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Learning Disability Psychiatry

Newsletter of the Faculty of the Psychiatry of Learning Disability

In this issue

Developing the future workforce – a balancing act

It is widely acknowledged that health policies have an impact on health outcomes of a nation, but it seems paradoxical that there is little mainstream debate about how politics of health can influence politics of health education. The Department of Health (2010a) White Paper *Equity and Excellence: Liberating the NHS* has for one ignited discussions on the government's commitment to secure high-quality health services in the UK. A consultation of the proposal document (Department of Health, 2010b) summaries the vision set out by the White Paper on improved patient outcome through provision of better education and training. It points out a progressively lesser involvement of the Department of Health and commits to assign local services a greater responsibility for planning and developing their healthcare workforce. But how are they hoping to achieve this?

Read the full article on p. 7

The art of formulation: a personal view

Formulation is a task that is central to psychiatric practice and, because of the potential complexity of people with intellectual disability and their particular circumstances, it is of specific relevance to our branch of psychiatry. Some argue that this is a skill that is dying out in medicine generally as history-taking and physical examination take second place to investigations, such as the use of various body scanning technologies. In this brief article, based on a talk given at the Faculty meeting in Leeds in 2010, I have tried to define the 'art of formulation' and to argue for its crucial role in psychiatric practice.

Read the full article on p. 3

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

Should you aim for AIMS?

The Royal College of Psychiatrists launched the Accreditation for Mental Health Inpatient Services (AIMS) in 2009 and due to the success of this scheme, AIMS for learning disability (AIMS-LD) was subsequently developed. This scheme is an initiative for quality improvement which identifies and acknowledges services that have high standards of organisation and patient care, and supports and enables others to achieve these.

Read the full article on p. 5



View from the Chair

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The exposure of very poor practice at Winterbourne View in-patient unit has not surprisingly dominated the agenda for the past few months. In our response to the BBC1 *Panorama* programme, we were able to promote good practice in the management of challenging behaviour, as described in the Faculty's joint guidance with

the British Psychological Society and the Royal College of Speech and Language Therapists. At the Faculty executive Strategy Day in July, we decided to make specialist in-patient care one of our key priorities over the coming year. Regi Alexander is going to lead a working group on the subject that includes an audit of current provision and the formulation of a Faculty policy on when specialist in-patient treatment is indicated, and when it is not the best option for people with learning disability.

The second key strategic area for the coming year is commissioning. The Faculty has already been working in the area, and Ashok Roy is leading the Faculty's input into the Joint Commissioning Panel. This is an initiative led by the Royal College of Psychiatrists and the Royal College of General Practitioners, as well as many other stakeholders including the British Psychological Society. It should help

shape the way health service reforms on commissioning are implemented. Ashok will also be leading a working group to produce some focused Faculty guidance on commissioning learning disability services.

Recruitment into psychiatry of learning disability is our third key area for the next year. We will develop existing initiatives to promote access to our conferences for people at all stages of medical training, and extend the range of prizes available to reward excellence in the specialty. We will also support trainee events run by Deaneries to ensure positive images of our specialty are promoted. The College has appointed Tom Brown as Associate Dean for recruitment, and Jo Jones, our education lead, and Helen Miller, recruitment lead, will be working closely with him.

Many people have suggested that we consider changing the name of the Faculty to reflect the range of our interests in the neurodevelopmental field. We have decided to get the members' opinions on this by means of an opinion poll, supported by an excellent paper by Tom Berney putting the arguments for different options. Changing the name is not straightforward, however, especially changing the name of our Certificate of the Completion of Training which is decided by the General Medical Council. But the results of the poll will help us decide how to take things forward.

Finally, I am really looking forward to our 2-day residential meeting in Bristol on 6 and 7 October. The programme looks particularly exciting, with some leading opinion formers giving talks and workshops, and I especially look forward to seeing all the poster submissions and new research presentations. So see you there, and if you want to be completely up to date, do not forget to 'like' Psychiatry of Learning Disability on Facebook and follow [@psychiatryofd](https://twitter.com/psychiatryofd) on Twitter! ■

Submitting articles

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

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

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

Disclaimer

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

Letter from the Editors

Geoff Marston

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Welcome to the latest edition of the *Faculty Newsletter*. During this time of government 'pause' on National Health Service reforms and 'post-Panorama' scrutiny of learning disability services, we have a few articles that may be of interest.

