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Learning Disability Psychiatry

Newsletter of the Faculty of the Psychiatry of Learning Disability

Letter from the Chair

Professor Greg O'Brien

Education, Education, Education

It is no accident that this edition of our newsletter (or is it a journal? I'm starting to wonder, considering its growing size, scope and readership) concentrates on educational matters. Our specialty faces important opportunities and major challenges in the near future in this regard, which are especially relevant to the mental health of people with learning disability. It is crucial that we all consider carefully how we can contribute to the current developments in education, so that we can best carry out our responsibilities now, and in the future.

Undergraduate education

has changed substantially, particularly in the medical schools. The expansion of medical school places has allowed greater geographical expansion in our contributions. At the same time the emphasis on providing community-based, naturalistic and experiential learning offers real opportunities for specialists in our field to contribute the insights derived from our work with people who have complex disabilities. It is, however, by no means an easy matter; time is tight on undergraduate courses, and keenly contested. Happily, the innovative developments in education which have been led by Sheila Hollins, Jack Piachaud and others, working in collaboration with people with disabilities and professional



actors (importantly, the two groups are not mutually exclusive!) are extremely well-received and excite interest all round. These insights are proving pivotal. Acceptance that our educational contribution is not confined to psychiatry but is important to various parts of the medical curriculum – especially teaching on disability and rehabilitation – can facilitate our work.

Beyond the medical schools, we see further interesting developments in undergraduate education. The extensive discussions that are taking place on the commonalities between the medical undergraduate experience and other courses yield interesting possibilities for us, and already this whole initiative has developed further. A growing group of teachers in our field now hold university appointments in Health Faculties, where the emphasis is on the education of other health professionals. Speaking as someone who recently joined this group, I can attest to its being a fascinating area of work, where our involvement is warmly welcomed. As always, whenever we operate out of our own traditional areas of work, it becomes an immensely enjoyable and educational experience for us; definitely to be recommended. (contd.)

PMETB

I don't think any collection of five letters currently excites as much interest, excitement, antagonism, heated debate and concern among medical personnel than this (with the possible exception of b.l.a.i.r.). For anyone who has managed to miss this acronym so far, it refers to the Postgraduate Medical Education Training Board. It has now begun to meet, to implement and monitor the wholesale revision of postgraduate medical education and training. Much of the well-publicised review makes good sense, although the overall shortening of time spent in training remains a matter of concern. Clearly, we face fundamental re-organisation of postgraduate medical education across all specialties. On the one hand, I think we can take heart, and see the whole thing positively but, on the other, there are issues which need to be watched carefully, from the top down, and from the bottom up.

At the top, PMETB has no psychiatric member. Our President has keenly contested this, with the result that we are now assured of representation on all of the associated committees, particularly on implementation and monitoring of the new structure. There is no substitute, however, for having a place at the top.

At the coal-face the devil is in the detail. We have been following closely the developments on the place of learning disability/developmental psychiatry education in the new proposals and, to date, it does look as though the need for training in our field at the level and depth currently enjoyed by trainees is in the plans. This needs to be watched and implemented carefully within local training contexts and will be a challenge for all of us.

In fact, much of the revision of training which is proposed for all medical specialties has already been taken on board in psychiatry training: the changes will be bigger for other medical specialties. Changes will occur for us and we need to make sure that they best serve the mental health needs of people with learning disabilities.

Core competencies

This will affect all of us, as you will see from the article by Mary Staines; if you haven't read the College document yet, please do and contribute to the debate by sending your comments either directly to the postgraduate department in the College or to Mary herself as Chair of PLDSAC.

Finally, in this world of electronically enhanced communication and learning, the web-site awaits you. (See Peter Carpenter's article in this edition)

Happy surfing! ■

Keeping up-to-date – the use of the web

Dr Peter Carpenter
CPD Committee

The world of the web is a vast conglomeration of information of highly variable quality, provenance and value. At its best it functions as an electronic library but, unlike the print media, few have developed electronic current-awareness services. In keeping up-to-date, I still use the printed Medline or BILD current awareness journals to keep up to date with what is out there; the BILD service includes books and the Medline abstracts. Both are relatively cheap and I would recommend that any library subscribe to one of them. The other main review journal I use is *Current Opinion in Psychiatry* and I find the *Advances in Psychiatric Practice* a good journal for keeping abreast generally.

The only 'updating service' of which I am aware is the Medline alert service on **Doctors.net.uk**, which enables me to receive abstract updates by e-mail on a regular basis. It can, however, be overwhelming at times – for example, submitting the key word 'Autism' can result in the electronic delivery of over 30 abstracts a week to digest!

Apart from limited updates, one can also peruse the net. There are three ways of doing this:

- the first is to look up paper materials that are also available on the web – your local regional NHS library link and the National Electronic Library for Health (www.nelh.nhs.uk) will provide you with access to a lot of the basic journals, including the Evidence-Based Psychiatry reviews. They have yet to take on the *APT*.
- the second is to have a series of favourite sites which one can check periodically, but few sites have a 'what is new' section – and when you think that the Royal College of Psychiatrists website alone has over 3000 pages the task may be daunting.
- Thirdly, one can carry out a search on a topic when needed. Most search engines disappoint me but I have not found anything that beats 'Google' (www.google.co.uk). The problem is the uncertain provenance of many sites, many of which, I have discovered are sponsored by people with other vested interests. As a person who is constantly asked about various novel treatments for autism, I have noted that most internet information on these is placed by people who are selling the products. In order to have a more balanced view, I would advise the use of various review sites. These are best listed in the BMA article on using the internet at www.bma.org.uk/ap.nsf/Content/healthinfonet.

