

Learning Disability Psychiatry

Newsletter of the Faculty of the Psychiatry of Learning Disability

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View from the Chair

Highs and lows of 2007

Sabyasachi Bhaumik



The past year has seen significant achievements for our Faculty, along with some difficulties. The position of the Faculty of the Psychiatry of Learning Disability within the College and also in the outside world has been strengthened through several initiatives. These include close working relationships with other faculties and division chairs. It is particularly worthwhile to mention the interface work between the Old Age Faculty and our Faculty, leading to the organisation of joint training events, production of an occasional paper and establishment of a joint working group with the British Psychological Society (BPS) and other stakeholders in the development of a Down's syndrome dementia guideline.

Dr Pru Allington-Smith and Dr Tom Berney have both been actively involved with the Child and Adolescent Executive and are contributing to keeping the agenda of child learning disability in focus. Dr Shaun Gravestock is working closely with the General and Community Psychiatry Faculty on social inclusion issues, and, through the College Education and Training Centre, we have organised conferences on commissioning in learning disabilities and Asperger syndrome, to name but a few.

Another key initiative is establishing quality standards for in-patient settings, which has been approved by the Education and Training Standards Committee of the College. This programme has been supported by the College Research and Training Unit (CRTU), and Professor Paul Lelliott is also advising us on our 'Payment by results'/'New ways of working' project.

Nationally, regular meetings have been established with the Royal College of General Practitioners (RCGP) on health

standards for people with learning disabilities. Dr Glyn Jones and Dr Roger Banks are working closely with Dr Jill Rasmussen from the RCGP in this area.

The joint guidelines with the BPS on managing challenging behaviours has now been published as a College report (CR144 – *Challenging Behaviour: A Unified Approach*), and joint meetings have been organised between the College President, Faculty Chair, Healthcare Commission, Commission for Social Care Inspection, Valuing People team and the Head of the CRTU. Our close working relationship with MENCAP continues on many fronts, and it is worthwhile mentioning that the Faculty is heartened by Professor Hollins's appointment as a member of the investigating team of the Department of Health (DH) on health inequalities in the wake of the publication of *Death by Indifference*.

Other significant achievements include the issuing of guidance on copying

clinical letters to patients, obtaining user and carer views on Faculty initiatives and the Faculty-based research initiatives on health inequalities. The position of the Faculty in the College has been further strengthened through the appointments of Dr Roger Banks as Vice-President (with a remit for developing the College's role in primary care) and Dr Helen Miller as the College Conference Director. Our sincere congratulations to both of them.

There have been, however, difficulties on many fronts, including issues related to Mental Health Act reform, the Medical Training Application Service/Postgraduate Medical Education and Training Board and recruitment in learning disabilities, the Sutton and Merton enquiries and general lack of resources in the trusts as well as in funded research.

We are particularly mindful of the ever-changing scenario in healthcare provision and would like to hear about both successes and pressures faced by clinicians nationally. A perfect opportunity for this will be at our Faculty residential conference in Belfast on 4 and 5 October. Please come along.

We have now decided the strategy for the Faculty for the coming years, which is in line with the College strategy. It includes developing professional standards for future psychiatrists in learning disability, establishing quality standards for in-patient care (as mentioned earlier), and developing information systems for users/carers.

So long for this time. See you at Belfast. ■

Letter from the editor

Angela Hassiotis

Dear colleagues

The new issue of the newsletter contains many interesting articles. First, Sab Bhaumik, Chair, gives an update on our Faculty and its strategic targets for the coming year. Professor Ann Gath offers her reflection on the birth and impact of the Penrose Club until its eventual winding down in October 2006. The club had as one of its aims to help trainees to develop their research skills, and in this issue we include an article by trainees presented originally as a poster, in addition

to an update on training matters and academic endeavour by specialist registrars. Professor Cooper and her colleagues provide a preview of a survey of Australian and British specialists in learning disabilities; Professor Dinesh Bhugra has contributed an article on the role of the psychiatrist drawing parallels with learning disabilities. Bunny Forsyth has written about the interface between private and state sectors and Neil McFarlane has something to say about forensic psychiatry. And I am pleased to include a short piece by service users who are training our doctors talking about their experience in their own words. Lastly, there was some confusion about the membership of the editorial group in the last issue; they are Asit Biswas, Helen Miller and Bala Raju. And thanks to Roger Banks for his continuing support. ■