Karen Poon and Heena Hargovan offer reflections on achieving AIMS status for two of Gloucester's in-patient services (pp. 5–6), showing that quality of care enriches not only the experiences of patients but also professionals. Miriam Isaac (pp. 7–8) highlights the potential pros and cons of proposed educational and training reforms buried within the Department of Health's *Equity and Excellence: Liberating the NHS* and subsequent consultation papers.

Thinking ahead, we hope that future editions of this newsletter will be available in electronic format, as part of the Faculty's efforts to improve its carbon footprint and manage costs more efficiently. This format will also give us scope to expand content and provide direct links to key references and resources as well as interactive surveys. Watch this space.

Finally, thanks to all those who have contributed to the *Newsletter*. We would again encourage you all to put pen to paper/finger to keyboard and send articles to us. We especially welcome contributions from medical students and any foundation and core trainees with an interest in entering learning disability psychiatry higher specialist training.

Happy reading. ■

Therapeutics in Learning Disability conference

28 October 2011
Holiday Inn, Leicester

Keynote lectures by:
Baroness S. Hollins, Dr S. Bhaumik,
Dr Q. Haque, Prof. P. Patsolous
and others

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The art of formulation: a personal view

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Formulation is a task that is central to psychiatric practice and, because of the potential complexity of people with intellectual disabilities and their particular circumstances, it is of specific relevance to our branch of psychiatry. Some argue that this is a skill that is dying out in medicine generally as history-taking and physical examination take second place to investigations, such as the use of various body scanning technologies. In this brief article, based on a talk given at the Faculty meeting in Leeds in 2010,[†] I have tried to define the 'art of formulation' and to argue for its crucial role in psychiatric practice.

Formulation is a process – it is a synthesis of knowledge about an individual patient and his or her circumstances, which in turn sets out a proposed course of action. It is not in itself a full summary of the history and findings, but frequently it is included at the end of such a summary. Its focus starts with the reason the person was referred and seeks to outline the understanding that has developed through the process of history-taking, examination, observation and investigation. It includes statements about the diagnosis of the intellectual disability and the presence or not of any comorbid conditions but goes beyond that in outlining, for example, the circumstances that surrounded the development of a comorbid illness and the implications of such observations for treatment. Perhaps the most important aspect of formulation is that it sets the understanding of that particular person and his or her problem (reason for referral) within the context of established theory. In the formulation one would expect to have reference to how a person's index problem behaviour was best understood – was it secondary to comorbidity, is it best explained within the theoretical framework of applied behavioural analysis, or is it related directly to the atypical pattern of development characteristic of a particular syndrome? Within a biodevelopmental–psychosocial model a formulation would seek to clarify what predisposed to, precipitated or was maintaining a particular behaviour or mental state. In setting out this understanding the interventions in many ways then speak for themselves. The process of formulation therefore represents the integration of the interfaces between evidence, conceptually robust models of understanding, and the history and other information obtained about the patient.

Why is formulation in the psychiatry of learning disability so critical to good clinical practice? First, intellectual disability

[†]The talk was entitled 'The interface between clinical practice and evidence-based medicine in the psychiatry of learning disabilities.'

addresses the concerns of one of the most heterogeneous groups of people that any service seeks to support. For some, there is a genetic causation for their developmental disability, with a subsequent atypical developmental trajectory. For others, the reasons for their disability may be multiple, with a complex interaction between nature and nurture and perhaps a long-standing history of neglect or abuse.

The use of such labels as 'learning/intellectual disability' alone cannot do justice to this heterogeneity. Second, we recognise that for some of the most complex and demanding clinical situations we encounter there is no one discipline that has the full body of knowledge necessary to fully understand and to intervene in an informed and evidence-based manner – interdisciplinary work is essential. The process of formulation is the way that an interdisciplinary team seeks to integrate knowledge and agree a way forward. It helps to ensure that there is a common framework that all are working to. Incidentally, this need for formulation highlights the importance of team meetings as a space where such issues are discussed – something that all too rarely happens and then time to be used for such activity is being eroded further. Finally, interventions require consent from the person with intellectual disability or an agreement as to what is in his or her best interests if he or she lacks the capacity to consent. In addition, interventions are frequently mediated through support staff and under these various circumstances a formulation provides the means for informing the person concerned and for engaging staff in this process as the formulation should give a clear rationale for what is proposed.