Unfortunately, all of these methods of keeping up-to-date have limitations and financial implications. It costs money to maintain websites and therefore many sites require subscriptions to enable access. If your NHS Trust employer, or you yourself, does not already subscribe to these services, it can become a very expensive undertaking to search so many different sites.

Clearly the best thing is to have a small list of reference sites that you visit occasionally and a few favoured search engines for finding new material. The College LD web page has what I feel is a reasonable shortlist, but I would welcome new recommendations.

I still do not know, however, how to find the site, where the Australian group of child psychiatrists are putting their new book on prescribing guidelines for children, which covers LD! If anyone else knows perhaps they could e-mail me the link! ■
(peter.carpenter@bristol.ac.uk)



A competency-based curriculum

Dr Mary Staines
Chair of PLDSAC
(Roger Banks – Editor)

At the recent faculty residential meeting in Barcelona, I was pleased to be able to present a workshop and a lecture on the 'core competencies' for specialist registrar training. I did this in collaboration with Dr Gareth Holsgrove, head of postgraduate education at the Royal College of Psychiatrists. The details of this approach have been published in a document entitled 'A competency-based curriculum leading to the Certificate of Completion of Training'. The former Dean, Professor Cornelius Katona, initiated the process of developing this document. During a period of consultation, the faculty and its training committee were asked to provide the content for the specialist competencies for the psychiatry of learning disability and I received tremendous help in formulating these.

Much of our education, as we progress from student to graduate and postgraduate studies, focuses on knowledge and the application or ability to use that knowledge. At higher levels of education, particularly

in medicine, the focus shifts from knowledge to competence and performance, in other words not just "knowing" and "knowing how" but the "doing", the consistent and competent carrying out of complex procedures or tasks (a more sophisticated, and safer, update of the ancient medical maxim of "see one, do one, teach one"?). The most important outcome of such an approach is the provision of high-quality, patient care.

At the stage of specialist registrar training, the emphasis is very strongly upon developing a high degree of professional competence since the completion of a CCT is the gateway to practise as a consultant.

The College document describes "three sets of obligations upon candidates, their trainers and mentors":

- to clearly describe the standards that must be achieved in order to complete specialist training
- to provide educational opportunities and support so that they can be achieved
- to ensure that doctors successfully completing the programme have indeed achieved those standards and, if necessary, produce evidence of this

The curriculum is set out in two parts. The first addresses general professional competencies, acknowledging that specialist registrars perform a variety of roles in their professional lives that extend far beyond being a competent clinician:

- Clinician
- Professional
- Educator
- Leader and team worker
- Researcher

There are other roles that overlap with one or more of the headings above:

- Health advocate
- Information manager
- Communicator

Finally, there is the specialist role, which is addressed in the second part and the related competencies are set out in a number of supplementary documents for each of the psychiatric specialties. Suggestions for learning and assessment methods are also detailed in the document.

If we look, for example, at one of the key roles:

Clinician

- Undertake clinical assessment of patients with possible mental health problems, learning disabilities and brain disorders
- Prescribe and deliver treatment to people with mental health problems
- Devise, co-ordinate and monitor care plans for patients with mental health problems
- Provide clinical supervision

(contd.)

we can expand on the related competencies for the first strand:

Conduct clinical assessment

Learning methods	Assessment methods
<ul style="list-style-type: none"> •Observation/modelling •Case conference •Supervised clinical practice 	<ul style="list-style-type: none"> •Validated self-assessment •In-training assessment •Clinical supervision •Direct observation •Video-stimulated recall

Competencies in the specialty of the psychiatry of learning disability are divided into two areas:

Key Competencies 1:

Work with others to assess, manage and treat people with a learning disability and associated psychiatric and behavioural problems

Key competencies 2:

To contribute to the organisation, development and management of effective, multi-disciplinary services for people with learning problems and associated psychiatric or behaviour problems and their carers. An example of these is:

•Proficiently assess and diagnose main syndromes at all ages and stages of development

Learning methods	Assessment methods
<ul style="list-style-type: none"> •Observation and modelling •Discussion with supervisor and other team members •Supervised clinical practice •Case conferences •Attendance at specific courses and workshops •Guided reading 	<ul style="list-style-type: none"> •Validated self-assessment •In-training assessment: •Clinical supervision •Direct observation •Case presentations •Review of case notes and other records •Chart-stimulated recall •Video-stimulated recall

This concept of competency-based training is comparatively new to medicine and therefore this competency-based curriculum has been developed “from scratch”. It has, however, been approved by a variety of experts and medical education specialists and is promoted very much as a “living document” to be improved and updated over time. The curriculum is now available on the website of the Royal College of Psychiatrists; a paper version will be published in 2004.

