



Psychiatry of Intellectual Disability

Newsletter of the Faculty of Psychiatry of Intellectual Disability

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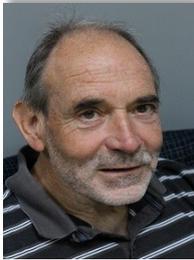
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Change



Editorial Group



Tom Berney



Ken Courtenay



Elizabeth O'Rourke



Giri Madhavan

Change

This month, the team has changed being joined by two trainees, Giri Madhavan and Elizabeth O'Rourke, and the Faculty's Vice-chair, Ken Courtenay, while Naomi Mehta is standing down.



As well as bringing a new look to the Newsletter, Giri has arranged for a printed copy to go out to our membership by post. While a printed Newsletter will have a limited word-count, it will have links back to the electronic copy which will allow more space and detail as well as the opportunity to explore and comment on the subject.

For example, in this issue, further vignettes from the community forensic workshop can be accessed directly from the article for those who are interested. You may notice also that relevant hyperlinks are interspersed throughout the electronic version.

Those with the paper copy can simply scan the QR code in the top right corner of the page using a QR reader app on their smartphone and will be taken directly to the relevant page to explore more and/or comment online.

Submitting articles This is the Faculty members' newsletter and we encourage anyone to submit articles. The shorter the article and the more straightforward its language and style, the more likely it is to be read. We welcome thought-provoking and controversial material which might get a constructive response from readers.

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

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Dr Ashok Roy

Chair of ID Faculty

Consultant in ID Psychiatry,

*Coventry and Warwickshire NHS
Trust*



It was lovely seeing so many of you in Dublin and in other meetings since I wrote to you last. Sujeet's hard work along with the support of Evan Yacoub, my counterpart in Ireland, helped make our joint conference a huge success. We even had two sunny days!

We have now published two College Reports on Epilepsy (CR 203 and CR 206) under Rohit Shankar's stewardship. CR 203 outlines the roles and competencies we need to manage epilepsy and CR206 gives advice on the usage of antiepileptic drugs

Ken Courtenay has been busy in his role as STOMP lead for the Faculty and has just completed a survey whose results he will be sharing with the Faculty shortly. We remain committed to reducing overmedication in our population as we improve adherence to NICE standards and the standards set out in our own Faculty report *Psychotropic drug prescribing for people with intellectual disability, mental health problems and/or behaviours that challenge: practice guidelines* (FR09).

It is heartening to see numerous examples of audits being carried out using these standards. An area where we could improve is in the structured recording of clinical outcomes and in the structured assessment of side effects. We discussed this at our Exec recently and agreed to recommend the use of HoNOS-LD and the Clinical Global Impression. The CGI can be accessed through the link below

<https://www.psywellness.com.sg/docs/CGI.pdf>

We are occasionally missing the diagnosis of ASD and ADHD in our patients. Can I make a plea that all new and existing patients are screened for both these conditions? This will help with more accurate diagnosis and management and better use of medication

We have John Russell as our new Chair of the Specialist Advisory Committee (PLDSAC) which marks the resurrection of an old term for those of you who can remember that far back. He informs us that over the next two years the ID Psychiatry curriculum will be rewritten to match with the GMC competencies. Recruitment to our specialty has fallen this year and we are looking at ways to continue to attract more applicants to our specialty. One key factor appears to be a positive experience of ID Psychiatry as a Core Trainee. So think about the experience your current trainees are having and look at ways of enhancing it. In this context Regi Alexander has worked closely with the Tizard Centre to make forecasts of consultant numbers. A report will be launched jointly with Health Education England on January 19th 2018 and is likely to make the case for a significant rise in consultant numbers to support the new model of services. Regi has also ensured that we maintain a healthy financial position and are able to support attendance at conferences.

Sherva Cooray confirms that ICD 11 is likely to be launched next year. It will include a revision of the section on ID (Disorders of Intellectual Development) as well as autism.

Our Spring Conference is taking place on April 20th at the College. I hope to see you there.

Ashok Roy

October 2017



Research Roundup

Rachel Steele

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



Rachel Steele continues the I-Spy Research Series with a look at parenting, friends and relationships together with a round-up of the latest Intellectual Disability research available.

Parenting, making friends and relationships

Romantic love is as important to people with learning disabilities as to the general population but how specifically do people with learning disabilities view romantic relationships? Bates et al. (2016a) sought to answer this question by interviewing 11 participants with learning disabilities. These participants confirmed that love was important to them, especially the companionship and support available from a loving partner, with the physical expression (especially kissing and cuddling) of love being appreciated by the participants. The interviewees indicated that love from a partner could alleviate negative experiences from suffering abuse.

However, while romantic love may be important to people with learning disabilities, how do they go about finding a partner? According to 11 people with learning disabilities, they typically found a partner within a segregated environment for people with intellectual disabilities, showing how poorly integrated those with learning disabilities are within mainstream society (Bates et al., 2016b). While these people expressed a desire for companionship and to be loved and be treated kindly, they placed less emphasis on the importance of financial support from a partner or the prospective partner's social status or intelligence (Bates et al., 2016b).

As with the general population, after choosing a partner, people with learning disabilities may then become parents. The *Journal of Applied Research in Intellectual Disabilities* ran a special issue on parenting and people with intellectual disabilities in May 2017. In a critical overview of research in this issue, McConnell et al. (2017) summarises that from the beginning of research into this area in the 1940s, research-

ers have observed tremendous variability in the parenting skills of mothers with (typically mild or borderline) intellectual disabilities with fathers being under-researched. The evidence does, however, suggest that parenting skills training is effective in people with intellectual disabilities (McConnell et al., 2017).

As well as romantic, and parenting, relationships, friendships are also important to people with intellectual disabilities in promoting social inclusion and decreasing loneliness (Fulford and Cobigo, 2016). In a thematic synthesis of 18 qualitative studies, three themes related to friendships were identified: (1) How do I know someone is my friend? (2) How do I know if someone is my girlfriend or boyfriend (3) What are the barriers, and facilitators, to friendship (Fulford and Cobigo, 2016). The latter category highlighted practical factors, such as living arrangements and transport, and emotional factors, such as the attitudes of family members and staff (Fulford and Cobigo, 2016).

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Research Roundup

I-Spy Round-Up

There is conflicting evidence regarding the effectiveness of psychological therapies with people with ID. Accordingly, McNair et al. (2017) undertook a systematic review to explore the effectiveness of DBT. DBT, and DBT skills groups, can be adapted to suit the needs of people with ID but further research is required before definitive conclusions can be drawn.

It is important to survey psychiatrists' practices on genetic testing given that a growing number of genetic causes of ID are identifiable by genetic testing. In a survey of CAMHS and ID UK psychiatrists, Wolfe et al. (2017) found that ID psychiatrists ordered more genetic tests and referred more patients to genetic services.

