realised that many patients with ID are living with multiple comorbidities and it is important to treat them holistically in psychiatry by exploring non-psychiatric concerns. Therefore, psychiatrists must be specialists in their own subject but also have a very good knowledge base across a wide range of medical specialties.

In the afternoon, I was taken to the inpatient unit for adults and given the opportunity to speak to one of the patients. This patient had a diagnosis of both schizophrenia and a mild ID. Initially I was nervous about speaking to this patient, but I quickly realised that the patient was equally as unsure about me. This patient provided me with an interesting insight into living with schizophrenia and the intrusive thoughts that they had experienced. I realised that I enjoy learning about people

and how their mind works. The inpatient area surprised me, and it was treated like a home from home for these adults, with many having home comforts such as computer systems. The staff encouraged patients to spend time with each other and there was a communal lounge area that was well used. I was expecting there to be more restrictions in place and that the patients would always have to be under constant supervision with very little private time or luxuries. I was amazed by the sense of community in the inpatient areas.

I attended a multi-disciplinary team (MDT) meeting whilst on placement and was able to witness first-hand the importance of working collaboratively with other HCPs involved in the patient's care e.g. psychologists, nurses, and social workers. The MDT approach demonstrated that each HCP had an expert knowledge in one area or another of the patient's care. This collaborative approach is often the best way of achieving goals for the patient and gaining a greater understanding of their behaviours. Nurses and HCAs will spend all day with patients and have a very good insight into triggers that lead to agitated behaviours. Quite often the aggravated behaviours were because of a sensory overload or distress at not being able to communicate their feelings or thoughts. Consistency of staff is critical as it allows the staff to get to know the patients well and understand their behaviours and build a rapport. I found this organised and robust teamwork very impressive. The support offered to the patient continued after discharge via the community team and thorough communication between the community and hospital teams was vital.

The most important learning point that I took away from this placement was the importance of effective use of communication skills. Although development of good communication skills is emphasised throughout medical school, it often comes secondary to assessing and diagnosing patients. In psychiatry, and particularly ID psychiatry, this is not the case and good communication is essential and comes before a diagnosis. Some patients with ID may find it more difficult to process complex information and it is therefore necessary to adapt your knowledge to the level of the patient, which is something that many doctors find challenging. The use of communication skills for each patient can vary depending on their underlying condition and the severity of their ID [2]. Therefore, adapting your approach for each patient and using a variety of communication skills e.g. visual cues or Makaton will allow for better communication and a better rapport to be built between the patient and HCP.

Rapport is vital when conducting a consultation with patients with ID and often trust is needed to be gained before you will get any kind of response. I witnessed a good example of this, when one of the psychiatrists knew that one of her patients really enjoyed posting on their YouTube channel and immediately asked about this when the patient arrived. This patient was keen to show her the latest videos that they had uploaded and instantly relaxed into the consultation.

Listening to patients is another important aspect of effective communication. Many of the patients with ID have a slower information processing rate. Patience is therefore important to allow the patient time to answer questions. Developing these listening skills will be useful in all aspects of medicine and will allow me to be a better doctor. A sensitive approach to all consultations is needed in this field of psychiatry. Even small words of encouragement are greatly appreciated by these patients, who are often used to being ignored or marginalised. Organisation skills are also essential in this career. Often patients with ID and autism spectrum disorder have an aversion to change. It is therefore important to try to stick to appointment times as closely as possible to minimise what is most likely an already stressful situation.

These consultations reinforced my knowledge that often the problems experienced by these adults with ID were often due to loneliness or feelings of isolation from their local community. The issues experienced by these individuals were often personal e.g. unemployment or difficulty at school and it was important to address these within the consultation and take a well-rounded approach to the patient's life. Although we had learnt about the biopsychosocial model of care, I feel that this is the first time that I have properly seen it in practice. I learnt a lot more about the social prescribing options available for adults with ID and to ensure that patients, and their families, are well-informed and sign-posted in the right direction e.g. to a link worker. I feel that throughout my career I would like to create more awareness around the benefits of social prescribing to support patients in all aspects of their lives [4].