In the context of this process of formulation, what then are our main responsibilities? I would argue that our primary role, as both medical qualified practitioners and as psychiatrists, is to bring a medical and psychiatric perspective to an understanding of the person with intellectual disability and to the problem that has resulted in the referral. This does not mean that we do not do other things, but if we do not undertake these particular functions, others are unlikely to do so and that aspect will be missing. Second, we have a key role in the process of formulation itself in that it is likely that we, as psychiatrists, have a breadth of knowledge that will help us to disentangle the key pieces of information that are crucial to the understanding of the person and the referral question, from that knowledge which is of less significance. Finally, like other disciplines, we also have the responsibility of setting the team's understanding of that particular person in the context of research evidence and the sound theoretical frameworks that exist about the aetiology and treatment of both physical and mental ill health, challenging behaviour, etc.

To end by returning to the theme of the original talk, the interface is the process of formulation. It is this formulation that provides the reasons and justification for action, the action itself often being a careful and logical approach to

intervention that may include focused and time-limited pharmacological and psychological interventions, changes in communication and management strategies, and modifications in the social care environment. The aim is to work in partnership with the person with intellectual disability and their supporters to facilitate changes that are of benefit to the person concerned. ■

Investigating the role of cerebral amyloid in Alzheimer's dementia in adults with Down syndrome

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Researchers at the Cambridge Intellectual and Developmental Disabilities Research Group (CIDDRG) at the University of Cambridge in partnership with the Down's Syndrome Association have recently been awarded a Medical Research Council (MRC) grant to pursue a vitally important area of learning disability research.

The team, led by Professor Tony Holland and Dr Shahid Zaman, in collaboration with the Wolfson Brain Imaging Centre at Addenbrooke's Hospital, is investigating the role of cerebral beta amyloid in adults with Down syndrome by using state-of-the-art technologies, including positron emission tomography (PET) scanning with a novel radioligand called Pittsburgh Compound B, which binds to fibrillar amyloid allowing the protein to be viewed in real time *in vivo*.

The research group has recently published the results of a pilot study (Landt *et al*, 2011) in which a small group of consenting volunteers with Down syndrome and mild to moderate intellectual disability were successfully and safely able to take part in magnetic resonance imaging (MRI) and PET scanning at the Wolfson Brain Imaging Centre. Despite the demands of venepuncture and the scanning procedures themselves, participant feedback was overwhelmingly positive. The key scientific finding from the study was an increase in amyloid binding in all participants aged 45 and over regardless of diagnosis of dementia. Patterns of amyloid distribution observed were congruent with previous autopsy studies.

Being able to observe amyloid *in vivo* will provide key information about the timeline and anatomical patterns of amyloid deposition in relation to cognitive decline in Down syndrome. Most importantly, researchers hope to 'capture' scanning information about people in middle age as they

transition from to being amyloid-free to amyloid-positive. These data will be crucial to informing the timely use of vaccines or other medications aimed at amyloid clearance in people with Down syndrome.

The research group expects that the depth and scope of the proposed MRC-funded study will be enhanced by a longitudinal design involving greater numbers of participants, and by measuring other biological correlates including serum apolipoprotein E, amyloid and mitochondrial (dys)function.

The team are looking to recruit any persons with Down syndrome aged 30 and over (regardless of diagnosis of dementia), and will reimburse costs incurred in participation. We are also keen to hear from clinicians who are involved in memory clinics for people with Down syndrome, or those with a special interest in the area. All papers resulting from this study will be submitted under the names of the key authors on behalf of the Down syndrome and dementia study group. All those who have helped us to recruit will then be named as members of that group. We are happy to provide written information or answer queries by phone (01223 746183) or email: downsproject@hotmail.com. ■

Reference

Landt, J., D'Abbrera, J. C., Holland, A. J., *et al* (2011) Using positron emission tomography and carbon 11-labeled Pittsburgh Compound B to image brain fibrillar amyloid in adults with Down syndrome: safety, acceptability, and feasibility. *Archives of Neurology*, **68**, 890–896.