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

The Penrose Club

Ann Gath, First President

The Penrose Club was born out of a discussion between Bill Fraser, John Corbett and me as we strolled down a long corridor in the Birmingham hotel where the Royal College of Psychiatrists was holding the Spring Meeting in 1993. We were aware that the Learning Disability Section was expanding and that, although we had some senior members whose work was published in international journals, our younger colleagues felt that they required more opportunity and leadership to develop academic skills, particularly in research. There was a parallel organisation in child psychiatry, a research club to which the three of us already belonged. We discussed whether we should have a similar group open to specialists in the psychiatry of learning disability and senior trainees.

These preliminary ideas were discussed informally within departments and at our section meetings. The idea of a club was acceptable but would need to cover projects involving the full range of subjects. Potential members all strongly believed that informality and an emphasis on providing an introduction to research for new recruits, for example, senior registrars, need not jeopardise the quality of what was presented. The younger colleagues required motivation, inspiration, training and support. There was no one-way traffic of ideas and members with a wide range of experience found much to learn and be interested in. By this stage some structure became necessary. We were lucky to have Jane McCarthy, already deep in research, as our first secretary.

Next came the search for a name for the fledgling club. The decision was made to call the club after someone who had published important work, was an example to younger researchers and perhaps more importantly whose work was of definite benefit to those for whom we were responsible. There was no argument; we were all in agreement. The one man who fitted the bill was Lionel Penrose.

Lionel Penrose was a geneticist as well as a psychiatrist, being one of the very few to be Fellows of the Royal Society as well as the Royal College of Psychiatrists. His book *A Clinical and Genetic Study of 1280 Cases of Mental Defect* (the

Colchester Study) was published in 1938 and reprinted in 1975 after his death. I met some of the participants at Turner Village in Colchester a few years after Penrose's death. They all remembered him with affection. To them the interviews were not perceived as such but were remembered as talks between friends.

I had found from my own experience of meeting Penrose in Oxford in the early '70s that he had a gift for hunting out new and inexperienced research workers. I was working on my first project on families of newborn children with Down's syndrome. On that occasion there seemed to be many people with an impressive track record of research, eager to meet him and perhaps to impress him. Yet he chose to discuss my work, which might have been of interest to him as he had published an authoritative book on Down's syndrome with G. F. Smith.

Many of us liked our research endeavours to be spiced with some humour, even fun. An early meeting encompassed a visit to Penrose's old home, Thorington Hall, perched on the scarp overlooking the Stour Valley in Suffolk. We were welcomed by Nicholas Wollaston, who was the life tenant, caring for the house for the National Trust. What was written on the walls of the house provided clear evidence that it had seen plenty of fun, of which we heard more when Roger Penrose came to talk to us. I particularly like the description of 'mental chess' – no board and no chessmen; it was played in a field with long grass so the youngest member of the family could not be seen as he ran from one player to another with news of the latest move.

In the following years, we heard talks from senior colleagues from far afield as well as many interesting contributions from people with plans of future work, problems of methodology or surprising and interesting results. However, gradually, other groups began to take up the time of our members. The faculties in the College were more active and the Multi-disciplinary Forum at the Royal Society of Medicine was thriving. Perhaps it can be said that the Penrose Club has made some contribution to the success of the others. So, gradually, and a bit sadly, it has been concluded that the Penrose Club has served its purpose. We hope that the enthusiasm will continue and research papers will continue to appear, both to teach the practitioners and to improve the lives of our friends with learning disability. ■

Bristol Trainee Support Group

Jon Nash and Jayne Kerridge

In 2005 a paper was published, written by previous trainees, about their experiences as senior house officers (SHOs) in learning disability in Bristol (Graham *et al*, 2004). They identified certain feelings that they associated with their work at the time, which included those of isolation and helplessness. They had also struggled with their negative feelings towards service users. As a result of this the authors had identified a need for a support structure for trainees, where they could talk through these complex feelings, to run parallel to sessions with a consultant supervisor. A Balint-style group had been established by a previous specialist registrar (SpR) (Cooke & Harvogan, 2005), but had ended when that trainee moved on to a consultant job.