The postgraduate education department at the College is very keen to provide support to trainers to develop their assessment skills. We are planning to conduct workshops to enable training programme directors and trainers to provide the appropriate learning methods and to develop the assessment tools. I would be very pleased if you could contact me (Mary Staines) through the College to discuss these or any further ideas or amendments. ■

Psychiatry and learning disabilities in post-communist countries – Experience from Lithuania

Professor Dainius Puras
 Head and Associate Professor,
 Centre of Child Psychiatry and Social Paediatrics, Vilnius University

To understand the complex nature of the transformation of the field of psychiatry and learning disabilities in the countries of the former Soviet Union, some comments are required on the prevailing attitudes in the past.

The field of mental health services and research was largely affected by communist ideology in the former Soviet Union. The reductionist “disease” model dominated the field, with a tendency to over-diagnose schizophrenia and to ignore psychosocial components in the approaches to the understanding, interpretation and treatment of all possible mental disorders. Interpretation of mental retardation and other developmental disabilities had some special features. In general, mental retardation was a territory of two fields – psychiatry and “defectology” (Soviet analogue of special education). Psychiatry and child psychiatry were responsible for the medical components of developmental disabilities. The general trend was to diagnose “oligophrenia” and to offer medical treatment, thus making an attempt to cure the disease or to reduce its medical symptoms. Medications offered were directed either to stimulate the development of the central nervous system (neurotropic medications have been very popular in the last decades) or to address other psychopathological symptoms and syndromes. Defectology was responsible for the strict classification of children into mild, moderate and severe cases of developmental disability. Only mild cases were allowed by the system to enter special educational institutions (mainly special boarding schools for mentally retarded children), while moderate and severe cases were regarded as “uneducable” with strong recommendations made for parents to abandon their children and to leave them to the care of the state in remote institutions. Children with autistic spectrum disorders were often labelled as ill, with early onset childhood schizophrenia; high doses of antipsychotic medications would be a main part of the treatment plan. Psychiatry and defectology were working in alliance to define such cases as both uneducable and incurable.

Training of psychiatrists in the Soviet Union was very short – usually one year of postgraduate training to receive a licence of psychiatrist or child psychiatrist. Mental retardation was one of many fields included in the curriculum of such very superficial training.

Almost 15 years have passed since major political changes occurred in the former Soviet Union. Lithuania, together with other Baltic countries – Estonia and Latvia – has undergone enormous changes in all fields and are now ready to join the EU in 2004. The field of psychiatry and learning disabilities has also witnessed major changes. After the fall of the ‘iron curtain’ in the end of the 1980s, Soviet concepts began to have to compete with those from Europe and Northern America. Many new demonstration services for children and adults with developmental disabilities were established in the community – early intervention services for infants and pre-school children, day care centres for moderately and severely disabled school age children, independent living centres and sheltered workshops for mentally disabled adults. All these innovations, however, met resistance from the traditional system of centralised state institutions. Mental health services appeared to be the most complicated field to be changed, because of a very high burden of stigma and a strong paternalistic approach from all stakeholders, including the general public, psychiatrists and other professionals, politicians and also users of services and their relatives.

The field of learning disabilities has been in a very special situation during this period. Psychiatry is gradually losing the interest and role and psychiatrists do not acquire much knowledge and skills in this field (despite the duration of postgraduate training in psychiatry being now extended to 4 years). This is due, in part, to further medicalisation of psychiatry, which in the last decade has been influenced by the pharmaceutical lobby and new health insurance schemes that prefer to fund medical treatment of illnesses such as schizophrenia and depression and have no interest in learning disabilities. The other explanation for the process of separation of the field of learning disabilities from general psychiatry is that innovations in the development of community-based services for children and adults with learning disabilities are mainly going on in the educational and social welfare sectors, so mental retardation (official term currently used) is increasingly perceived as more of an educational, developmental and social issue rather than a psychiatric or medical one. This has both advantages and disadvantages. Certainly post-Soviet psychiatry needed a dose of de-medicalisation and in this context it is very important to involve families, communities, schools and the emerging infrastructure of social services in supporting individuals with learning disabilities. However, it is important to maintain close links between the fields of psychiatry and learning disabilities and shared examples of successful models of services and training schemes from the UK and other EU countries would be very important. Good examples of developing links between psychiatry and learning disabilities in Lithuania can be demonstrated in the

field of child mental health. Fifteen years ago, excessive institutionalisation of mentally disabled children was perceived as a major political pressure. The newly established society of parents with mentally handicapped children “Viltis” (“Hope”) began to put political pressure on changing laws and attitudes; this was one of the first effective examples of civil society in then Soviet territory. Politicians responded with the establishment of the Vilnius University Child Development Centre, which became a demonstration clinic and catalyst for reforms in a broad area of child mental health – including both child and adolescent psychiatry and interdisciplinary support for children with learning disabilities and their families. The Centre continues to function, combining clinical programmes (child psychiatry, early intervention for infants and pre-school children with developmental disabilities), undergraduate and postgraduate training of different professionals (affiliations with Medical School, Pedagogical University, etc.) and research.