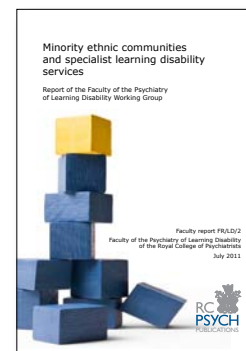
Minority Ethnic Communities and Specialist Learning Disability Services: Report of the Faculty of the Psychiatry of Learning Disability Working Group

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A new report on minority ethnic communities and specialist learning disability services has been published and is available on the Faculty website (www.rcpsych.ac.uk/pdf/FR_LD_2%20for%20web.pdf). This is the outcome of a Faculty working group on improving access for people with intellectual disability from minority ethnic communities. The report was developed using available evidence from literature, focus group discussion, information from consultation with a user group and a workshop in the

annual Faculty residential meeting in 2010. It summarises the available knowledge regarding the use of learning disability services by minority ethnic communities and provides guidance for improving access to services, using good practice examples where available. ■



Should you aim for AIMS?

Karen Poon and Heena Hargovan

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The Royal College of Psychiatrists launched the Accreditation for Mental Health Inpatient Services (AIMS) in 2009 and due to the success of this scheme, AIMS for learning disability (AIMS-LD) was subsequently developed (Cresswell *et al*, 2010). This scheme is an initiative for quality improvement which identifies and acknowledges services that have high standards of organisation and patient care, and supports and enables others to achieve these.

The process involves assessments against standards in eight domains.

1. Physical environment
2. Staffing
3. Access
4. Care and treatment processes
5. Security and safety
6. Access to therapies
7. Links with other services
8. Service user rights and safeguards

Services are then categorised against the standards at one of three levels:

- failure to meet the standards
- standards an accredited ward should meet
- standards an excellent ward should meet.

There are three phases to the accreditation assessment process: self-review assessment, peer-review assessment and, finally, an accreditation decision by the accreditation advisory committee, which awards you one of four categories of accreditation status (accredited with excellence, accredited, accreditation deferred or not accredited).

Our trust (2gether NHS Foundation Trust) viewed AIMS as an opportunity to systematically and in an evidence-based way improve the quality of in-patient services for people with intellectual disability and to provide objective

information for service users and commissioners. There are two in-patient units within the learning disability services in the Trust and we are involved in the process in our capacities as lead consultants. Our aim in sharing our experience in engaging with this process is to encourage our colleagues not to be deterred by the commitment required in terms of time and workforce as well as the seemingly unachievable outcome of gaining accreditation.

Achievable

To date, 37 wards/units have joined the scheme and despite the seemingly endless list of standards to meet, 12 have achieved accreditation and others are being reviewed or had their accreditation deferred. We dived straight into the daunting task of going through the pages of standards that we had to achieve to gain accreditation. This proved to be quite a reassuring exercise in that we found out we were actually meeting the criteria for a number of standards without any changes to practice, but a lot of energy and time had to be spent on evidencing our practices.

Involvement

A piece of good advice we were given by others who have gone through the experience was to keep the preparation group multidisciplinary. Managers, allied health professionals, healthcare assistants, administrative staff and service users were involved in the preparation process. This has proven to be valuable as each discipline could take a lead on issues most relevant to their practices, thus saving time on fact-finding before deciding whether we meet the criteria or whether further information or changes are necessary.

Maintenance

As a result of the AIMS process, we are now in a position to continue to maintain good practice from what we have gathered during our investigatory period, while setting up working groups to take this process forward. Specialised subgroups have been formed (e.g. forensic, Asperger syndrome, epilepsy) and this has improved communication and contributed towards achieving audit targets and other clinical governance issues within the Trust.

Service

The service delivered to all patients progressing through the in-patient units is truly multidisciplinary and collaborative. There is a seamless joining up of experiences shared between community teams, Social Services and in-patient teams to accomplish a hospital stay that is least restrictive and minimised to the fewest possible days. The AIMS has helped us acknowledge the tireless effort of all those working to deliver a service that is highly regarded by service users, their family and carers.

Learning

Learning happened on a number of levels. One was inter-professional learning that gave us insight into the work of others within the multidisciplinary teams. The surprise of it all was the lack of policies on some of the perceived commonly occurring situations or issues and how quickly those needed to be drafted and put in place.

Development

By the end of the process, the acronym 'AIMS' has almost gained a taboo status among all within the in-patient services. However, the feedback from everybody involved was how useful this experience has been in improving the quality of service directly as a result of changes in clinical practice, as well as indirectly through the development of policies and better administrative processes.