In a 20-year cohort study of people with Down syndrome, McCarron et al. (2017) reported that 75 of the 77 people in the sample developed dementia with 55 years being the mean age at diagnosis. This study confirmed earlier findings of the relationship between dementia and late-onset epilepsy.

To explore organisational barriers and facilitators to healthy lifestyles for people with ID, O'Leary et al. (2017) undertook qualitative research with residential services in Northern Ireland. They found that the organisations under study did not have the cultural ethos or resources to implement sustained staff involvement in health promotion.

In an examination of the effects of a 2-month Wii-based exercise programme on the physical fitness, functional mobility and motor proficiency of adults with Down syndrome, positive findings were reported in these broad domains with observed improvements in aerobic capacity and lower limb strength (Silva et al., 2017).

Young-Southward et al. (2017) used Scotland's 2011 census data to compare the health of those with, and those without, ID during transition to adulthood. The prevalence of physical, and mental, health issues was higher amongst the young people with ID. The authors concluded that transition is a time of health vulnerability for this group.

There is anecdotal evidence that people with ID are over-represented in prisons. Hellenbach et al. (2016) undertook a systematic review to explore this. International data suggests prisoners with ID make up between 7 and 10% of pris-

on populations. Most frequent comorbidities are hearing/vision impairments, obesity, diabetes and mental health conditions such as anxiety and personality and conduct disorders.

Little is known about what happens to people with ID when they are released from prison. As such, Murphy et al. (2017) contacted men with ID after leaving prisons in England. They reported that the men were receiving little support in the community and many had been re-interviewed by police.

In a qualitative study (interviewing health professionals), Blamires et al. (2017) sought to understand how deprivation of liberty safeguards (DOLS) are used for people with ID. The interviewees reported DOLS as being a framework facilitating positive outcomes for people with ID with some inpatient stays being prevented. However, concerns about DOLS were also raised.

While domestic violence has been researched in women in the general population, women with ID have received less research attention. McCarthy et al. (2017) reported that a sample of women with ID had experienced severe and frequent domestic violence, with negative impacts on physical, and mental, well-being. Women's awareness of refuges and available help was low.

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[Full references available online via this link.](#)



The Spring meeting

Nicola Phillips

*Consultant in Forensic Learning Disability Psychiatry
Northumberland, Tyne and Wear NHS Foundation Trust*

The bright lights of London were calling (or maybe just for those of us living in the north). It was time to meet with psychiatric and allied health profession colleagues for a day of learning, reflecting and information sharing.

After a warm welcome from Dr Ashok Roy, it was very sad to hear about the passing of Professor Bill Lindsay, Consultant Psychologist described by Dr Roy as an honorary member of the faculty.

Professor Baroness Sheila Hollins provided a brief overview of a **drafted ID bill** which she had compiled in an astonishingly short period of time following discussions just the previous evening. Watch this space for updates about this as a working group is due to be established to take this further. The day then got off to a resounding, hard hitting start with presentations outlining the points of view of a commissioner and a CMHT Psychiatrist about **Transforming Care**. This is clearly having a huge impact upon all of our services and shaping the way in which our work is changing over time. The morning continued with a presentation on the protection of the **Human Rights** of people with ID in our present, financially stretched climate, covering issues which may arise as a result as well as the possible repeal of the Human Rights Act.

There followed a host of morning workshops which covered a variety of topics ensuring that there was plenty to interest everyone.

One workshop was on the **Books Beyond Words**, conversations inviting change which was a narrative-based approach aimed at helping people to deal with difficult or challenging situations. Two cases were presented by participants of the group. It was an interesting and engaging process which acknowledged the complexity and dilemmas within the cases. There was also a workshop on the Choice and Partnership Approach to deliver transforming care.

The afternoon workshops focused on **substance use and misuse**, a comprehensive overview of the assessment and management of **ADHD**, and on **Community Learning Disability Forensic Skills**, a brainstorming session around forensic patients and transforming care. Transforming care presents obvious challenges within forensic services, where historically many patients have been managed on inpatient wards. Using case vignettes the attendees split up into groups to discuss the complex issues presented within the cases and considered what skills and recourses community teams would need in order to manage these patients robustly in the future.

There was also included was a workshop on **Child and Adolescent ID services** which gave an overview of a somewhat bleak picture of the situation at present but was inspiring due to the presenters planned future actions.

In the latter part of the afternoon, there were enlightening talks covering the management of **epilepsy** in people with an intellectual disability. This included the fact that standards have been developed and are outlined within *The management of epilepsy in adults with ID* (CR 203). There was a presentation about the management of **dementia** which covered the number of parallels which exist between Old Age Psychiatry and ID Psychiatry. The take home message being that there has been lots of research involving dementia medications but, while they all only provide a minor benefit, it can be disastrous if and when they are stopped, affecting the patient's condition, cognitive functioning and independence.

The final lecture of the day was delivered by Dr Ruth Bevan, Consultant Psychiatrist at the Northern Region **Gender Dysphoria** Service. This was a truly enlightening presentation which provided a small insight into the interesting work done by this service. Dr Bevan has previously written an article about Gender Dysphoria and Intellectual Disability for the January 2016 Newsletter which is well worth a read. [Click here.](#)

Throughout the day there were also a wide variety of posters available to be viewed. The meeting was brought to a close by Dr Roy and it only remains to be said that for those of you that did not attend, why not and hopefully you were able to attend the [Faculty Annual Residential Meeting on 5-6 October 2017](#) in Dublin.



The Annual Conference

Elizabeth O'Rourke



Higher trainee representative West Midlands Deanery

After an early start I arrived in Dublin on Wednesday morning in time to do a spot of sightseeing and take brunch with colleagues before a busy day spent attending the executive meeting and dinner.



A spot of sight-seeing with Dr Meera Roy and Dr Christine Joiner

On Thursday morning Dr Ashok Roy gave a warm welcome highlighting the enormous amount of knowledge to share with the 163 delegates at the impressive Raddison Blu Royal Hotel.

The day then began with a highly informative presentation from Dr John Hillery, President of the College of Psychiatrists of Ireland, who emphasised the importance of evidence based work. This was followed by Lord Keith Bradley who gave an inspiring presentation on new care models that are being implemented for offender treatment pathways. The overarching theme was the importance of early intervention in forensic care at the first point of contact. He also reminded us that people with Intellectual Disabilities are: 'often victims as well as perpetrators'. I found this particularly interesting as I am currently doing a rotation in forensic services, and have now been signposted to read the [Bradley report](#) 2009 which is a review of people with mental health problems or learning disabilities in the criminal justice system.

Professor Angela Hassiotis gave a talk on the evidence behind early intervention and presented the HTA funded EPICC-ID trial which has started at UCL division of Psychiatry. There was an informative presentation by Finian Mc Grath, minister for disabilities, Republic of Ireland which highlighted that personalised budgets may be one of the mechanisms to empower people with Intellectual Disabilities to live independent lives with tailored support.