Our experience in trying to combine and look for “common denominators” in child and adolescent psychiatry and learning disabilities has been very interesting and unique. While working with the health sector (Ministry of Health, Medical school, professional groups) we have been trying to highlight the importance of non-medical issues (empowerment of clients and families, networking in the community) that had previously been ignored. While working with non-medical professionals and parents we were making a strong emphasis on medical and psychopathological issues of developmental and learning disabilities. We have developed links with different partners in Europe, UK, US, Canada and Australia. Our strategy was to be as open as possible to a variety of approaches in the field of child mental health and developmental disabilities and we have learned a lot from different countries that have developed effective services for children and young adults in this area. However, we have also observed tensions and conflicts in developed countries between traditional models of child and adolescent psychiatry, practitioners in the field of learning disabilities who tend ignore a medical model and the links between learning disabilities and general psychiatry.

We have a lot of work to do in both “west” and “east”. At this moment we in the “east” still have to learn from the “west” but it may be that in future many innovative schemes may come from the “east”. The economic difficulties of post-communist countries require us to develop services that have to be as cost-effective as possible and to involve families and communities to the maximum level. If democracy and civil society becomes stronger in these countries, they may become very innovative in the development of an effective infrastructure of human services. ■
dainius.puras@mf.vu.lt

Experiences of an SpR representative.

Dr Eileen McNamara
Specialist Registrar, London

It was without premeditation that I put myself forward as a candidate for SpR representative last July. Bunny Forsyth had completed her time in the post and was looking for an interested SpR to take over from her. So having no knowledge of what the role involved I found myself unable to inhibit the impulse to volunteer. Six months later, I have no regrets and thought it might be useful to describe what I have been doing on the job.

The annual residential conference of specialist registrars in psychiatry of learning disability was held in London in July 2003. Sujeet Jaydeokar and William Howie from the North West Thames and St George's rotations arranged an impressive academic and social programme. The theme of the conference was Autism, with excellent lectures on topics including assessment and treatment, genetics and neuro-imaging, forensic issues and eating disorders. It was a valuable learning experience, particularly for those SpRs working in areas where access to specialist autism services is limited. The comfortable surroundings of the Marriot Hotel and a rather sumptuous evening at the Café Royal no doubt facilitated learning.

One of the first tasks I faced as SpR representative was to find a volunteer to organise the 2004 conference. Given the high standards of the London event, it was no surprise that there were no volunteers for the task. Financial problems further complicated the issue. The organisers of the London conference ended up absorbing a significant monetary loss owing to a miscalculation of funds outstanding from the previous conference in Oxford and the general high costs of London as a venue.

The problem was considered at the SpR meeting at the faculty conference in Barcelona in November. We agreed that the SpR conference was important and worth continuing. However, steps needed to be taken to prevent financial complications in the future and this issue is currently being discussed within the faculty. Meanwhile, Georgina Parkes has taken on the role of treasurer and is reviewing the accounts from last year.

The problem of next year's venue was also addressed. Many thanks to Edward Da Costa from the North East Thames rotation, who is currently aiming to host the 2004 conference in November, with the theme being "Forensic Aspects of Psychiatry of Learning Disability".

The other responsibilities of the SpR representative are to sit on the Executive Committee of the Faculty of the Psychiatry of Learning Disability and to attend meetings of the Psychiatry of Learning Disability Specialist Advisory Sub-Committee [PLDSAC]. In total this amounts to about 8 meetings a year and they are generally held at the Royal College of Psychiatrists. My role is to represent the views interests of trainees at these meetings.

PLDSAC is responsible to the Specialist Training Committee [STC] of the College and oversees the training of SpRs in psychiatry of learning disability. Much of the work involves assessing the higher training schemes and advising the Higher Specialist Training Committee on the ongoing accreditation of these schemes. PLDSAC have also been involved in the development of the proposed competency-based curriculum for higher training. Documents outlining both the general and specialist competencies required for Certificate of Completion of Training (CCT) are available on the College website and are well worth reading as they are relevant to our training.

I have attended one meeting of the Faculty Executive Committee so far and am only beginning to grasp its workings. Thankfully, Raja Mukherjee from the Collegiate Trainees Committee (CTC) also attends and he is gifted with a greater understanding of the workings of the College. Broadly speaking, the Executive Committee are involved in the development of policies aimed at promoting the health of people with learning disabilities and in expanding knowledge about psychiatry of learning disability.

In my view, the job of SpR representative provides an excellent opportunity to learn in situ about the workings of the College. It is a challenge to consider how the issues discussed may affect trainees and to represent the views of SpRs as a group rather than my own personal views. I have found email an invaluable tool for gathering opinion and many thanks to those who have replied to my various queries in recent months. So if anyone is interested in taking on the role, I hope this brief article helps you make an informed choice rather than an impulsive one. ■

University of Birmingham - National Conference
Therapies in psychiatry of intellectual disability
- do they work?
14th May 2004

Birmingham Medical Institute,
Highfield Road, Edgbaston, Birmingham
Enquiries / Details: 0121 678 2353
s.deb@bham.ac.uk

Simulated patients with learning disabilities in the training of medical students

A.J. Thacker, W. Perez, N. Crabbe, C. McCluskey, A. Cleary, S. Hollins, O. Raji

St George's Hospital Medical School

During the past 4 years, more than a thousand future doctors at St George's Hospital Medical School, University of London, have benefited from training by actors with intellectual disabilities.