Unlike in most areas of medicine, medication is not always the answer in ID psychiatry. I learnt about the 'Stopping over medication of people with learning disability, autism or both' (STOMP) initiative. This has given me a much better insight into alternative ways of overcoming challenging behaviour in adults with ID. The therapeutic treatment



provided in ID psychiatry is based on the development of good relationships. It has also highlighted the importance of regular medication reviews to ensure that medications are only being taken if needed [5].

ID psychiatry is a difficult career and although it does not have the fast pace of emergency medicine, you need to be able to work well in challenging situations. I think that psychiatrists are often looked down on by other members of the medical profession and are not considered 'real doctors'. I would completely disagree with this statement and this placement has given me a considerable amount of respect for psychiatrists. Psychiatrists can make incredible changes to individual's lives solely through conversation. Many of the patients that the psychiatrists see will keep returning to the inpatient service due to ineffective support or other issues in the community. These patients will never be 'cured' of their condition and will continue to have mental health issues, which cannot be fully resolved. This goes against the very nature of a medical student or doctor, to treat the individual and solve all their problems. Accepting this must be very difficult and psychiatrists in this field must often feel that their efforts are inadequate. I feel that this job requires a lot of emotional resilience.

Patients with ID have poor health outcomes when compared to the general population [6]. This could be related to various causes, but one of the suggested causes is barriers to accessing appropriate healthcare [7]. Some of the potential barriers for a patient with ID include ineffective communication, lack of time to take an adequate history, misdiagnosis, and ineffective treatment [7, 8].

I do not think that enough training is currently given to HCPs with regards to supporting a patient with ID and often they feel uncertain about how to approach these consultations. I would like to try to encourage as many of my colleagues to learn more about ID and effective methods of communication by being an advocate for patients with ID. This placement helped me to confirm that ID Psychiatry is an area of medicine that I will be considering for my future career. This is a field of medicine that is entirely focused on the individual and every day creates a different experience. It is a very rewarding career that allows you to foster a unique bond with often marginalised and forgotten patients who seek comfort and support through communication, which is

frequently neglected in the fast-paced world of medicine. I decided on a medical career because I have empathy and compassion for others, and this is something that I want to demonstrate every day that I come to work. I feel that ID Psychiatry would allow me to do this.

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Psychiatry through a computer screen—is there a bright side?

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Introduction

The year 2020 has changed people's lives all over the planet due to the COVID-19 pandemic spreading around the world, resulting in devastating effects on people's physical and mental health. Besides people becoming ill and the loss of life, social lives and the way we work professionally have changed as well.

The use of virtual communication has exploded since the pandemic. The world is using new technology and using it much more; social meetings with friends and family as well as professional business meetings are arranged through Zoom, Microsoft Teams, Skype and other platforms.

Psychiatrists, for whom the vast majority of their daily work consists of seeing and talking to patients, have also changed their way of working significantly. Aiming to reduce the risk of the spread of the virus, many patient consultations are happening virtually through video-calling, rather than face to face.

Seeing patients remotely comes with understandable hurdles. Not seeing the patient face to face could mean losing a large part of the holistic assessment: the interaction with the patient in the room; their environment; accompanying family; the physical interaction with the patient; any smells or other impressions which could be lost through a virtual consultation.

Psychotherapists normally work with a "frame", a safe environment; a room where the psychotherapist meets the patient, every week, same time, same place. A psychotherapist might be worried about losing this "frame" when seeing patients virtually. Setting the frame is essential to any type of psychotherapy; it establishes boundaries and sets up a safe relationship in which patient and therapist can work. (1)

The patient might wonder – could there be a family member in the same room, listening in? Is the psychiatrist really on their own? Might the psychiatrist get distracted by a package being delivered, or the washing needing to be taken in?