There followed four morning workshops which covered a range of topics. I chose to attend a workshop on Epilepsy which was facilitated by Dr Rohit Shankar and Dr Lance Watkins. This was a really interactive session using case vignettes to illustrate the guidance available in the new college reports; [CR203](#) and [CR206](#). The take home message for me was that Aripiprazole is the antipsychotic that has the lowest propensity to lower seizure threshold.

After lunch there were presentations on the current research in autism which is being carried out by Professor Ann Le Couteur, and Professor Christine Ecker. This highlighted the value of specific training on joint attention and play skills. Dr Jean O'Hara gave an inspiring talk on the importance of clinical leadership in shaping culture and how to create an environment where everyone can achieve their best. After this there was a variety of workshops including a workshop on Intensive Support teams which proved so popular that the conversation continued well after the session had ended.



A moving performance on STOMP by Mixit Days.

The day was concluded by [Mixit days](#) an inclusive theatre company from County Durham who gave a moving performance on STOMP by bringing to life a patient's journey from an inpatient to the community. They were applauded with a standing ovation. Following this I attended the trainees' meeting. It was good to meet some new trainees and



The Annual Conference

find out how things were in training in different parts of the United Kingdom.

On Friday morning I participated in one of the six Alec Shapiro research presentations. Although it was a slightly nerve-wracking experience, I found it to be a great way of showcasing research and quality improvement work you are involved with. I would highly encourage all trainees to consider applying next year.

After the faculty business meeting there was an enthusiastic address from Paul Rees, Chief Executive Officer, on the future of the Royal College of Psychiatrists. This highlighted the recent popular recruitment campaign #Choose Psychiatry.

There was then a broad range of workshops covering ECT, capacity report writing, CAMHS-ID services and ADHD. Dr Tony Kearns provided the Jose Jancar lecture this year. After lunch there was a series of key note lectures covering the autism genome project, Ageing and Intellectual Disability and Anti-cholinergic Burden in Adults with Intellectual Disability. Professor Chris Oliver gave a fascinating presentation on his work on self-injurious behaviour illustrated by a series of photographs which emphasised that this is an incredibly challenging and distressing behaviour. An important message was that the clinical site of pain may not be the site of self-injurious behaviour for some individuals.

Throughout the two days there were 44 posters to be viewed covering a range of interesting topics.

The conference was brought to a close by Dr Ashok Roy who reflected on the two exciting days we had shared and the opportunity to improve our clinical practice with evidenced based work. Delegates applauded the presentation of faculty prizes to Dr Lindsey Mizen and Dr Sam Tromans. In summary, it was a truly inspiring conference. The next meeting is the Spring Conference on 20th April 2018 and I hope to see you there!



Sunshine in Dublin



Sam Tromans receiving Faculty prize



Community Forensic Learning Disability Skills Framework Workshop

Dr Gill Bell

*Consultant in Forensic Adolescent
Learning Disability Psychiatry*

Methodology

We carried out a workshop at the Faculty of Intellectual Disability Psychiatry 1 day meeting in London on 5th May 2017. The workshop was attended by over 30 Psychiatrists the majority of which were Consultants. Within the workshop group there were 2 Consultant Psychiatrists who worked in Forensic Services and the rest of the Psychiatrists worked in Community Services. There were some Higher Trainees and SAS doctors in the audience. A minority of the attendees worked in inpatient settings and the majority worked in the community. The workshop session was facilitated by 2 facilitators who were part of the Health Education England Expert Reference Group for the development of a Competency Framework around Community Forensic Learning Disability skills, Drs. Gill Bell and Ashok Roy. At the beginning of the workshop we introduced the two outputs that we wanted from the workshop. One was around consideration of the case vignettes and the other in relation to skills required to work with forensic learning disability service users in the community.

In relation the case vignettes, for the purpose of the workshop we used three case vignettes (Appendix A); one supplied by a Speech and Language Therapist, one by an Adult Inpatient Forensic Psychiatrist and one of the original ones that we had submitted to Health Education England. All case vignettes had mild learning disability and forensic mental health needs. In relation to feedback about the use of case vignettes as a tool to think about skills required to support people in the community the overall majority felt that case vignettes were a useful way forward. All the Psychiatrists recognised that patients with mild learning disability were the population that they would consider to have forensic mental health needs and the ones that they identify as having most concern about supporting and managing in the community. They felt that case vignettes were a helpful way of thinking about this population and the skill set that

the community would need. As part of the dialogue from the day (which is highlighted in the second section) is the definition of Community- not only thinking about the health input but also from other agencies such as care providers, housing etc. In relation to the number of vignettes to look at they felt that a number between 4 and 6 should capture all the widely different issues to be considered. In relation to the detail they felt that some of the vignettes we presented were too detailed, in some more detail could be required and they thought that a single side of A4 would be enough detail for people to think about how their team would manage particular individuals.

Overall they supported the use of case vignettes and a wider survey either to get information from a wider survey of clinicians in relation to what skill sets they feel that their team could acquire or as a tool to get teams to think about how they would manage individuals in the community prior to having to do so to help them start acquiring skills or developing relationships.



The group split up into four groups with the Forensic LD Psychiatrists being in two separate groups. Each group was given the same set of case vignettes to discuss. Each group approached it slightly differently and the facilitators supported each group along the pathway that they had chosen. Some groups liked to consider each scenario in turn and to think about what specific needs they would need to support within the community and how they could do it. Other groups took them more as a framework to have a conversation in relation to either ways they are currently working or

ways that they would like to work in the future.

Emerging themes

Themes that were consistent across the four groups were:

The definition of community and the identified need for multi-agency working and multi-agency skill-sets, including both generic mental health teams and generic learning disability teams, housing, social care, providers, fire service, police, etc.

These “community” services were identified as having needs in relation to: autism awareness, communication needs, risk assessment/presentation as modified by co-morbid LD/ Autism, resilience, formulation skills and behaviour support plans (Positive Behaviour Support), supervision skills; support and debriefing skills, and understanding of Legal Frameworks.

Then in relation to the “intervention” services, be that generic or specific community forensic etc. the skills set were all of what was above but with a greater level of detail. Particular issues around legal frameworks, Mental Health Act, Mental Capacity Act, Deprivation of Liberty Safeguards etc. communication, formulation, substance misuse work, risk assessment.

The third area was about specific specialist skill sets around risk assessment, early warning signs and relapse prevention plans, specific offence programmes such as arson work, sex offending.

Other themes

Other themes that emerged related to the management of the community forensic population.