A fellow trainee, Dr Jon Nash, and I conceived of the idea for the Trainee Support Group following discussions with Dr Andrew Clarke, who supervised us both during our psychotherapy training. We chose, both pragmatically and out of a feeling that there would be psychological benefits of the approach, an egalitarian model, in which members of the group would support one another. Soon after, it became clear that issues affecting junior trainees were common among SpRs too, and so the group was extended to include them. There were 10 trainees in total who would potentially be present at any group, which seemed sufficient that, even with absences, the group was large enough to run comfortably.

We meet twice a month, needing to balance other time commitments, so that trainees are not left holding important problems. One trainee, although not leading the group, acts as 'housekeeper', reminding trainees of dates and times and making sure the group does not stray from its remit. Group members are asked to take any training issues to the Educational Supervisor or Programme Director, and it

focuses largely on interactions with service users, carers and the systems that surround them. Discussions are confidential within the group.

Themes that have been covered in groups have included dying, identification with our patients, the role of the learning disabilities psychiatrist in the broader team, the issue of boundaries, the nature of autonomy and advocacy for vulnerable people.

Benefits for me have included fostering a sense of common purpose and values. I have found it incredibly valuable to have the space to think in more depth and to look from different perspectives at issues that have troubled me. I have felt that in respect of our work and the feelings that come out of it, not one of us has had any great knowledge above anybody else, regardless of seniority.

There have been drawbacks to the support group that we identified in a recent evaluation (www.aldern.nhs.uk), particularly that of time commitment. On balance, however, feedback has been positive and the role of the group seems for most people to helpfully complement clinical supervision.

We can recommend the Trainee Support Group model to any training scheme as offering a unique chance for reflecting on our work in an emotionally supportive environment. ■

Email: Jayne.Kerridge@nhs.net; Jon.Nash@nhs.net

References

- Graham, S., Herbert, R., Price, S., et al (2004) Attitudes and emotions of trainees in learning disability psychiatry. *Psychiatric Bulletin*, **28**, 254–256.
- Cooke, L. B. & Hargovan, H. (2005) Development of psychotherapeutic training in learning disability. *Psychiatric Bulletin*, **29**, 111–113.

Specialist Registrars' Column

Suchithra Thirulokachandran

Chair, Specialist Registrars in the Psychiatry of Learning Disability

From the trainees' perspective, it has been a period of mixed emotions.

We are looking forward to this year's SpRs Annual Residential Meeting to be held on 8 and 9 November at the Village Hotel Coventry, West Midlands. The Conference Organisation Committee formed by the West Midlands Region SpRs have taken on a real challenge, given the standards set by the previous conference held in Edinburgh.

I have been reliably informed that the conference is open to consultants, other trainee psychiatrists and medical students as well as SpRs. The theme will be a pick-and-mix of topics, with leading experts presenting on research or clinical topics, and the conference will qualify for four hours of external continuing professional development (CPD) per day. I am confident that the Brummies will live up to their wild reputation by providing a fitting entertainment programme for the conference. Delegates can contact the SpR Conference Committee on 07756957658 or email a.isaac@nhs.net.

On other issues faced by trainees, the scenario is rather sobering. This has been a turbulent year for medical trainees of all grades and in all specialties, including psychiatry. The number of ST4 training posts in the psychiatry of learning disability was 15 for the 2007 intake. While there are no

comparators with regard to annual intakes in previous years, this is less than one-third of the current existing national training numbers, indicating that possibly there will be an overall reduction in specialist training opportunities in this field. Over time, this will have implications on the available workforce, as there has been a longstanding deficit of appropriately trained clinicians in this specialty.