This programme's goals are:

- To produce medical practitioners who are skilled, sensitive, and confident in communicating directly with and managing the health needs of people with intellectual disabilities. To improve the ability to observe and understand non-verbal cues and innovative or idiosyncratic use of language. Students practise effective techniques for checking their patient's comprehension and for administering valid consent procedures. Future doctors learn to tolerate and manage refusal to consent by adults with intellectual disabilities. They involve accompanying informants appropriately while maintaining a primary focus on the people with intellectual disabilities.
- To circumvent diagnostic overshadowing.
- To improve access to information and decision-making by clients.
- To afford wider access to health services for a traditionally disadvantaged group.

As far as we can determine, this is the first such programme in the world.



Training

Twenty actors have been recruited following their participation in drama courses and productions run by the Strathcona and the Baked Bean Theatre Companies in London. The actors are employed under similar conditions to, and receive payment at exactly the same rate as, professional actors without disabilities. Patient scenarios are devised by the authors with help and advice from the actors. Training takes place within the medical school, and actors are asked to practise their roles at home.

Actors practise communicating information both verbally (through speech and gestural language) and non-verbally (for example through posture and eye contact).

Many of the problems which have been encountered in performance in fact reflect the difficulties which health professionals are likely to encounter in authentic situations. These include over-compliance on the part of the patient.

Employment:

Simulated patients with LD participate in teaching throughout both the 5-year and 4-year MBBS curricula. Students practise health-screening procedures prior to genuine consultations in community learning disability clinics. Simulated patients meet with the class afterwards to feed back their impressions.

SPLDs assist in OSCEs in the second and fourth years. Since 2001, SPLDs have taken part in the final examinations (psychiatry) of the MBBS. This phase of the examination carries equal weight to other medical specialties.

Evidence for effectiveness will be published elsewhere.

The funding for recruiting, training, and employing the first actors was provided by a Department of Health Shared Training Award.

The simulated patient project team is now developing a National Simulated Patients Project, which will inform interested medical schools in methods of actor recruitment, training, employment, and curricula and examination materials. Any medical school wishing to develop a similar programme should contact:

Professor Sheila Hollins,
Dept of Mental Health,
St George's Hospital Medical School
Cranmer Terrace
London SW17 0RE
shollins@sghms.ac.uk

Medical Student Essay Prize



The Faculty has recently created an annual essay prize for medical students.

£250 will be awarded to the best essay submitted by a student giving an account of a study module or project undertaken that brought him or her into direct interaction and collaboration with a person (people) with learning disability. The essay should focus on the ways in which the student's training has been influenced as a result.

For full details contact the Postgraduate Department at the Royal College of Psychiatrists

Raising the profile of learning disability psychiatry in psychiatric training

Dr Neill Simpson / Dr Peter Carpenter,
Faculty Executive Committee

The executive committee of the faculty held a workshop on training issues at its strategy day on 26 June 2003. The question to be answered was: how to increase the competence of all psychiatrists in providing a service to people with learning disability? A small, hard-working group spent less than two hours on the topic, and produced twelve proposals. If the College acted on these suggestions, we believe that the competence of psychiatrists at all levels would increase.

Some of these proposals are demanding. There would be an increased demand for training and, therefore, for time from existing learning disability specialists. Submitting patients to an exam centre is time-consuming, hard work. Asking PLDSAC to be insistent that service gaps are filled may result in training programmes having their approval limited. It is probably not feasible to do all of these at one time. Which of these should be the highest priority? Are there any of these with which you disagree? Are there other ideas that have been overlooked?

The executive committee received the notes of the meeting and decided to seek feedback from the membership of the faculty via the newsletter. Please email your comments to:

Neill.Simpson@glacomen.scot.nhs.uk or Peter.Carpenter@banes-pct.nhs.uk

	Level of training	Suggestion	Action
1	Undergraduate	All medical schools should provide some clinical contact with people with learning disability.	The College should advise the GMC to monitor whether medical schools genuinely offer clinical teaching on learning disability and to disapprove courses that fail to do so.
2	Undergraduate and basic	Improve career guidance offered by regional advisers and others.	Faculty exec should maintain an up-to-date file of career guidance material. Advice given to trainees (e.g. by regional advisers) should be monitored and action taken to remedy inappropriate advice.
3	Basic	College examiners should be competent at assessing the ability of MRCPsych candidates to undertake clinical assessment of a patient with learning disabilities.	The College should request examination observers to monitor this and report on whether all exam centres are including this assessment.
4	Basic	Every exam centre should include a proportion of patients with learning disabilities. Target of 20%.	The faculty exec should provide support to encourage members to submit patients to exam centres.
5	Basic	Specialty tutors should be supported in fulfilling their role.	Faculty exec should review the job description of specialty tutors. There should be more active communication between the exec and the specialty tutors.
6	Basic	Encourage the creation of multimedia training materials to achieve competency.	Faculty exec should identify priorities for training materials and act as a broker, for example by offering links to appropriate websites.
7	Basic and higher	The competency framework should be complemented by a statement about other experience necessary to practise in a service.	1) Faculty exec should define the additional experience required, which may include practising in a range of service models. 2) Faculty exec should consider whether a time-related criterion is necessary (for example, portfolio to include treating a patient with a recurrent disorder through more than one episode of illness).
8	Basic and higher	Encourage innovation and development of training programmes.	Encourage TPDs and specialty tutors to identify a small excess of training slots over funded posts.
9	Higher	Ensure that all higher trainees are offered opportunities to train in services to meet the full range of clinical needs. Some training programmes are continuously unable to offer some aspects of training because of critical gaps in services, which are never remedied.	Invite PLDSAC to be more insistent that long-term service gaps are addressed.
10	Higher	Prepare doctors for appraisal.	PLDSAC should suggest to the STC that preparation for appraisal should be part of higher training.
11	CPD	Identify models of good practice in peer groups. Are cross-specialty groups better than within-specialty groups?	Faculty exec should undertake a survey of experience of peer groups.
12	CPD	Enhance the quality of appraisal.	Faculty exec should ask the College to consider how to measure the quality of appraisal.