- Issues around multiple pathology and multiple difficulties and the need for accessing a multi-disciplinary team (with access to Speech and Language, Psychology, OT, Nursing, Psychiatry),
- the need for specialist support within the community be it resilient providers or specialist housing providers,
- issues in relation to discharge planning and that the community team should be involved early in the discharge planning and should work in collaboration with an inpatient service to manage that effectively (this is thinking about moving people out of hospital into the community but also in relation to the future scape),
- the intensity that this population requires - often with the chaotic lifestyle there actually needs to be a greater frequency in relation to contacts whether that be due to meet a crisis or because of DNA's
- risk assessment or risk formulation needs regular review.

Appendix A

Community Forensic Vignettes

Example 1:

A young woman in her early 20's who was convicted of arson where she set fire to the hostel in which she was living because she was angry. At the time of the offence, chaotic lifestyle, polysubstance misuse. Convicted and sent to prison on an IPP. Deteriorated in prison; unable to cope within the regime, vulnerable to others and self-harming. Mild learning disability identified, with good social façade, but significant issue in relation to problem solving and interpersonal skills. Transferred to hospital for assessment and treatment. On discharge (via MHRT and parole board) will need support from Community Forensic team.

Example 2:

A man in his 30's with a conviction for offences against children. Mild/moderate learning disability, personality traits, hypochondriacal, dysthymic. Currently in placement with 24/7 supervision. Structured support plan, as when well supported, risk with regards to children is manageable as works with team and recognises his risk behaviours and manages them; when becomes chaotic and “uncontained”, risks towards children increase as he moves to “manufacture” situations where he will become increasingly exposed to his associated risk factors and potential victims. Early relapse indicators all innocuous, currently displaying these behaviours.

Barry

Barry is a twenty seven year old man with a mild learning disabilities and schizophrenia. He has four brothers, one sister and contact with his grandmother. He has no contact with his biological parents, and some sporadic contact with foster parents, whom he lived with from the ages of 7 -18, due to allegations of neglect. Barry finished school aged 16, and continued his education in college where he received some support for his literacy. Barry was not known to LD services prior to committing his index offence.

Barry received his first conviction for ABH aged 13, and subsequent convictions included three offences against the person (aged 15,18, 21), two offences related to breach of custodial discharge, failing to surrender to custody at appointed time and several miscellaneous offences. Barry has a history of drug and alcohol use.

Following an incident causing GBH and setting a fire Barry was detained under MHA section 37/41. Barry undertook one to one therapeutic work in a Low Secure Hospital and engaged in detailed relapse prevention work. After a four year period, Barry transferred to a locked rehabilitation

setting.

In locked rehabilitation setting, Barry engaged in assessment work with a Speech and Language Therapist. Key findings from this assessment process indicated:

Barry could not understand and follow sentences with more than three pieces of information and had difficulties with the words before and after.

Barry had significant difficulties processing and retaining information – retaining information for 10 minutes was difficult and Barry would retain only 25% of information following a ten minute period. Retaining information over longer periods was significantly more difficult.

Barry had difficulties recognizing emotional states in others and working out whether others were being sarcastic or sincere in their interaction.

These findings lead to reasonable adjustments being made to ensure that Barry was able to engage in therapeutic work effectively and support his retention of this work and were incorporated into risk assessment and management plans.

Barry engaged in therapeutic work, and engaged well in Cognitive Analytic Therapy work to explore his understanding of relationships from his childhood and the impact on his presentation and current interactions. He equally engaged well in mental health awareness work and detailed work around how his mental health, and engagement/activity linked to risk issues and risk management – this work was adapted significant to meet his needs described. The MDTs financial capacity assessment indicated that Barry did not have financial capacity and would continue to be vulnerable around interactions with peers. The relapse prevention work continued to be explored and adapted in order to maximize Barry's understanding and retention of information. Barry is managing well with Section 17 Leave to community settings, and engaging well in risk management work, and engaging in adapted work to support his understanding of a conditional discharge. The RC is applying to the MOJ for conditional discharge.

The CLDT state that they do not have experience of supporting a conditionally discharged patient and are concerned about risk management.

The Enhanced Crisis support service do not have experience in managing forensic risk.

The Community Forensic Mental Health team have limited experience in providing the reasonable adjustments required to meet Barry's needs

There are equally limited residential / supported living service providers with the skills required to consider daily risk management issues alongside a health and social care team.

Group Discussion

1. A clear definition of 'forensic' patients
2. Risk of offending (but not known to Ministry of Justice yet)
3. Specialist Training for staff (substance misuse)
4. Ability to work with other services
5. Supervision skills for managing risky behaviour
6. Awareness of diversion services
7. Developing clear pathways of transferring patients from CFT to generic services (good interface between CFT/ Inpatient services)
8. Experienced staff able to respond to EWS/
9. Allocated Social Worker/OT



**For further vignettes and to
comment**

[click here](#)



STOMP so far

Dr Ken Courtenay

Vice- Chair of ID Faculty

*Consultant in ID Psychiatry, Barnet
Enfield and Haringey Mental Health
NHS Trust*



STOMP – ‘Stopping Overuse of Medication in People with Learning Disabilities’ is a campaign to reduce the prevalence of antipsychotic use among people with Intellectual Disabilities (NHSE 2015). It grew out of findings from Transforming Care where it was highlighted that people with ID were using a lot of psychotropic medication without clear clinical evidence to support their use in managing problem behaviours and mental disorders.

The campaign began in 2015 gaining momentum since its launch on 1 June 2016 supported by all the major relevant Royal bodies serving people with ID. The Faculty is a signatory to the STOMP Pledge. It has been promoted by NHS England as part of the National Learning Disabilities Programme with the intention of reducing the use of psychotropic medication by people with ID. The campaign is not only relevant to England and Wales but to clinical practice in all jurisdictions.

How have Psychiatrists reacted to the campaign especially where we could be perceived as the professionals most responsible for their use? What is the role of Psychiatrists in prescribing and managing antipsychotics? What has happened since June 2016 to professional practice?

I suspect that as Psychiatrists we have been perceived to be responsible for people using so much antipsychotics. This is an easy and reflex conclusion to make and satisfies a desire to attribute responsibility to a single group. STOMP has revealed that the issues are more complex than just prescribing medication and tagging responsibility to one group especially when you consider that in the community Psychiatrists advise, and General Practitioners prescribe. And prescribing takes place in other clinical situations too. Inpatient and Forensic services prescribe and stabilise people on medication before passing on to community services. Children’s services commence medication to manage behaviour especially in the presence of neurodevelopmental

disorders. So, STOMP applies to all circumstances where medication is prescribed including by General Practitioners.