While the increase in training posts in psychiatry as a whole is welcome, the reduction in specialist training posts may well reduce the opportunity for doctors to experience working in subspecialties and further reduce the number of doctors who would wish to enter the field of learning disability. The indirect effects of these changes on current SpRs have been variable over the country. In a few areas, current SpRs have been requested by their employing trusts to 'be available' for clinical duties that have been traditionally provided by SHOs. This is envisaged to be a particular issue for a brief period until the new trainees are appointed and settle into their duties.

While the experience of the changes in training structure have been challenging for a lot of people in a variety of ways, it is important for all the members of the Royal College to remain engaged in the process and inform individual faculties of any problems that arise so that they can be resolved before the next round of recruitment.

I have kept trainees abreast with the proceedings of the Faculty Executive meetings by way of emails and an internet group. This group is open to all, including consultants and trainees at all levels of training, and has provided a quick and informal forum to access information and support from colleagues. Anyone wanting further information on this is welcome to email me at suchithra_t@yahoo.com. ■

The views of psychiatrists in the UK and Australia

Sally-Ann Cooper, Gregory O'Brien, Gillian Jess, Jennifer Torr, Nicholas Lennox, Nicole Edwards and Jennifer Glea

Some of you may remember completing a questionnaire about your views on the role of learning disability psychiatrists and the provision of psychiatric services and supports for people with learning disabilities. Thank you for taking the time to do so. The same questionnaire was also completed by psychiatrists in Victoria, Australia. We thought it would be interesting to compare results between the two countries, because of the many similarities between the UK and Australia, but the different model of psychiatric provision – a specialist model in the UK, and a generic mental health model in Victoria.

We found that the specialist model of training and service provision (the UK model) results in psychiatrists and psychiatric trainees who hold positive views about the services they work within and between and who are flexible in their approach to service delivery, in the range of mental health needs and population needs they address and the range of treatment approaches they endorse. They are knowledgeable, experienced and consider themselves to be well-trained, competent and confident in their work. They want to work with people with intellectual disabilities.

The generic model of training and service provision (the Australian model) results in psychiatrists and psychiatric trainees who believe that a different model (that is, a specialist model) of services should be provided and are more restrictive (compared with the UK psychiatrists) in their approach to service delivery, the range of mental health needs they address and the treatment approaches they endorse. They believe themselves to be unskilled, undertrained and unconfident when working with people with intellectual disabilities. They lack experience in such work and continue to be underexposed to such work.

Addressing these issues is a challenge, as the lack of specialist intellectual disabilities services and psychiatrists with specialist skills in this area results in difficulties for trainees in accessing training opportunities in Australia. Australian psychiatrists as a group were ambivalent regarding working with adults with intellectual disabilities.

The full results of the study are forthcoming later in 2007 in the *Journal of Applied Research in Intellectual Disabilities*. ■

The demedicalisation of psychiatry: lessons for the psychiatry of learning disability

Dinesh Bhugra, Dean,
Royal College of Psychiatrists

To define the term deprofessionalisation in medicine can be difficult, whereas the meaning of demedicalisation is probably clear. By virtue of their training and their calling, many of those practising medicine followed a vocation for a large number of people. Doctors aspire to altruism, excellence, duty, service, honesty to others, integrity and accountability. Self-regulation is an important aspect of any profession. Lifelong learning and shared knowledge form an integral part of a professional's portfolio. Medical professionalism signifies a key set of values, behaviours and relationships with which the trust of the public in doctors is built and maintained. Commitment to values of compassion, integrity and continuing improvement of the self and delivery of services becomes an integral part of a medical professional's life.

