

# Workshop Presentations

W201 - DUAL DIAGNOSIS - 3 SEPTEMBER 2009 - ROOM 8

## **Developing a competency standard in the field of co-occurring mental illness and intellectual disabilities: a North American certification**

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Persons with co-occurring mental illness and intellectual/developmental disabilities have complex medical, psychiatric, and behavioral support needs. Additionally these individuals have been identified as the most medicated persons in society (Aman, 1999). In many states and counties, the ID/DD system and the MH system are structured in such a way that the unique behavioral needs of this population are inadequately addressed. In today's behavioral health field, a license or degree cannot predict competency in working with this cross-system population. Three American entities, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Developmental Disability Program Directors (NASDDPD) and The National Association for Dual Diagnosis (NADD) are developing a competency-based credentialing process for programs and practitioners who demonstrate the clinical and programmatic elements that lead to successful treatment outcomes.

Certification on dual-diagnosis is important to provide a care system with a demonstrated level of expertise in co-occurring MI/ID, provide a workforce with validated level of assessment and treatment skill, assure that public and private healthcare dollars are purchasing effective services and assist families/advocates about making informed choices. This interactive workshop will detail the underlying competency issues and describe the multi-year initiative of developing these competencies that will be held as the gold standard for clinical, direct support staff and programs that assert expertise in co-occurring ID/MI.

Participants will be invited to share their experiences from a clinical or programmatic perspective and discuss the value of a national credential. The co-presenters have extensive experience from both an academic and provision of service perspective.

## **Developing Mental Health Assessment and Treatment Units for people with intellectual disability**

*S.H. Hardy, South London and Maudsley NHS Trust, LONDON, United Kingdom*

*E.H. Chaplin, South London and Maudsley NHS Trust, LONDON, United Kingdom*

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Individuals with intellectual disabilities and mental health problems do benefit from admissions to generic units, specialist units are able to treat individuals with greater challenges, by offering planned admissions that provide specialist assessment and treatment not available through generic services. The unit offers evidence-based treatment for clients who require specialist assessment and treatment due to complex i.e. unusual clinical presentations and those with a number of different diagnoses requiring a range of skills. The aim is to address specific clinical questions effecting mental health and other quality of life issues such as future service requirements, risk assessment and management, and to evaluate medication and other prescribed treatments.

The new unit at the Maudsley Hospital was relocated to the Bethlem Royal Hospital as it was not able to meet the demands of this group of people for a number of reasons including meeting demand because of size, scope to develop and the ability to offer dedicated gender separation. The unit offers non secure accommodation and has been proven locally to bring significant longer term care and cost benefits for referrers, as clients are allowed to recover in less restrictive settings. This is also designed to avoid the need for hospital re-admission or higher cost secure accommodation. With a lack of specialist services nationally for this client group, this new service offers the opportunity for people from all over the country to be able to access specialist services.

This workshop offers the opportunity for participants to explore assessment and treatment service models and their design, to best meet the needs of people with intellectual disability. A brief overview of current research will accompany the workshop to provide a context.

W202 - CHALLENGING BEHAVIOUR - 5 SEPTEMBER 2009 - ROOM 9

## **Gentle teaching, an alternative for controlling challenging behaviors**

*J.P.S. van de Steepkamp, Stichting Gentle Teaching, NIEUWEGEIN, The Netherlands*

*S. Schipper, Prinsentichting, PURMEREND, The Netherlands*

As a result a combination of personal vulnerabilities and the life history, many people with a mental disability or mental illness don't feel safe and connected with others. This makes it difficult to help them. Under emotional or psychological stress, they do not reach out for help, but turn inwardly and often react with violent or destructive behaviors. Strategies which focus on controlling or changing the behavior may have some result for the short term, but also result in more emotional loneliness for the client. The client doesn't learn to feel safe with

the caregiver and so the chance of turning inwardly in stressing situation remains. Gentle teaching is a strategy which focuses on developing safe relations between caregivers and clients.

In a careful process, caregiver and client together learn to feel safe, loving and connected with each other. The profound feeling of safety itself will prevent most of the escalations, but it is also a condition for the client to reach out for help when he feels emotionally or psychologically stressed. Gentle teaching does not heal the mental illness or mental disability, but it heals the relation between the client and important others. It creates a fundament for personal growth and supports more specific healing therapies. Gentle teaching benefits both the clients and the caregivers. The client will feel safe and unconditionally supported by the caregiver. The caregivers will not only face fewer incidents, but they will relate with the client in a more positive perspective instead of defensive or controlling.

In the workshop we will present the methodology of gentle teaching and illustrate it with some case-studies. In the methodology we will focus on the development of both the client and the caregiver.

### **Video observations of problem behaviour in persons with a deep and severe intellectual disability**

*H.W. Wouters, Stichting M.M. DELACROIX, LEUVEN, Belgium*

In our practice we use the observation scheme of Jacques Heijkoop, a well-known Dutch psychologist, to describe what goes on in non-verbal persons with an intellectual handicap when they show problem. In a first phase we carefully describe what we observe: the facial expression, the look in the person's eyes, the posture of head and body, the movement of arms and legs, the way in which he moves about, his position in space, his sounds with a certain volume, certain pitch, certain rhythm, and the changes in them.

In the second phase, we interpret these observations by asking ourselves the question of what might be going on inside the observed person at that time. What are his motives? What are his thoughts? What are his feelings? What are his sensations? With regard to these elements we formulate hypotheses. Afterwards we check if these suppositions are correct. By regularly looking at the behaviour of mentally handicapped persons with this diagram in the back of your mind, you can quite easily become an accurate observer. You learn to notice when someone's inside changes, which elements come to the foreground, when tension is building up, when this tension ebbs back down and so on. These are very important elements for mentally handicapped persons with problem behaviour, which frequently are not dealt with during meetings.