We wish to acknowledge the contribution of the members of the group who produced these suggestions: Professor S Brown, Dr R Mukherjee and Dr B Fitzgerald).

Pharmacotherapy and pharmacovigilance in learning disability

Dr Sabyasachi Bhaumik, University of Leicester

Dr Dasari Mohan Michael, Leicester Frith Hospital

A workshop held at the College annual meeting on 1st July 2003, addressed areas of concern in drug treatments for mental disorders in people with learning disabilities, based on current evidence and expert clinical opinion. Following an initial discussion about the evidence base, the group work tried to gather clinical opinion, produce a summary document and consensus statement.

The following issues were identified:

- a. Diagnostic difficulties (including dual diagnosis)
- b. Evidence base for neuroleptic use in adults with learning disabilities and its limitations.
- c. Varying sensitivity to and bioavailability of medication.
- d. Propensity to develop side effects; lack of reporting of these.
- e. Lack of NICE guidelines.
- f. Varying clinical practice.
- g. Use of medication outside licensed indications.

It was acknowledged that the use of neuroleptics to manage behaviour disturbances is frequent, although the recent trend has been to use atypical neuroleptics more widely than traditional antipsychotics. Potential reasons for this include limited resources, lack of clinical psychology input, inability to change environment meaningfully, lack of suitably trained staff to manage private residential homes, pressure from nursing and other professionals for immediate resolution of problems. It was acknowledged that many people do not have meaningful employment or day care opportunities. There were concerns about the identification of long-term side-effects of psychotropic medication and it was accepted that review of medication, especially in long stay wards, may be far from regular. Sometimes, despite the use of optimum resources and professional input, behaviour problems remain unmanaged, causing serious risk to self and others. Some individuals do respond well to neuroleptics, for example those with autistic spectrum disorders, stereotypies and behaviour problems. For some, medication brings down the arousal level, allowing them to participate in other therapeutic approaches. However, the evidence for the use of medication in behaviour problems is limited and there is the ethical

issue of using “chemical straight-jackets” in the absence of adequate resources.

Pharmacovigilance is an important issue, particularly in those with reduced communication skills. Compounding the issue is the practice of polypharmacy and lack of monitoring sometimes due to the involvement of multiple carers in different settings. Co-morbidity and multiple drug treatments leading to potential are important, e.g. existence of behaviour disorder together with active epilepsy and mobility problems.

The group considered how to improve pharmacotherapy and influence pharmacovigilance; suggested solutions were identified as follows:

- Diagnostic difficulties - when in doubt, clinicians should review and reassess with the help of multidisciplinary team members and may use rating scales, e.g. PASSAD, DCLD, REISS or PIMRA. A second opinion may be sought and a working hypothesis arrived at with a clear plan for a therapeutic trial of medication with regular reviews.
- Establish a clear multidisciplinary management plan with identified pathways of care.
- A clear plan for the assessment of outcome of treatment should be provided.
- Advance directives based on the risk-benefit analysis and alternative approaches should be undertaken with the client and the carers, where possible.
- Short-term and long-term side-effects of treatment should be discussed and recorded.
- Medication should be given in adequate doses for an adequate time, using outcome measures such as the Aberrant Behaviour Checklist, REISS or PIMRA.
- If a drug fails to produce sufficient benefits, it should be withdrawn.
- Polypharmacy should be avoided; newer antipsychotics /antidepressants may have a better side-effect profile.
- Drug interactions, especially when there are co-existent health problems (e.g. epilepsy) should be taken into account.
- Information leaflets for service users and carers should be developed (these could be disseminated to others through the faculty).
- A robust information system (e.g. lithium register) should be used where possible.
- There should be education of service users / carers about diagnoses and treatments, including alternative ways of managing the same problem.