There is no doubt that the public, our patients and their carers expect and value professionalism. This moral contract between the doctor and the patient is the crux of the doctor-patient interaction and therapeutic endeavour. For psychiatrists, the responsibilities are even greater as we are not only doctors by training and by basic qualifications, but our interests in psychological, social and, recently, cultural models of diagnosis and management often set us apart from our medical colleagues. The danger sometimes is that we shift away from our medical responsibilities and are in serious danger of giving away our professionalism, being dictated to by dark mysterious figures in the corridors of power.

The specialty of psychiatry of learning disability can provide a lead into regaining professionalism. With the existence of comorbidity of physical and psychiatric disorders and social stigma towards patients with learning disabilities, practical solutions can emerge. Patients may sometimes be silent participants in therapeutic endeavour but their carers certainly are not. Engagement with carers and other non-statutory stakeholders can lead to a genuine partnership – a kind of third way, where patients' and carers' expectations can be channelled into partnerships to demand and receive resources that enable and empower patients. Patients and their carers must be part of the endeavours in redefining medical professionalism, with a clear emphasis on the sense of vocation that first attracted doctors to the profession. Social changes and social expectations need to be harnessed. A supportive and equal partnership between patients and carers on the one side and doctors on the other can lead to better care locally and policy changes at the national level.

The many external factors that are threatening the profession include central controls in turning doctors into technicians. As a profession we must form strong alliances with other medical specialties and disciplines but with a very clear acknowledgement of our differences. Public trust can be regained by celebrating good practice and by protecting patients from bad practice and poor clinicians. Decisive action is the only way forward. The Modernising Medical Careers and MTAS fiasco teach us this.

We need to get together to reclaim the lost ground and define what we mean by professionalism and reach agreement with our allies and key stakeholders. These are exciting times for change but sustained change can only come if we want it and grab the opportunity. As a profession we must identify our flag and tie our colours to the mast.

In the end, all of us expect to be treated by good doctors – so let us ensure that we produce them. ■

Implementation of mental capacity legislation

Ian Hall, Royal College of Psychiatrists
Parliamentary Liaison Lead and Finance
Officer, Faculty of Psychiatry of Learning
Disability

Judging by experiences in Scotland following the introduction of the Adults with Incapacity Act 2000, the implementation of the Mental Capacity Act 2005 in England and Wales from October 2007 is likely to have considerable implications for professionals, service users and carers. Some of the issues are listed below.

- The most crucial first step is training. This, of course, will mean changes to the psychiatric curriculum, but medical undergraduate training is perhaps equally important as the issue affects all doctors directly treating patients. Capacity issues also affect all health and social care professionals, both within specialist learning disability settings and in the wider health and social care economy.
- There are likely to be significant implications for clinical workload and priorities. The Mental Capacity Act code of practice is clear that psychiatrists and psychologists are experts in assessing capacity, but that other team members should also have or acquire skills in this area, reserving the psychologists and psychiatrists for assessment of

controversial or complex cases. I think we will have a clear role in the dissemination of good practice, and enhancing the skills of other team members.

- Advance decisions for people who may lose capacity in the future would at first glance seem most relevant to old age psychiatry: however, we know many clients whose cognitive function deteriorates either as part of a dementing process, or acutely when physically unwell. We need to think about new ways to support people with learning disability who have capacity to make advance decisions.
- Perhaps the most challenging may be the deprivation of liberty provisions for people who lack capacity but do not object (previously known as 'Bournewood'). It remains to be seen how the procedures now passed into statute will work out on the ground – how cumbersome will they be, how many people will be judged to be affected.

Faculty members are likely to have a lead role locally in all these areas including the development of local policies and procedures. They may also be concerned with difficult prioritisation and resource allocation decisions – what if there are insufficient funds to act in someone's best interests? The Faculty is planning to survey the membership in 2008 to assess the Mental Capacity Act implementation, but if you have ideas to include in the survey, wisdom from a Scottish perspective, or other comments, please contact me: ian.hall@thpct.nhs.uk. ■

Better practice in the independent sector

Bunny Forsyth

The independent sector has become increasingly important in managing many of the more complex and challenging service users in our field of practice. Many differing providers offer varying models of clinical care. Clinical governance processes, outcome measures and quality of care provided can lead to a robust practice, but also at times their implementation may be patchy. The extent to which providers liaise with NHS colleagues and services also varies.