Conclusion

'And what was the outcome of your assessments?', we hear you ask. One unit was awarded an accreditation with excellence, whereas the other received a deferred status. We have submitted the evidence that was thought to be missing on the day of the accreditation visit and are eagerly awaiting the outcome. However, the improvement in service seems to have made a bigger impact on everyone than the accreditation status, although gaining accreditation in the end will most certainly be a valuable bonus for the other unit in our services. In light of recent investigations into the care of people with an intellectual disability, accreditation would certainly prove to be a useful outcome measure for quality assurance in addition to Care Quality Commission inspection.

We acknowledge that even though this process was very time consuming and intense, credit should be given to those staff that worked tirelessly to gather the information, making it available and signposting it effortlessly to the visiting panel on the day of the assessment. ■

Reference

Cresswell, J., Blesley, S. & Lemmey, S. (2010) *Accreditation for Inpatient Mental Health Services – Learning Disabilities (AIMS-LD) Standards for Adult Inpatient Learning Disability Units – Assessment and Treatment Units*. Royal College of Psychiatrists (<http://www.rcpsych.ac.uk/pdf/AIMS-LD%20Standards%20-%20Second%20Edition.pdf>).

Developing the future workforce – a balancing act!

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It is widely acknowledged that health policies have an impact on health outcomes of a nation, but it seems paradoxical that there is little mainstream debate about how politics of health can influence politics of health education. The Department of Health (2010a) White Paper *Equity and Excellence: Liberating the NHS* has for one ignited discussions on the government's commitment to secure high-quality health services in the UK. A consultation of the proposal document (Department of Health, 2010b) summaries the vision set out by the White Paper on improved patient outcome through provision of better education and training. It points out a progressively lesser involvement of the Department of Health and commits to assign local services a greater responsibility for planning and developing their healthcare workforce. But how are they hoping to achieve this?

From good to great

Liberating the NHS clearly acknowledges flaws in the current system and sees an opportunity for major reshaping. Suggestions are made to employ a skill-mix appropriate for local health needs, with effective relationship between health and educational providers in order to achieve this, alongside the need to change that blend frequently to satisfy the evolving healthcare needs of the local community (Department of Health, 2010a, pp. 3–6). The focus is both on new recruitment and on continuing professional development. Greater emphasis is given to clinical leadership and adaptability as a prerequisite for raising the standards of training. It hopes to bring greater clarity and transparent investments into education. Sadly, what the document lacks is clarity on how these concepts can be effectively implemented in the current health market.

One too many changes?

The proposal has evoked passionate debates at various levels to say the least. In April 2011, the government launched an independent advisory panel, the NHS Future Forum, as part of the 'listening exercise' to test issues and ideas emerging from the discussions. The Forum produced a series of reports, including an education and training report (Department of Health, 2011), based on the feedback. Although welcoming the general direction of the White Paper, the primary note on the report was about the pace and scale of change. It also acknowledged the anxieties of smaller professions and subspecialties about their voices not being heard or being overlooked. The Forum recommended that Health Education England (HEE) should establish frameworks for educational commissioning for specialties with smaller numbers of practitioners.

Despite best efforts to feel enthused about the spirit behind proposed changes, one cannot but feel a sense of *déjà vu* on certain aspects of these reforms. Not so long ago higher medical training in the UK was provided by local teaching hospitals. The question is, are we spending our valuable resources reinventing the wheel or giving in to knee-jerk responses?

The standardisation of workforce training can be a concern as local needs of populations vary across the country. Training based purely on local service needs does not necessitate achieving scientifically sound academic targets, often set out by training bodies. Potentially, there will be variability on the skill-sets of trainees depending on where they receive training. This may limit the opportunities for transferring skills nationally, possibly concentrating specialised skill pools in tertiary centres and reducing flexibility of individual training needs. The health needs of minority sectors of the community such as people with intellectual disability many not be entirely translated to training needs. Without undermining inherent strengths to the model (Table 1), building on existing education and training strengths seems arguably a more sensible solution than embarking on a complete re-haul. The education report eloquently voices this concern: 'Mistakes may be costly and the impact of mistakes on both the health service and the public will be long lasting (...) It is essential that these [changes] are not rushed' (Department of Health, 2011, p. 6).