- Better mechanisms are needed for recording adverse events (e.g. the use of monitoring forms)
- Pharmacists should be involved in multidisciplinary meetings and medicines management on a regular basis from the outset of care.
- A detailed drug history should be made available for service users and carers to aid better understanding of the current management plan.
- Mechanisms should be in place for regular review of medication, at least every 3 months.
- Peer review groups and audit processes with clear standards should be used to improve clinical practice over time. Guidelines for the use of psychotropic medication in learning disability should be established for national use through the faculty; information about these and medications generally could be made available for service users and carers at a local web site. ■



'Looks Like Terry's Fingers' by Rhondda Cynon Taff Integration Project Thursday Morning Pottery Group. Slipped and glazed earthenware vessel. Photo by John Lunn.

Through our information service we respond to over 1000 queries a year on a huge variety of issues around disability and the arts. We produce a bi-monthly newsletter, *'What's On'*, which is packed with information on events, training, funding opportunities and websites. Our own website is available in English and Welsh and includes a showcase of visual art and writing by disabled people. ADW has a fast increasing membership, which includes disabled artists, disability organisations and arts organisations. We often arrange meetings or visits with our members to talk through the issues and discuss possible ways forward.

In December we organised a Disability Arts cabaret; an opportunity for our members to help us celebrate ADW's 21st birthday. **Cabare!** took place at the Chapter Arts Centre in Cardiff, where there was music and comedy by some of the best performers on the disability arts circuit in Wales and England. All tickets for the event were taken within two weeks of being marketed.

The degree of interest in **Cabare!** reflected the growth of the disability arts movement in Wales. The importance of disability arts is that it is led and controlled by disabled people, bringing a whole new perspective and a very considerable challenge to the arts establishment. It is incredibly exciting to be at the forefront of a new arts movement, and Arts Disability Wales is proud that our work in bringing down the barriers for disabled artists is starting to take effect.

Our project work has highlighted increasing confidence among disabled people as artists, performers and writers. In December 2000 we held a visual arts competition, **cADWyn**, and received 150 contributions of work by disabled artists. Twelve finalists were chosen by an independent panel of judges. The finalists received a cash prize, and their work was reproduced onto high quality postcards which were distributed free to over 100 venues throughout Wales. Such has been the success of the scheme that more than nearly three years on, some of the venues continue to ask for more postcards.

Arts Disability Wales

Maggie Hampton

Operational Manager

Arts Disability Wales (ADW) is an organisation with an all-Wales brief to promote opportunities for disabled people to participate in and contribute to the cultural life of Wales. ADW's services include information, advice, training and developmental projects. Our work encompasses all art forms, and we work with any disabled people who have an interest or involvement in the arts. All we ask is that the individuals concerned consider themselves to be disabled; we do not check or ask for 'proof of disability'. We aim to make our work fully accessible; our projects have included work by people with mobility impairments, deaf people, blind and visually impaired people, people with learning difficulties and people with mental health issues.

We do a lot of work with arts organisations throughout Wales, and consider partnerships to be a productive way forward for all concerned. Disability Equality Training is another important element of our work; we have a team of trainers, all disabled people, trained by ADW to work specifically with arts organisations. Disability Equality Training addresses the barriers to inclusion in the arts, and can be highly effective in helping organisations to prioritise and plan for a more accessible future.

As yet there are few opportunities for disabled people to train to professional levels in the arts, and there is much to be done in this field. We are currently fundraising for a Training Officer who will have responsibility for developing new training initiatives.

In 2002 the original art works from **cADWyn** along with new work by the artists were shown in a small touring exhibition, **Connection**, which visited arts centres in Brecon, Pontardawe, Wrexham and Shrewsbury. For many of the artists these projects have given their careers a considerable boost, raising the profile of their work, and bringing further opportunities to exhibit. Our current project is called **The Write Stuff**. Eighty-six people are participating, working towards publication of the first-ever anthology by disabled writers in Wales. Groups have been meeting in Cardiff, Carmarthen, Colwyn Bay, Llandrindod Wells, Newport and Swansea, and four groups worked from home via post and email. The launch of the book, which will be published by Parthian Books in 2004, will include readings of work across the country. This will be a significant step in raising the profile of disabled writers contributions to Welsh literature.



Invisible Man by Gerald Edwards Mono print.
Photo by Brian Tarr.

As Arts Disability Wales celebrates its 21st birthday, we feel we have much to celebrate. The energy and commitment of disabled artists continues to be an inspiration, and the support shown by many individuals and organisations will ensure that disability arts in Wales can only go from strength to strength. ■

For further information contact:

Email: arts.disability@btconnect.com
www.artdisabilitywales.com

In conversation:

Prof. Dinesh Bhugra is interviewed, following his recent election as Dean of the Royal College of Psychiatrists.

Dr Philip Dodd (interviewer)

In July 2003, Professor Dinesh Bhugra, Professor of Mental Health and Cultural Diversity at the Institute of Psychiatry, was elected Dean of the Royal College of Psychiatrists. Prof. Bhugra, who is Honorary Consultant at the South London and Maudsley NHS Trust, graduated from Pune in India, and has worked in Cork, Northampton, Leicester, Eastbourne and London as a Community Psychiatrist. His research interests include cultural psychiatry, spirituality, sexual dysfunction, and diversity. He has

published widely, including books on cultural psychiatry, management, and religion and psychiatry.