As we all strive for better clinical practice, examples of excellence in the independent sector could positively influence other independent providers as well as public sector practices. In other fields (for example, industry and education), private and public partnerships are encouraged by government policy.

At the most recent Faculty meeting in April 2007, Dr Angela Hassiotis (Senior Lecturer in the Psychiatry of Learning Disabilities at the Royal Free & University College London Medical School) and the author hosted a well-attended and lively workshop to discuss these issues.

Positives

Many positives emerged, reflecting areas of strength in the independent sector. The ability to access significant funding for infrastructure development within closed tertiary systems outside the public-sector monolith has allowed greater flexibility of response over time, to meet increasing demand.

The fact that the independent sector is also more highly regulated and open to greater scrutiny than the NHS arguably gives greater patient protection. The need for scrutiny has been particularly poignant given the major challenges associated with difficulties exposed in Cornwall and Sutton & Merton NHS Trusts recently.

Challenges

Concern was raised, however, about the potential for profiteering. Although increasing competition should reduce this likelihood, it is clearly an area of ethical importance. It was important to counterpoint private-sector fees against the cost of care for similar individuals in NHS (non-secure)

acute beds. Department of Health (2001/2002) data show these average approximately £2,300 per patient per week (£120,000 per annum), reaching as high as £9,177 (£477,000 per annum) across trusts and PCTs in England.

There can be wide variability of care standards and quality in the independent sector. There is a perception that sharp practices may prevail in some services, with them holding onto patients for too long or stalling move-on.

From the other side, it has been notable that often patients are placed out of area with little or no monitoring or interest from referrers with little knowledge of the individual.

For clinicians, there has been the danger of professional isolation and lack of potential for providing training expertise. As partnerships across the sectors increase and independent services grow this is lessening.

Ways forward

Suggestions were made around the idea of external benchmarking of practice across both sectors. This would be welcomed by all high-quality services, help to improve lower-quality services, and potentially be a valuable commissioning aid.

The promotion of high-quality sharing of best practice ideas and forums by clinicians on both sides was felt to be vital: 'Proper systems are needed to develop, manage, and monitor co-operation between public and private sectors' (Poole *et al*, 2002).

As a starting point, the session itself perhaps illustrated this process well. ■

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References

- Department of Health (2001/2002) *Annual Financial Returns of Primary Care Trusts and NHS Trusts: TFR2C – Maincode:059 Cost Per Patient Day [058/056]*. UK Department of Health.
- Poole, R., Ryan, T., Pearsall, A., *et al* (2002) The NHS, the private sector, and the virtual asylum. *British Medical Journal*, 325, 349–350.

Conference Report

Royal College of Psychiatrists Forensic Faculty Annual Residential Conference, Prague, 7–9 February 2007

Neil McFarlane

Having found myself ranting against the takeover of psychiatry by the forensic subspecialty, following the workshop on personality disorders at the October 2006 annual residential meeting of the Faculty of Learning Disability Psychiatry, and having become a forensic psychiatrist myself in a small way, with a new eight-bed continuing care unit in my own area, I thought it a good idea to attend, for the first time, a forensic faculty conference.

Returning to Prague, and inevitably comparing the two faculty conferences, I was struck by two related sets of observations. The first concerned the sheer scale of the forensic event: with over 400 forensic delegates the venue (a five-star hotel) had to be commensurably larger, while the conference itself lasted three days rather than our two; on the last day there were eight parallel workshops, which repeated, so that there were sixteen in all. Second, there was no doubting the underlying confident mood of contemporary forensic psychiatry among both presenters and ordinary attendees: the only minor anxieties about the future I detected concerned the timing of one's moves from public to private sector or vice versa.