Table 1 Potential pros and cons of proposed model

Opportunities	Threats
<ul style="list-style-type: none"> ▪ Increased autonomy ▪ Local accountability ▪ Local training ▪ Involving patient/carer groups ▪ Leadership opportunities ▪ Innovations ▪ Local lobbying and advocacy for mental health and learning disabilities 	<ul style="list-style-type: none"> ▪ Ambiguity of the document ▪ Variability in skill-sets of trainees and standards of training ▪ Needs of people with learning disability may not be well represented and therefore may not reflect as training needs ▪ Variation in commissioning strengths between subspecialties ▪ Education needs entirely based on local service or clinical need ▪ Hasty implementation ▪ Lack of proper consultation with various training bodies

The need for further clarity and detailing on concepts of 'responding to local needs' and being 'adaptive' is important if it were to have an influential role in education and training.

Should there therefore be a wider discussion about what contributes to improved clinical outcomes? Can improving educational outcomes alone improve clinical outcomes? Must we consider how the proposal can be branched out to education and training of other professional groups providing support to people with intellectual disability in the community, such as care assistants? Whether one sees them as opportunities or challenges is at the heart of such debates. The role of professional bodies such as the medical Royal Colleges may become pivotal in providing clarity and direction on such matters. Nevertheless, the time seems ripe for us as clinicians to work at a local level to up the ante. Our representation and advocacy for the health needs of people who are less able should continue to be powerful, compelling and resilient. ■

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Department of Health (2010a) *Equity and Excellence: Liberating the NHS*. Department of Health.

Department of Health (2010b) *Liberating the NHS: Developing the Healthcare Workforce*. Department of Health.

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Psychoanalytic psychotherapy and learning disability psychiatry: lessons learnt

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I believe some experience of psychoanalytic psychotherapy methods can help psychiatrists in learning disability improve their diagnostic and communication skills, efficiency, effectiveness and understanding, as well as helping us to recognise the emotional demands of the job.

Psychoanalytic psychotherapy training guidelines for specialist registrars (now ST4–6) in psychiatry of learning disability (Royal College of Psychiatrists, 2004) include 9 knowledge objectives and 11 general skills objectives (Box 1), guidance as to how these skills might be developed and assessed, as well as who should provide supervision.

David O. Driscoll (psychoanalytic psychotherapist working in the Hertfordshire Partnership NHS Foundation Trust

Specialist Loss and Bereavement Service) and I ran a 1-day training programme in psychoanalytic psychotherapy for learning disability ST4–6 in the Eastern Deanery. During the training we discussed these skills objectives (Box 1), believing them essential to the role of consultant. As a result, we have set up a bi-weekly supervision/work discussion group. A similar group was set up in Bristol (Graham *et al*, 2004; Cooke & Hargovan, 2005) after trainees were surveyed and difficulties were identified that included feeling vulnerable, inadequate and that their interventions were in some way futile. Trainees often felt helpless, lacking in the necessary expertise and powerless to effect change. As well as providing emotional support, the group attempted to expand the competencies of the trainees through supervision of a once-weekly psychoanalytic psychotherapy training case. Unfortunately, the group ended when the supervisor changed jobs, but the trainees valued the experience and continued to meet in a peer supervision format (Nash & Kerridge, 2007). I myself was a trainee in such a group, which ran for over 10 years in the Joan Bicknell Centre in south London. It has now ended, again as a result of interested individuals leaving the service. As psychoanalytic psychotherapists are rarely employed in their own right in

Box 1 General skills objectives

By the end of training, trainees will be able to:

- communicate appropriately and effectively with people of all degrees of learning disability
- identify psychological and emotional factors relevant to the development or maintenance of disturbed behaviour
- assess indications, motivation and capacity for psychological intervention in persons with learning disability who present with psychiatric, behavioural or emotional disorders
- adapt psychological treatments to the needs and abilities of persons with learning disabilities regardless of causation
- recognise how the various residential settings, and particular dynamics thereof, may affect the implementation of psychotherapy and the need for a supportive framework to facilitate the delivery of treatment
- recognise the constraints upon psychological interventions when abuse procedures are in progress
- recognise how experiences of dependency, disempowerment and exclusion can influence a person's emotional capacity for exercising choice
- formulate problems from a systemic and organisational viewpoint, understanding the impact of various events such as abuse, death and violence upon particular settings
- facilitate multidisciplinary case reviews and management plans that encompass the dynamic issues involved between self, staff and clients
- conduct a family interview in which the referred patient has learning disability, and assess the family dynamics and the appropriateness and nature of further family-based interventions
- recognise and manage the personal impact of working with chronic disability.