Virtual psychiatry through modern technology: Help or Hindrance – Could there be a bright side?

Let us now consider doctors and psychiatrists seeing patients virtually. One can imagine many disadvantages as well as possible advantages.

For psychiatrists, a disadvantage that comes to mind at first is not seeing the patient face to face and missing that human connection.

The main advantage would be to reduce the risk of the virus spreading by not seeing patients face to face. Furthermore, we could consider the reduced travel time, less inconvenience to the patient and their daily activities, and reduced costs. Conducting therapeutic sessions virtually has cost benefits for both the psychiatrist and the patient; the cost of booking rooms, reception staff and travel costs are minimised. In addition, patients can be seen in their own natural environment rather than a hospital or clinic room (which is an artificial environment). This may also have a positive impact on therapeutic engagement and psychiatrist and patient being relaxed in their own environment to allow for therapy to proceed.

Are we missing out on a holistic assessment of the patient and transference because we are not in the room with them? Transference is the phenomenon whereby the patient unconsciously transfers feelings and attitudes from a person or situation in their past on to the psychiatrist, in the present. For example: the psychiatrist might (unconsciously) remind the patient of their father and they might experience feelings which are directed at their father, towards their psychiatrist. Psychiatrists use transference in the process of assessing patients and in psychotherapy. (2) In psychotherapy, the psychiatrist is trained to be aware of their own feelings, emotions and reactions towards the patient. It is important to be aware of these feelings and reactions during the meeting with the patient and to be mindful of transference as well as countertransference. Countertransference is the response that is elicited in the

psychiatrist by the patient's unconscious transference communications. When taking the above example: the

patient has feelings towards their father which they are expressing towards the psychiatrist. In response to this, the psychiatrist might have an unconscious and emotional reaction towards the patient. (2)
It can be difficult to monitor your own reactions, while also concentrating on the patient and what they are telling you.

Within a virtual consultation, the psychiatrist now has a novel experience of seeing themselves on the screen - a real-time observation of his or her behaviour. They can be observant of their own thoughts and behaviour. This could have a positive impact on their own understanding and reflections; the psychiatrist can now actually physically see their own reactions, their own body language, their posture, their facial expressions. We can notice, when looking at ourselves on the screen, whether we are, for example, mirroring movements, whether we have sat back and moved away slightly, whether our arms are crossed, or if we are looking disinterested, fidgeting, moving closer or further away from the screen. This adds a new dimension to the consultation, where the psychiatrist has a new way of monitoring their own reactions during the conversation with the patient.

Another potential benefit could be that the patient can actually see the notes being written, live on the screen. The Psychiatrist could write notes and share them on the computer screen so the patient can see it straight away and respond to it if they wish to. This is a significant change from the usual practice of the notes being written out of sight, usually after the consultation has finished. The patient would not see the notes that were written, unless they requested to have access to their patient records. This adds a novel way of the patient being actively involved in their care.

Another possibility is that therapeutic sessions could be recorded for the patient to revisit at a later date. We are aware that patients may not recall all the information in therapy due to the raised anxiety or the charged nature of the topic. However, if the sessions are recorded for the benefit of the psychiatrist and patient they may be able to revisit this information for greater benefit.

We also consider that very rarely there may be a difficult interaction or aggression (playing out) in the session which could put the psychiatrist at risk of physical aggression. This could be minimised through virtual therapy sessions.

Whilst it may still be possible to understand the real raw emotion or transference despite the physical barrier of not being in the same room, these issues may also be picked up in supervision or further learning.

Conclusion

We propose that there may be additional benefits from the use of virtual consultation in light of the current pandemic. With adequate supervision and training the psychiatrist may be able to combine the benefits of therapy with the convenience of virtual technologies. This may bring down the cost of therapy as well as reducing burden on the climate by travelling, and potentially allow more access to therapists from around the world for patients.