Given the theme of 'Forensic psychiatry in 2020', there was an emphasis on psychopathy and offending behaviour somewhat to the detriment of psychosis and affective disorders. Without wanting to read too much into the choice of presentations, I wonder whether this reflects a feeling that the link between offending (especially homicide) and schizophrenia has now been comfortably established and can be given less of a priority. I was certainly expecting an openness to growth areas such as autistic-spectrum disorders, so I was rather surprised at the lack of even a single passing reference to the relationship with psychopathy, in two hour-long presentations by Professors Sheilagh Hodgins and James Ogloff, both of whom explored aspects of Hare's construct in some detail. To an extent this was rectified by the workshop on 'Psychopathy in young people', in which Dr Peter Misch suggested that one-third of the referrals to his adolescent forensic psychiatry service were 'on the spectrum', but this was not repeated, so only about 15 of us were present to discuss this issue. Note also that of the 164 references that Dr Misch provided in a handout, only a handful appeared to explore the relationship between

psychopathy and attention-deficit hyperactivity disorder, and none referred to autistic-spectrum disorders.

It also appears that forensic psychiatry in 2020 is not going to be very concerned with learning disability, as none of the main presentations or workshops substantially addressed this (to be scrupulously accurate, three of 43 posters did, while another poster by Dr Juli Crocombe, Richard Mills and Dr Lorna Wing reported a survey of autistic-spectrum disorders in female patients in Broadmoor). One would not have to be an extreme inclusivist to suggest that this was a substantial omission in an event of this size and scope, which included four major contributors from the USA and Australia, and which was attended by more than a few forensic learning disability psychiatrists.

It would be wrong to give the impression that our forensic colleagues as a group entirely lack self-criticism, and after all one could argue that they are fully entitled to stress the various links between mental disorder and offending, even suggest that certain forms of offending are mental disorders in themselves. Two examples of what could be described as dissent from the current position of forensic dominance came from Professor Tom Fahy and Dr Adrian Grounds. Professor Fahy proposed that forensic psychiatry should aim to abolish itself and suggested that it was awash with poorly spent resources (for example, one-quarter of a million pounds being spent annually on some dangerous people with personality disorder), while adult mental health services were being cut-back despite managing patients with greater immediate risk. The resource argument was also made by Dr Grounds, in the course of a well-received satirical account of the development of the specialty in the UK and Ireland ('The end of faith: how forensic psychiatry lost its soul'), in which he deplored the shift that psychiatry has made towards risk reduction as an end in itself.

So after three days I returned from Prague (again), no longer ranting against, although still not entirely accepting of, the forensic psychiatry takeover. Can anything be done? I think so, but one has to be more realistic about the shift back towards a strong link between mental disorder and violence, which may after all be the historical norm (so that the perception of a weaker link, which prevailed in the 1970s and 1980s, becomes an anomaly). Readers of the newsletter may or may not find it a comforting thought that, at the current rate of growth, by 2020 we could all be forensic psychiatrists anyway. ■

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Teaching and training in the psychiatry of learning disability: service users' perspectives

Asit Biswas

Miss S.K. and Mr D.C. have participated in the teaching programme in the psychiatry of learning disability, as part of the Leicester–Warwick medical school training programme in psychiatry, providing input on a number of occasions much appreciated and valued by medical students.

Both consented and happily provided their views as trainers who are also service users for this publication. It was planned as an open-ended feedback. None the less, both chose to provide written answers in their own words, to one or more of the four questions provided as a guide.

Q1: How did it feel being part of the teaching programme?

DC: It felt good. I've done it before and was comfortable doing it. I like doing anything like that.

Q2: How do you think your contribution helped with the teaching?

DC: It showed we can do it. It's better coming from us because we're in it.

SK: When talking to the patient he or she must speak slowly and clearly. She or he should understand what is going on. Students should answer any questions that the patient may have. Students must take time to speak with the patient, not to rush or make the patient feel unimportant.

Q3: Do you think the teaching could have been improved in any way?

DC: We should have had more time to plan it.

SK: Students must introduce himself/herself to the patient.