Adapted from Royal College of Psychiatrists, 2004.

adult learning disability services, these groups seem to be provided only by interested individuals and not by services.

An illustration of how my psychotherapy skills help me in my everyday work as an in-patient and community consultant is the following case vignette.

Case vignette

A female patient says that the social worker tried 'to make a baby' with her. I know that professionals always visit in pairs and that even though she has been abused in the past, this is not the whole story for her and how she is now. I reflect on her words and situation and say, 'Perhaps that was in your mind, that you wanted a baby?' She agrees and nods, repeating my words enthusiastically. She tends to have echolalia and so we move on without any further discussion. I know I have made a sound interpretation when she comes back to it later – 'I want to be a wife', and 'Why do I feel sad?', 'I want to have a baby'. We discuss her natural wish to have children and get married and that she feels sad because this has not happened yet. I am filled with sadness when she speaks, experiencing countertransference in psychoanalytic terms, as I am certain it is not my own feeling. Her wish, reflecting the biological drive to have children, is common in childless women of a certain age, yet in women with intellectual disability it can be a taboo subject that is never spoken about or denied. My psychotherapy training and experience have equipped me with the knowledge and ability to interpret her initial comment and open up this dialogue. These skills can bring honesty and acceptance into everyday situations. In the past, these statements of hers have always been taken as false allegations against men, which have led to a red alert on her record. After our conversation she appeared relieved, her voice was quieter, speech more coherent and understandable.

To bring together those interested in psychoanalytic psychotherapy within the learning disability field, David and I have decided to relaunch the learning disability section of the Association for Psychoanalytic Psychotherapy (APP) in the National Health Service (NHS). We hope to plan a conference and a special issue of Psychoanalytic Psychotherapy, the APP journal, as well as wanting to provide a network for section members. Any psychiatrists interested in joining should contact me (see email at the beginning of this article). Associate membership provides subscription to Psychoanalytic Psychotherapy, the APP newsletter, free annual lecture and discount rates to APP conferences. Associates are those interested in psychoanalytic principles in their everyday work.

I am also a full member and trustee of the Institute of Psychotherapy and Disability which includes non-NHS organisations and promotes psychotherapy for people with all disabilities. Training can be undertaken to become a member. Other levels of training are also provided – those interested should contact me for details. ■

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Meeting Emma

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Last year I worked at a centre for children and young people with intellectual disability. It was while working there that I met Emma, a 16-year-old girl who has been diagnosed with Asperger syndrome, dyslexia and depression.

The first time we met I introduced myself to Emma and tried to initiate some general small talk. However, she responded with what were little more than monosyllabic answers. Her facial expressions were limited, even wooden, and she avoided eye contact with me. Meeting Emma made me aware for the first time of the practical challenges of communicating and achieving rapport with a person with such complex intellectual disability. In Emma's case, she tended to interpret figurative expressions literally. Because of this I learnt the importance of adapting my language to make it simple and accessible.

Emma's intellectual difficulties were at that time compounded by psychiatric difficulties, as is common. In fact, children and young people with intellectual disability are six times more likely to have mental health problems than other young people (Emerson & Hatton, 2007). The first time that Emma's mental health problems manifested themselves in my presence was when I heard her talking to herself and sobbing. At the time she was sitting with her back to me, reading a book. I was obviously concerned and asked her what was wrong. At this she turned around and, transforming her face into a wide smile, told me that nothing was wrong. Then shortly afterwards, when it seemed she had forgotten about my presence, she again started to talk to herself and cry. Alternatively, Emma would sometimes start to laugh uproariously without any apparent reason.