The effect of STOMP has been to highlight the reasons why medication has been prescribed in particular when managing challenging behaviour where it has been considered to be an effective if short-term solution to complex behavioural problems occurring for environmental reasons rather than because of the presence of a treatable mental disorder. Calls for prescribing can be strongest from carers who may not have the resources to manage behaviour through non-pharmacological means. STOMP has the power to strengthen Psychiatrists clinical decision not to prescribe based on opinion that not all behaviour should be treated using medication. It places responsibility for managing challenging behaviour on the multi-disciplinary team emphasising that managing challenging behaviour is ‘everyone’s’ business including families and not the domain of Psychiatrists.



What of people who use psychotropic medication to manage mental disorders? STOMP is relevant to prescribing in these circumstances in challenging how we manage and monitor medication use. It has the potential to have an impact on clinical practice as measured by clinical audit and Quality Improvement initiatives.

The Faculty has developed its aims in meeting the STOMP Pledge. We have promoted the Pledge among members, raised awareness of academic work (Sheehan et al 2015), and collaborated with partners such as General Practitioners (Royal Society of Medicine 2017). STOMP is not just a campaign but it is about culture, changing culture and attitudes and not solely among Psychiatrists but other professionals and carers too. In 2017 Social Care partners have

joined the campaign raising awareness among care providers of medication use in the people they support.

STOMP has demanded that we take a good look at how we manage challenging behaviour whether in the community or in in-patient services. It raises the issue of the role of medication when developing care plans to manage challenging behaviour. Medication can be a valuable element of a robust care plan but it is not a substitute for considered, holistic care plans incorporating behavioural support, the responsibility for which lies with the care network and not just on the shoulders of Psychiatrists.

What of the impact on clinical practice in the future? I already see positive changes taking place in the culture in services. Current innovations include the development of medication pathways in services, reviews by GPs of their patients with ID who are using psychotropic medication led by innovators in Hertfordshire and Newcastle. In the treatment of mental disorders we need to embrace the 'optimisation of medication' that will allow us to avoid over-medication – the right drug at the right dose for a specific clinical indication. There is potential for us to have fewer clinics dedicated to reviewing medication that could allow us to concentrate on people with more complex presentations supported by colleagues in clinical teams. The time is right for us to embrace STOMP for the benefits it will bring patients and the positive impact it will have on our clinical work.

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How do we measure the treatment outcomes of patients treated within forensic / secure intellectual disability services?

Verity Chester

*Verity Chester, Research Associate, PiC
LDS, Norfolk and PhD Candidate, University
of East Anglia, Norwich, Norfolk*



measures of outcome to assess value of a service, however this is clearly a challenge for forensic ID services, which treat highly complex patients according to their individual needs. This problem was the topic of a recent evidence synthesis project, led by members of the Clinical Research Group for Forensic Intellectual and Developmental Disability (CRG:FIDD - <http://www.forensiclearningdisability.com>).

Forensic intellectual and developmental disability (FIDD) services operate at the interface of the health, and criminal justice systems, caring for a highly heterogeneous patient population. Patients typically have multiple diagnoses, high levels of serious mental illness, personality disorder, developmental disorders, substance misuse histories, extreme levels of psychosocial disadvantage, and histories of abuse from others. While offending behaviour or criminal conviction is a common prerequisite for admission, some patients take an “upwards referral” pathway, where they are moved from general mental health or intellectual disability services to forensic units, despite never have been convicted.

This group utilise high health expenditure, at approximately £180,000 per patient per year, with a median length of stay of 2.8 years (Alexander et al., 2011), and some patients remain in services for indefinite periods (Vollm et al., 2017). While some studies describe the outcomes of psychological treatment programmes, such as fire setting or sexual offending, few studies describe care models followed at the service level, or the short (during admission / point of discharge), or long term (post-discharge) treatment outcomes.

One of the difficulties in this area is methodological, as individual patient care pathways differ based on the discussed heterogeneity. A young male patient admitted for seriously assaulting his sibling during a psychotic episode, may follow a regimen of pharmacotherapy and cognitive behaviour therapy. Whereas, a female patient with a history of personal trauma, subsequent diagnosis of borderline personality disorder, serious self harming behaviour, and public order offences, will likely be treated with a combination of therapeutic milieu, and psychological therapy targeting her traumatic experiences. One individual may respond quickly and positively to treatment, and one may suffer from motivational issues, and take a year to engage and benefit.

Healthcare commissioners value simple, quantitative

A systematic review and synthesis of outcome domains for use within forensic services for people with intellectual disabilities[†]

Catrin Morrissey, Peter E. Langdon, Nicole Geach, Verity Chester, Michael Ferriter, William R. Lindsay, Jane McCarthy, John Devapriam, Dawn-Marie Walker, Conor Duggan and Reg Alexander

Background

There is limited empirical information on service-level outcome domains and indicators for the large number of people with intellectual disabilities being treated in forensic psychiatric hospitals.

Aims

This study identified and developed the domains that should be used to measure treatment outcomes for this population.

Method

A systematic review of the literature highlighted 60 studies which met eligibility criteria; they were synthesised using content analysis. The findings were refined within a consultation and consensus exercises with carers, patients and experts.

Results

The final framework encompassed three a priori superordinate domains: (a) effectiveness, (b) patient safety and (c) patient and

carer experience. Within each of these, further sub-domains emerged from our systematic review and consultation exercises. These included severity of clinical symptoms, offending behaviours, reactive and restrictive interventions, quality of life and patient satisfaction.

Conclusions

To index recovery, services need to measure treatment outcomes using this framework.

Declaration of Interest

None.

Copyright and usage

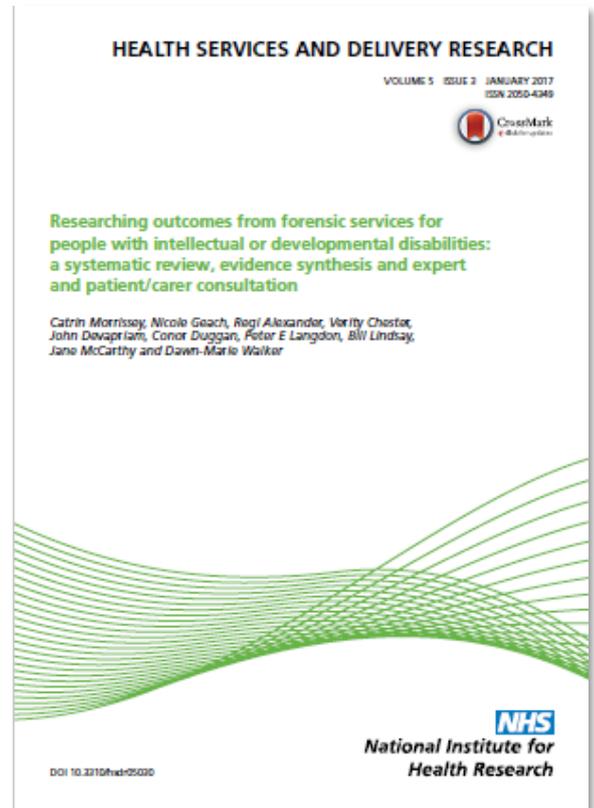
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The project examined how outcomes of the FIDD population should be measured, by examining the outcome domains of relevance to patients, their families or carers, measures used within published studies, and by asking clinicians and researchers. The results of each exercise were collated and contrasted through a Delphi exercise, to establish the outcome domains of most value to stakeholders. For example, while lots of research focused on length of stay, this variable was critiqued by clinicians, who felt this was a crude measure of limited utility. Families talked about the “right” length of stay, as not too long, but also not so short that their relative could not benefit from treatment. This process continued for each variable, and the researchers then developed an outcome framework, featuring the domains of a) effectiveness, (b) patient safety and (c) patient and carer experience. Within each of these, further sub-domains emerged, which included severity of clinical symptoms, offending behaviours, reactive and restrictive interventions, quality of life and patient satisfaction. The authors concluded future service evaluations should measure treatment outcomes using this framework, and are planning a future prospective, national outcomes study.