References

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Upcoming conferences

DATE	TITLE	LOCATION	ORGANISATION
MEETINGS			
<p><i>All face-to-face conferences and events associated with the RCPsych have been moved to a virtual format this year (2021); please see the College website for the most up to date information regarding online/virtual seminar details.</i></p> <p><i>Please see https://www.rcpsych.ac.uk/events/conferences for most up to date details</i></p> <p><u>Faculty of Psychiatry of Intellectual Disability Conference 2021</u></p> <p><i>Thursday 7th and Friday 8th October</i></p> <p><i>STILL TIME TO BOOK, up until 10.30am, Wednesday 6th October</i></p> <p><u>BOOK HERE</u></p>			



COVID-19 Resources

The RCPsych ID Faculty has also provided a number of resources to support professionals and patients during this pandemic.

These can be found at: <https://www.rcpsych.ac.uk/members/your-faculties/intellectual-disability-psychiatry/news-and-resources>

These include a statement from the Faculty about the current situation as well as a number of other resources.

THE NATIONAL INTELLECTUAL DISABILITY TRAINEE CONFERENCE

HOSTED VIRTUALLY BY THE WEST MIDLANDS ID TRAINEES

SPEAKERS INCLUDE:

Professor Regi Alexander

Dr. Mary Barrett

Dr. Ken Courtenay

Dr. Conor Davidson

Professor Richard Hastings

Professor Tony Holland

Dr. Deborah Kinnear

Professor Peter Langdon

Professor Rohit Shankar

PRICES:

Consultants and Specialty Doctors: £20

Higher Trainees: £20

Core Trainees: £15

Foundation Doctors and Medical Students: Free

THURSDAY 11 NOVEMBER 2021

The National ID Trainees conference is approaching!

Book tickets here: <https://www.eventbrite.co.uk/e/id-trainees-conference-2021-tickets-167078912525>

For more information contact: idtraineeconference2021@gmail.com



Upcoming prizes, awards and bursaries

DATE	TITLE	LOCATION	ELIGIBILITY	PRIZE
PRIZES				
01.12.2021	The Professor Joan Bicknell Medical Student Essay Prize	Submit essay by email	Medical students in the UK	Prize: £250 Awarded for an essay written by a medical student about their contact with a person or people with learning disability
31.12.2021	The Gregory O’Brien travelling fellowship	Submit application proposal by email; if successful you will be expected to submit a report and present at one of the Faculty meetings	CT1-ST6 in UK approved training scheme or within 3 years of consultant post	Prize: £1000 Awarded every 2 years, to encourage psychiatric trainees to broaden their academic and clinical knowledge in a centre of excellence (UK or abroad)
Available throughout the year	Faculty of Intellectual Disability Psychiatry bursary	Application by email	Doctors in training, Staff grade or associate specialists	Up to £200 per applicant having difficulty securing funding elsewhere, to attend any appropriate educational event
Summary by 30.04.2022 Final submission by 30.06.22	The Brian Oliver Prize	Submission by email then winners will be invited to present a report at the Faculty Annual Meeting, held in October 2022	CT1-ST6 in UK approved training scheme or within 3 years of consultant post	Prize: £500 Awarded for research (original work or literature review) undertaken in Psychiatry of Intellectual Disability
Usually end August Same as abstract submission deadline	The Jack Piachaud Medical Student poster prize	Presented at the Faculty Annual Meeting, held in October 2022	Medical students based at a UK university	Prize: £75 Students should present a poster based on a project/audit in learning disabilities at the Faculty Annual Meeting
Usually end August Same as abstract submission deadline	The Alec Shapiro Prizes for Specialty Trainees	Presented at the Faculty Annual Meeting, held in October 2022	UK specialty trainee CT/FTSTA 1-3, ST4-6/LATs and SpR, or be a member of the College in a training post	Two prizes, best poster presentation (£150) and best oral presentation about a topic relevant to Psychiatry of ID (£200).