Q4: What do you think the students were expecting from your participation in the teaching?

DC: I think I did well, but didn't know what they were expecting. ■

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Announcement The Seattle Club Conference

The 2007 Seattle Club Conference on Research in Intellectual Disabilities will take place at the University of Glasgow on 10 and 11 December. The Seattle Club is an annual meeting for researchers in the field of intellectual and developmental disabilities in the UK and Ireland. The idea of a UK/Ireland conference for researchers crystallised at the International Association for the Scientific Study of Intellectual Disability World Congress in Seattle, USA, in August 2000. Much of the UK/Irish research community in the field attended this congress, and it was noted that there was no regular data-focused conference for researchers available in the UK and Ireland.

The Seattle Club conferences are open to any researcher based in the UK or Ireland who has new data relevant to the study of intellectual and developmental disabilities. Delegates carrying out research from behavioural and social sciences perspectives are welcomed, and delegates' backgrounds have included psychology, psychiatry, sociology, special education, professions allied to medicine, and those with broad social sciences training. Further details of the Seattle Club and this year's conference are available at www.seattleclub.org.uk

Key deadlines

Online submission of abstracts: 26 October 2007

Applications for the 2007 Seattle Club Studentships: 26 October 2007

Registration: 16 November 2007



College Education and Training Centre conferences

The commissioning of learning disabilities

29 November 2007, Birmingham

This national conference is focused on improving the standard of commissioning of learning disability services and will gather expert views on the commissioning framework.

Keynote: Dr Rob Greig, National Director, Learning Disabilities, Care Services Improvement Partnership (CSIP).

Speakers include among others: Dr Sabyasachi Bhaumik, Chair of the Royal College of Psychiatrists Faculty of the Psychiatry of Learning Disability; Ms Liz Neil, Director of Mencap Cymru; and Mr Nigel Walker, National Lead – Commissioning, Care Services Improvement Partnership (CSIP).

For full details, visit www.rcpsych.ac.uk/cetc or contact sedinboro@cru.rcpsych.ac.uk

Asperger syndrome in adults

Tuesday 4 December 2007, Birmingham

This one-day conference will provide an overview of the issues around diagnosis and management of Asperger syndrome. It will also provide you with an opportunity to work in small group sessions to discuss awareness and recognition and look at how to obtain help, advice and support when we come into contact with service users and carers with this particular autistic-spectrum disorder.

Speakers include among others: Dr Terry Brugha, Consultant Psychiatrist and Professor of Psychiatry, University of Leicester; Mr Richard Mills, Director of Research, The National Autistic Society; and Professor Digby Tantam, Clinical Professor of Psychotherapy and Co-Director of the Centre for the Study of Conflict and Reconciliation, University of Sheffield.

Learning disabilities and older people

28 February 2008, Leeds

Details will appear shortly at www.rcpsych.ac.uk/cetc



REMINDER

IASSID World Congress 2008

The International Association for the Scientific Study of Intellectual Disabilities (IASSID) will be holding its 13th World Congress

**Cape Town, South Africa
25–30 August 2008**

Over 1500 delegates are expected, including experts in all aspects of intellectual disabilities, including early childhood, health & social care services, families, epidemiology, aetiology, inclusion, ageing, physical & mental health, education, employment, parenting, quality of life, end-of-life, empowerment, basic research, forensic issues, communication and social policy. For information about all the wonderful sights around Cape Town go to the tourist office website at www.tourismcapetown.co.za

The World Congress venue is CTICC, the Cape Town International Conference Centre, a beautiful modern conference centre. In order to see the venue go to www.cticc.co.za for a virtual tour.

The conference management will be conducted by the University of Cape Town conference management centre. The conference management centre website is at www.uct-cmc.co.za. The Local Organising Committee includes four distinguished South African members of IASSID: John Cruickshank, Jennifer Cartwright, Jennifer Kromberg and Chris Molteno.

Abstracts may now be submitted until end of December 2007. For further details, updates and draft programme, visit www.iassid.org.