The papers are freely available through open access and the links are as follows:

Morrissey, C., Langdon, P.E., Geach, N., Chester, V., Ferriter, M., Lindsay, W.L., McCarthy, J., Devapriam, J., Walker, D-M., Duggan, C., Alexander, R. (2017). A systematic review and synthesis of outcome domains for use within forensic services for people with intellectual disabilities. *BJPsych Open*, 3 (1) 41-56. <http://bjpo.rcpsych.org/content/3/1/41>

Morrissey, C., Geach, N., Alexander, R.T., Chester, V., Devapriam, J., Duggan, C., Langdon, P., Lindsay, B., McCarthy, J., & Walker, D.(2017) Researching outcomes from 'forensic' services for people with intellectual and/or developmental disabilities: evidence synthesis and expert and patient/carer consultation. *Health Services and Delivery Research*, 5(3) 1 – 102. <https://www.journalslibrary.nihr.ac.uk/hsdr/hsdr05030#/abstract>



**Psychiatry of Intellectual Disability
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Learn! Explore! Network! Enjoy!



Children with Intellectual Disability, Autism and Challenging Behaviour: Challenges we face

Bhathika Perera

*Consultant in ID Psychiatry, Barnet
Enfield and Haringey Mental Health
NHS Trust*



It is a Monday morning. I have already received several emails and phone calls about a 17-year-old male who was taken to the Section 136 suite over the weekend due to extremely challenging behaviour and significant risks to others. He has a diagnosis of Intellectual Disability and Autism with long standing challenging behaviour. He is assessed and deemed detainable under MHA but the question is which hospital is he going to or could he be managed in a community placement? Everyone is ringing around, but the answer is clear - there are no inpatient beds in NHS or in the private sector. Bed managers have exhausted all their resources. Due to the severity of his behaviours, Psychiatric Intensive Care (PICU) is suggested but there are no PICU beds for people with ID. The clock is ticking on he remaining in the S136 Suite where he has been for more than 48 hours. The family members are extremely unhappy. An urgent CTR is called but that does not solve the issue which is a lack of ID beds or community placements. It should be the least restrictive option, someone says. The possibility of a residential placement where the risks can be managed is looked in to, but social services are advocating in-patient admission. A community placement sounds like the best option, it looks great on paper and fits with national policies, but where are those community placements? The ones with vacancies are not willing to take him given the severity of behaviour over past few days. This is a losing battle for health and social care professionals working with children with ID, Autism, and extremely challenging behaviour especially when they get to the age of 16/17 years. When it happens, it challenges all systems we have within NHS and Social Care.

This case raises two main issues. Firstly, do children with ID, Autism and challenging behaviour in the community receive adequate support and interventions to prevent deteriora-

tion of their behaviour? Secondly, are there in-patient beds and community placements to meet needs of people with ID and CB when they can no longer live with their families?

Everyone is ringing around, but the answer is clear - there are no inpatient beds in NHS or in the private sector.

Level of care for children with ID, Autism and challenging behaviour

NHS and social care are under tremendous financial pressures that has led to significant reductions in staff and services provided to people with ID. Children's ID services have historically been under-funded in many parts of the country. Most teams are limited to part-time Consultant Psychiatrists responsible for large populations of children but working with part-time nurses and psychologists. Such limited resources limit their ability to assess and provide the necessary interventions to prevent deterioration of challenging behaviour in young people with ID. Most of their work is reactive only. It is not surprising to find children with ID, Autism and long standing CB been transferred to adult ID services without any communication assessments or behaviour support plans in place. Is this Monday morning call about the 17-year-old a result of a failure in the system to manage such individuals and provide necessary therapeutic interventions? And who is responsible? Such incidents are not limited to children with ID but certainly happen with adults with ID. Services that are well resourced with adequate psychiatry inputs and multidisciplinary teams tend to have fewer admissions, but do commissioners understand and value the preventative work that happens in the community?

Lack of service provision

There has been a significant reduction in in-patient ID beds linked to Transforming Care. Most private sector beds for people with ID are in the forensic sector and thus admitting someone with ID who needs inpatient assessment and treatment is a challenge for most community psychiatrists unless they have access to dedicated ID beds within their area. The focus is on managing and assessing people in the

community using the least restrictive approach but there has not been an increase in community providers who can manage people with ID and CB. The threshold for detaining someone with ID and CB under the MHA can fluctuate from one area to another depending on community facilities and resourced community ID teams. This creates dilemmas for Section 12 approved doctor when someone with ID and CB is assessed when answering the question whether community treatment options have been explored. One person who is detained in one part of the country may not even be considered in a different part of the country due to differences in the availability of community placements and services.

Victim of this battle at the end is the patient and his family/carers. It is the end of the day and time to head home. Someone shouted across the corridor, did you know that there are no 'blue light CTRs' anymore. I told myself, it would not have made much difference anyway in this case. As I was leaving I wondered how many Psychiatrists face these situations in their clinical practice or am I the one of the few who happens to face these situation.