Prof. Bhugra has been active in the College since 1985, and has Chaired the Collegiate Training Committee (1987); the Overseas Doctors Training Committee (1996-present); and the Faculty of General and Community Psychiatry (1997-2001). He has been a member of Council and the Court of Electors and Sub-Dean for Examinations (2001-2003).

PD: How are you enjoying your new post as Dean?

DB: Very much! At the moment I'm still discovering College committees that I'm now a member of. The task of getting to grips with the job of Dean is both daunting and exciting.

PD: How do you divide up your working week?

DB: Before I went for the job, I approached my Trust as well as the Institute, requesting permission, and we worked out a plan in the event of me being successful. They were very supportive of my plans. Now, as Dean, I devote approximately 3 sessions per week to College work. I go into the College for at least 1 session a week to deal with administrative and paper work-the rest is usually taken up with meetings. Luckily, many of my meetings are in London, which saves a lot of time.

PD: What aspects of the role of Dean encouraged you to want this post?

DB: In my own training experience, I have had the benefit of training and working in different countries. When I came to Britain, I initially felt an outsider. I was acutely aware of both the similarities and differences in training that I had received. This experience has made me very aware of the need to constantly monitor and assess the effectiveness of the various parts of training that we have in psychiatry; it also made me very aware of the needs of the trainee. Being Dean, of course, gives one the opportunity to shape training. I suppose it is this that motivated me to seek the post.

PD: What are your priorities?

DB: There are two key issues that are going to have a huge impact on training in psychiatry: the EU Working Time Directive for Junior Doctors, and the planned changes in SHO training. These impending changes are going to dictate the need for change in the content as well as assessment of training, and by that I mean the examination process, as well as the whole process of supervision and teaching. In many ways my priorities of work have already been set by ongoing changes that are taking place in medicine as a whole. With the examinations, I think we need to be

Conferences & Meetings

5th International Congress, NADD, Boston, USA, March 17th- 20th, 2004.

“Evidence based practices/Practice-based evidence in mental health and developmental disabilities”.
www.thenadd.org

Faculty Spring Meeting Joint mtg with BPS, Regent's College, London. 1st April 2004

“Challenging behaviour – towards an integrated Understanding”

International Autism Conference, Autism Cymru, Cardiff 17th – 19th May 2004

“Strategy and practice surrounding developments in autistic spectrum disorders”
www.autismcymru.co.uk

Institute of Psychotherapy and Disability Conference, London Methodist Centre 20th May 2004

“The Boundaries Conference”
roger.banks@cd-tr.wales.nhs.uk

University of Birmingham, Birmingham Medical Institute 14th May 2004

“Therapies in psychiatry of intellectual disability - do they work?”
s.deb@bham.ac.uk

12th IASSID World Congress, Montpellier, France, June 14th- 19th, 2004.

“Towards mutual understanding: person, environment, community”.
www.iassid.org

Royal College of Psychiatrists, Annual Meeting, Harrogate International Centre. 6th – 9th July 2004.

www.rcpsych.ac.uk/conferences/index.htm

assessing competences more and more. I feel that we need to look at what a consultant psychiatrist needs to do in modern practice, work back from there, and then change the design of the syllabus, and assessment process accordingly. I think that the standard of entry into psychiatry needs to be raised in order to attract good candidates for training. Psychiatry needs to become a first choice of career for more medical graduates than before. Once a trainee starts in psychiatry, they need to be nurtured, and encouraged. I think the process of training from SHO to SpR to consultant needs to be a more streamlined process, each training experience building on the one before.

PD: How do you hope to achieve all of this?

DB: With difficulty! In solving most problems, you have to look at alternative solutions, seek wide opinion, reach a consensus, and move forward. Therefore, I have been successful in getting agreement from E and F (Executive and Finance committee of the College) to recruit a researcher to work with me. We need to look at different training and assessment practices in other countries, and also examine the impact of globalisation on this work. I hope to produce a document for consultation, as soon as the research is carried out.

PD: What is your view on the proposed changes for SHO training?

DB: Overall, I welcome the thrust of the changes. I believe that the College must be involved in the proposed common medical exam at the end of SHO year 2. Postgraduate medical education has to benefit from the Royal Colleges co-operating like this with training.

PD: To date, have you had any direct involvement with the Faculty of the Psychiatry of Learning Disability?

DB: Of course my first contact with the psychiatry of learning disability was while I was working as an SHO in Leicester. There I enjoyed a 3-month placement working in one of the learning disability hospitals. More recently, one of my first tasks as Dean was to attend an Executive Committee Meeting of your Faculty, where I made some new friends. I'm looking forward to working closer with the Faculty, and I will also be seeking your views on all of the changes that will inevitably be taking place in training.

From the Editorial Board:

Articles and correspondence are more than welcomed! We would greatly appreciate feedback on the newsletter contents and format.

Contributions should be submitted in a recognisable Windows format by email or on a 3.5" disk. The editors reserve the right to edit contributions as deemed necessary. Please limit contributions to a maximum of 700 words unless agreed beforehand. Letters should not exceed 200 words. Opinions expressed in the newsletter are those of the authors and not of the College, unless expressly stated. Each article remains the copyright of its author but the College reserves the right to reproduce the article on the faculty website pages.

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