I had never encountered behaviour such as this before, either as a medical student or in my everyday life. Emma's talking to herself, crying and inappropriate laughter breached social norms. And to be fully frank, on that first meeting with her I was a little unnerved. I know that stigma associated with intellectual disability and mental health

problems is wrong and extremely harmful. Nevertheless, my personal feelings in response to Emma's unusual behaviour taught me how easy it is for any of us to harbour such negative attitudes. However, when the staff explained Emma's history and her recent experiences I came to realise that her behaviour was an understandable, albeit unhealthy, response to difficult circumstances. Moreover, I came to realise that if I were to experience what she had, my own response might not be so different.

In Emma's case, due in particular to dyslexia, she was experiencing great difficulty in her schoolwork. The prolonged experience of failure was severely damaging her self-esteem. On top of this, due to Asperger syndrome, Emma was finding it difficult to chat with her peers and make friends, despite keenly wanting to be accepted. In school she was misinterpreting things in conversations and failing to pick up on the winks and nods of social situations. Thus, she was unknowingly saying and doing inappropriate things. Consequently, Emma was excluded and at times ridiculed by her classmates. I came to realise that we cannot overestimate the psychological burden of academic and social failure. This is especially the case when we consider that children spend the bulk of their life at school, an environment in which the expectation to succeed academically and socially is very tangible. Thus, although Emma has endogenous depression, these environmental stressors certainly exacerbated it.

Bullying and social stigma are frequent experiences for people with intellectual disability. Recently, the government strategy for adults with autism has identified the need to increase awareness and understanding of autism within businesses, the public and among front-line professionals (Department of Health, 2010). I think that additionally there could be great benefit in educating school children about intellectual disabilities and the need for acceptance and tolerance in the classroom and the playground.

Addressing Emma's multifaceted needs was achieved because of the coordinated actions of a multidisciplinary team. A child psychiatrist assessed and diagnosed Emma with endogenous depression. To counter the neurotransmitter imbalance, Emma was prescribed fluoxetine, a selective serotonin reuptake inhibitor. Additionally, Emma is currently undergoing cognitive-behavioural therapy, which is helping her master her emotions and achieve 'mind over mood' control. An educational psychologist liaising with Emma's teachers and parents arranged for her transfer to a special unit for pupils with autism and Asperger syndrome. At this unit Emma has the support of a special needs assistant. Emma's curriculum is specifically tailored so that she experiences both stimulation and success. Furthermore, Emma is being coached in social skills. I have been able to take part in role-play training in which we rehearse responses to different situations: meeting someone for the first time, feeling left out in a conversation or chatting about your weekend.

Thinking of the not so distant future, Emma is 16 and is rapidly approaching adulthood. Her parents and care team are conscious that she will require particular care and protection in her life, but also that to feel fulfilled she will need to achieve as much independence as possible. The government has acknowledged that adults with autism are significantly underrepresented in the labour market. They have pledged to improve access to housing and employment for people with intellectual disability and mental health problems (Royal College of Psychiatrists, 2003). With the support that she needs, it is feasible that in the future Emma will realise her dream to work in a florist's shop, arranging flowers, doing what makes her feel happy and successful. ■

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24–25 November 2011

The conference season is upon us again and the higher trainees in Leicester are pleased to announce that we will be hosting this year's Higher Trainees Conference.

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For more information please contact Rohit Gumber
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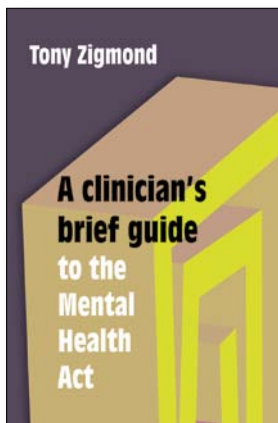
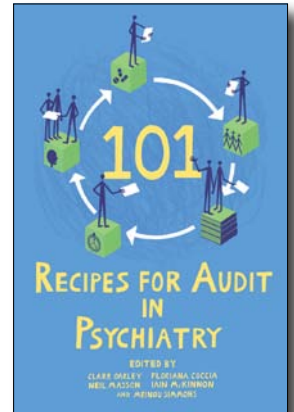
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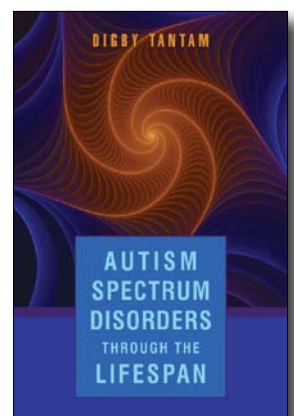
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