The College has formed a new Special Interest Group in Neurodevelopmental Psychiatry .
<http://www.rcpsych.ac.uk/workinpsychiatry/specialinterestgroups/neurodevelopmentalpsychiatry.aspx>

The Inaugural Conference is to be held at the College on Monday 20 November 2017

NEURODEVELOPMENTAL PROCESSES – IMPORTANT TO ALL IN PSYCHIATRY

10.00	Registration and Refreshments	
10.25	Introduction Dr. Tom Berney	
		<u>Morning Chair: Prof Marios Adamou</u>
10.30	Autism: Bringing psychiatry up to speed Dr Ian Davidson	
11:15		Break
11:30	The neurobiological underpinning of Borderline Personality Disorder Dr Cath Winspear	
12.15		Lunch
13.00	Business meeting of the Neurodevelopmental Disorder SIG	
		<u>Afternoon Chair: Prof Traolach Brugha</u>
13.45	Anorexia and Autism Dr William Mandy	
14.30		Break
14.45	Foetal alcohol syndrome; rarely considered but in all our work Dr Raja Mukherjee	
15.30	ADHD in the mainstream: The role of emotional dysregulation and its overlap with common mental health disorders Professor Phillip Asherson	
16.15	Concluding comments	
16.30		Close

Cost: Standard £100 Reduced £50 (trainees, students, retired members)
Online booking at <http://www.rcpsych.ac.uk/traininpsychiatry/conferencetraining/>





BBC Radio 4: Test Case

Dr Ken Courtenay

Vice- Chair of ID Faculty

*Consultant in ID Psychiatry, Barnet
Enfield and Haringey Mental Health
NHS Trust*



While not paying much attention to the broadcast on the radio, my ears pricked up at the mention of 'Bournewood'. Suddenly, my interest was aroused by a drama on the events of Bournewood in 1997 and how they unfolded. The listener is led back in time to hear almost first hand from the carers and the professionals what happened in an ordinary day service for people with Intellectual Disabilities in Surrey twenty years ago.

The listener is brought on a journey from the accounts of carers in the day centre to the admission of 'H' to an assessment unit where he remained as an informal patient until detained under the MHA. We hear the perspectives of the carers, the social worker and community nurse, the Consultant Psychiatrist, and the solicitor who advocated on behalf of 'H'. The Tribunal was re-enacted for the listener provoking questions on the legality of the detention. The arguments for and against his detention are clearly spelt out through the course of the radio play with robust positions adopted by all.

The play recalled for me the events of the time when I was a trainee taking me back to a time when I gained a greater understanding of mental capacity witnessed through legal debate and subsequent advice on practice. At the time we knew what was happening in Bournewood was important but we did not fully appreciate the far reaching impact it would have in years to come on our clinical practice and the care of people who lack mental capacity. What started as a matter for a man with an Intellectual Disability soon had huge import for all people lacking mental capacity and the services working to meet their needs. Bournewood led to the Mental Capacity Act 2005 in England and Wales but it took eight years for the issues it raised to be legislated for. No longer could we say what was in the best interests of people lacking capacity, we had to establish they lacked capacity and then justify our reasons for our proposals. Ex-

perts in our profession played an important role in the development of legislation.

It is tempting to judge events and actions of the past by the standards of practice common today but this is not justified or fair to circumstances and people. The Consultant Psychiatrist practised in the context of the time with the support that was available. The actions of the Psychiatrist led to a chain of legislative debate and discourse on the care of people who lack mental capacity. What we take for granted today in the education of health practitioners has had a long and tumultuous road since 1997 that has included the development of Codes of Practice, Court of Protection, Deprivation of Liberty Safeguards, and that 'a gilded cage is still a cage' (Cheshire West 2014). Twenty years on, we are practising the consequences of events and decisions taken on one weekday afternoon in a day centre in Surrey.

Link

BBC Radio 4 Test Case <http://www.bbc.co.uk/programmes/b092fbr0>





The Fluidity of Role

Dr Juzer Daudjee

ST4 Trainee

North Bristol CLDT



Elm Tree Farm is a small working Care Farm with an on-site farm shop, providing a variety of occupations for over fifty people with learning disabilities. Originally part of Stoke Park Hospital (founded in 1909) in the middle of Bristol, it is now the flagship social enterprise project run by the Brandon Trust

‘Not those ones John, we picked those yesterday. Come around to this side.’ Three very immature French beans appeared in my hand. Three less for the market, oh well, I thought to myself. My other hand held a box slowly filling up with a majestic plethora of vegetables. Multi-coloured beans of various hues: purples, pale creams, light greens and dark earthy greens. A pleasant sight for mid-summer at the social enterprise. I turned to the gentleman on my right, ‘Is it ok to have them all mixed together or should I keep them separate?’ ‘Together, these ones separate,’ he said. I moved the runner beans over to one side.

‘Over here John. You did those yesterday. Come round to this side.’ One of the original members having been working here for twenty years. I notice his bulky old style hearing aids and wonder if his hearing meant he couldn’t always understand me.

Another client is shuffling on his knees with oversized wellies on. He is harvesting handfuls of beautiful French beans. ‘I always get so muddy.’ We walk over to the courgettes. I look between the rows of low-growing green palmate leaves to see giant yellow fingers in amongst larger bulbous orange and pale cream fruits. The group hangs back chatting idly and spotting courgettes and squashes. A new client who suffers with autistic anxiety is eagerly engaged in conversation with mostly himself. His 1-1 support worker who drove him from Weston-Super-Mare is attempting to redirect him. ‘Zucchini, zuchinni,’ I hear. The conversation only ends if he speaks last and so far does not seem to end. I open my

Opinel pocket knife and carefully step into the squash forest. Brilliant colours hiding away in the undergrowth – I cut away two large green striped courgettes and a medium sized patty-pan. He is being careful but this new client cannot break the thick firm stem. ‘A zucchini in a mankini. A zucchini in a mankini,’ he chants. He has been punning persistently. This is to the calibre of Johnny Vegas, I think to myself while stemming what I think would be inappropriate laughter. My sharp blade cuts easily through and I stretch over to hand the vegetables to other members of the party to store in the boxes. ‘Watch out – they’re prickly,’ I say.

On to the orchard. We pick the plums – two varieties. The ten-strong team easily strip the trees. ‘If they feel soft – take them,’ I say. ‘Leave that tree John – none of them are ready yet.’ Mouth-puckering. ‘Wow – these are sour,’ I hear from behind me. I select half a dozen greengages for the next box myself - instructions to select the right ones would have been too complicated.



Mr James Walter please water the aubergines. On to the tomatoes – an incredible variety. I read raspberry malinowy – a type of polish heritage tomato – and watch another gentleman pick the five lowest ones for my box. I answer some questions and mention the Mediterranean diet, lycopene and being healthy. ‘Oh no – leave the green ones, they’re not ready and try to keep the stems, like this,’ I demonstrate with one that does not break away easily.

There is a stream of jokes from the new gentleman. ‘How do you make a tomato blush? Show him the salad dressing.’ I laugh and say those are better than in Christmas crackers. He looks perplexed. After a full two minutes staring at the ground, he says ‘because jokes in crackers are really good.’

We split up with half weighing and sorting vegetables and

half of us planting out seedlings. I am coordinating the seedlings. In my team a gentleman is rapt with conversing with me on a multitude of topics but keeps coming back to 'if I'm coming again tomorrow' in his mild dysarthric manner. The gentleman who was shuffling beside the beans earlier in the morning repeatedly asks me if he can go and get changed. I say, 'it's still a little early Tom. Can you go and get the eggs?'

The three individuals I am working with have varying fine motor skills and many plants are broken. 'Ar ya com morrow?' I hear again. I say I'm not able to tomorrow. He looks up at me from where he is bent down and says something that sounds like 'ca oo el me'. He is holding on to a half full bag of compost. He repeats this and I mistakenly assume he is asking about if I am coming back. A long intense moment passes and he is still bent over holding the bag. It finally clicks. 'Of course I can help you with the bag,' I say to the very efficient worker.



Interview: Pru Allington-Smith



Interview conducted by Tom Berney, Newsletter Editor

Consultant in CAMHS ID Psychiatry, Coventry and Warwickshire NHS



The Newsletter plans a series of interviews with Faculty personalities. We start with Pru Allington Smith at a point when she has retired from the NHS although she will continue with part-time clinical work. Pru has become well-known for her work in developing the hybrid speciality of the Psychiatry of Young People with an Intellectual Disability (ID). She has been a leader in service development, locally as well as nationally, establishing the specialist community service in Coventry as well as one of the UK's few specialist inpatient units.

Tom Berney spoke to her one evening (on FaceTime), an interview that started with some areas agreed in advance.

I have known Pru for many years but, this time, blunt and intrusive questions brought out a side that I had not appreciated fully. She fielded this clumsy approach with a style that was straightforward and matter of fact but softened by humour; so comfortable that I had to resist letting it slip into an interview of me by Pru.

We started with the standard 'why this area of psychiatry and how did you get here,' which took us back to Pru's family and

especially her mother. When I entered ID Psychiatry I had heard of Dr. Allington-Smyth as a formidably sensible and effective specialist in the field. She, like many others at that time, had started in Child Health before moving on to Intellectual Disability. She had also had a child with intellectual disability, Pru's older brother. All in all, it was unsurprising that Pru should enter the Royal Free as a medical student with the intention of eventually working with children with ID. She approached a guest lecturer, Ben Sachs (the enthusiastic Professor of Developmental Psychiatry at Charing Cross), who recommended that she did two years in paediatrics before she went into psychiatry. Taking his advice Pru found that it included a year's neonatal work which gave her a solid grounding in the onset of disability and the responses it brought out from families. She then joined the training scheme in the West Midlands where she has remained ever since, qualifying both in Child and Adolescent Psychiatry and in ID Psychiatry before taking up a consultant post. While in adolescent psychiatry she found that she met many young people whose problem behaviour had become stubbornly entrenched for the lack of earlier help in childhood. She found working with families particularly rewarding, both then and now, leaving her with a sense of gratitude for what they taught her. With ID came an additional, more organic, layer of complexity which called on her medical skills. In Birmingham she experienced the creativity of John Corbett and the example of Mike Prendergast who, besides his remarkable clinical skills, had an unusual ability to talk to patients and families.

Service development brought committee work. Here Pru's



Interview: Pru Allington-Smith

style of comfortable conversational sanity has meant people listened to what she had to say. It also meant that she had to learn how to juggle her time and to use whatever came to hand, notably email and messaging, both to keep up with her work and to stay in touch with her colleagues. She has appreciated the extent to which the last have encouraged and supported her.

What things would she like to change? Like many, Pru would like to forestall the disheartening erosion of established, working services which have taken time to build. This year, her main concern has to be that the governmental juggernaut which is reshaping the NHS appears to be giving bed reduction a degree of priority means it is happening before any compensatory change in community provision.

Clearly Pru's main difficulty has been to avoid becoming over-extended. She would not have wanted to reduce her exposure to patients and their families for this was what she enjoyed and what had brought her into psychiatry. At the same time, she realised that she had to attend meetings for it was there that she did the groundwork essential to the maintenance of her service, let alone its development. In the end, she owed a great deal to her colleagues who, in sharing her workload, had allowed her the space to develop. She talked about their immense support, especially from Ashok Roy (her Medical Director) as well as from others, notably Harm Boer. Indeed, it was only on looking back over her career that she fully realised how much they had contributed to her achievements and to the enjoyment of her job.

Retirement will allow her to pursue singing (a soprano, she particularly enjoy oratorio and chanson, singing both solo and as a member of the City of Birmingham Choir), to go to France (seen below), to move house and, simply, to enjoy life with Peter, her husband of the last five years.

Reflecting on what might survive her, she picked out the services she has set up although she regrets that she was unable to negotiate a tailored inpatient unit (admissions are limited by the structure of her present unit). Overall, she thought her main achievement might lie in the network of trainees whom, she hopes, have been infected with her enthusiasm for the nature of the work and its family contact, an attitude out-lasting ephemeral services.



A Plea from Ian Davidson, The College's Autism Champion

Autism affects millions of people's lives – either directly or indirectly – in the UK. Receiving a diagnosis of autism is often seen as critical to enabling access to early intervention, appropriate education and social care planning and family support services.

Psychiatrists play a key role in caring for individuals of all ages worried about their own functioning where this is impacting on or impacted by their mental health and for supporting parents, family members and others caring for and about those individuals. They may do this directly or as part of a clinical team or by helping to shape services in multiple ways. But little is known about the views and experiences of psychiatrists who work with Autistic people.

This 15-20 minute survey seeks to do just that. The information you provide will critically identify what works and what doesn't work for you, as a psychiatrist, and for the individuals and families you support. It will also inform the design of training materials as part of the RCPsych's strategy for autism.

We very much hope you would like to take part! You can access the survey here: <https://www.surveymonkey.co.uk/r/KQZ7QVH>





Upcoming conferences and prizes



<u>DATE</u>	<u>TITLE</u>	<u>LOCATION</u>	<u>ORGANISATION</u>	<u>COST</u>	<u>CPD points</u>
MEETINGS					
20.11.2017	Neurodevelopmental Psychiatry Conference	21 Prescott Street	RCPsych	Standard £100 Reduced £50 (trainees, students, retired members)	6 CPD hours per day
24.11.2017	Higher Trainee Conference	Manchester Conference Centre	ID Trainee National Conference planning committee	£25-75 dependant on training level	TBA
20.04.2018	Faculty of Psychiatry of Intellectual Disability Spring Conference	21 Prescott Street	RCPsych	TBA	6 CPD hours per day
PRIZES					
01.12.2017	The Professor Joan Bicknell Medical Student Essay Prize	Presented at the Faculty spring meeting, usually held in April each year	Eligible: All clinical medical students in the UK	Prize: £250 Awarded for an essay written by a medical student about their contact with a person (or people) with learning disability during the course of their studies	
30.12.2017	The Gregory O'Brien Travelling Fellowship	Presented at the Faculty spring meeting, usually held in April each year	Eligible: Applicants must be in an approved UK training scheme working at CT1-ST6 level or within the first 3 years of a Consultant post.	Prize: £1,000 Intended to encourage psychiatric trainees and young Consultants to broaden their academic and clinical knowledge in a centre of excellence either in the UK or abroad.	