Non-verbal persons need carers who specialise in this. In this workshop we watch some video clips from which we gathered insights that were important for treating the problem behaviour of the persons involved.

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## **W203 - ASSESSMENT - 4 SEPTEMBER 2009 - ROOM 8**

### **The effectiveness of the ASD-navigator**

*W.G. Liefhebber, Philadelphia, ZWOLLE, The Netherlands*  
*I. Steenman, Astus, GRONINGEN, The Netherlands*

The ASD-navigator is an intervention method that arose out of daily experiences. The planning of the method is based on scientific insights concerning autism spectrum disorders (ASD). The core of the ASD-navigator: the way in which interpretation is given to regulation. Regulation means what is described in literature as structure: offering and creating perspective and predictability. What is unique about the ASD-navigator is that regulating is seen as more than activity within the environment. Not only do the parents or social workers regulate, but so does the person with ASD. The first step is mapping their own regulation and based on that, deciding which regulation needs to be offered within the environment. Main goal of the ASD-navigator: Based on systematic analysis we have come to a honed way of supporting a specific person, and as a result of this, perspective can arise and development is possible.

Herewith, we have tried to do as much justice as possible to what the person with ASD wants and what the people around him think is necessary. To realize this main goal there are a number of steps within the ASD-navigator that have been distinguished from one another:

1. Mapping their own regulation
2. Mapping the ways of regulating that others use
3. Harmonizing the different ways of regulation
4. Making development possible

The research is an effect study; a product evaluation. The intervention is: the use of the ASD-navigator'. The research group concerns people who with ASD and a mild/severe intellectual disability, who reside in a 24 hour facility.

Research planning:

Literature research: January - October 2008

Pilot: November 2008 - August 2009

Effect study: September 2009 - September 2012

In the workshop the results from the pilot study are presented.

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**Routine outcome monitoring (ROM) for adults with intellectual disabilities***J. Wieland, Rivierduinen, LEIDEN, The Netherlands**S. Kapitein-de Haan, Rivierduinen, Kristal, Centrum Psychiatrie en Verstandelijke beperking, LEIDEN, The Netherlands*  
*F. Zitman, LUMC, LEIDEN, The Netherlands*

Psychiatric disorders are far more common among adults with intellectual disabilities than in the general population, but diagnoses are often missed. It is likely that due to a lack of adequate diagnostic and follow-up techniques, a large percentage of people with both intellectual disabilities and a psychiatric disorder do not receive the treatment they deserve. This situation could be improved by systematic use of assessment instruments to diagnose psychiatric disorders and determine the severity of symptoms: Routine Outcome Monitoring, especially designed for adults with an intellectual disability. Routine Outcome Monitoring (ROM) is a method for systematic use of assessment instruments to gather information about patients.

In the Netherlands, ROM is used by a growing number of mental health care institutions. ROM can be especially beneficial for people with borderline intellectual functioning or mild intellectual disabilities. Because together they constitute about 10% of the population of the Netherlands, an improvement for this group will lead to a substantial improvement in mental health care.

The purpose of this workshop is to explain to you the concept of Routine Outcome Monitoring (ROM) and tell you more about what it entails. We will focus on the opportunities and pitfalls of ROM and the implementation at Kristal, Centre for Psychiatry and intellectual disability. We will talk about the possibilities for using assessment instruments for people with intellectual disabilities, the specific disorders where ROM should be applied and the daily practice of ROM within Kristal.

**W204 - TREATMENT (FORENSIC) - 3 SEPTEMBER 2009 - ROOM 10****The treatment of mild mentally disabled offenders who commit aggressive offences***N.A.M. Prevo, Pompestichting, NIJMEGEN, The Netherlands*

In Kairos, the forensic psychiatric outpatient clinic of the Pompe foundation, patients are treated who commit aggressive offences. The treated offenders live and work partly or completely in society but often struggle to cope. What they can bear and their experienced burden often is out of balance. This results not seldom in aggressive behaviour. The aim of the treatment program is to reduce recidivism of aggressive behaviour in these mild intellectually disabled offenders. From literature and research can be concluded that what at least is necessary is learning aggression control skills and new social skills. This has to be executed as multimodal as possible by practicing more than talking, repeating a lot and incorporating the environment within the treatment.

Kairos has based on these facts developed a group treatment incorporating 'aggression replacement training' which is proven evidence based effective for normal adolescent aggressive offenders. This method is adapted for intellectually disabled and combined with motivational issues, a relapse prevention model and intensive working with the environment of the patient. The treatment contains 8 months of weekly 2 hours sessions. If necessary individual extra treatment is offered. The treatment groups are divided in a low IQ group with IQ rates 55-70 and a higher IQ group with IQ rates 70-90.

The treatment has been given now for several years and although a lot can be improved it seems to work well. More than 50% completes the group treatment; the patients and the environment report reduction of aggression and improvement in behaviour overall. Research will start in September 2009 supported by the University of Nijmegen. The treatment outcomes will be officially evaluated. This research will be longitudinal and will use 'Routine Outcome Measurement' to evaluate the results. The treatment program is promising.

**Legal protection for people with id in the criminal justice system***E.S. Søndena, Research centre, Brøset, TRONDHEIM, Norway*

Recent studies have found a prevalence of learning disabilities among 10% in the inmate population in Norwegian prisons. Problems concerning identification and service adaptation during all steps from the person's first contact with the police until discharge and preventing reoffending have been the basis of this project. The knowledge that people with learning disabilities often struggle, with the language, procedures, requirements, and mainstream services in the criminal justice system, has inspired us in focusing these issues.

The aim of the project is to bring different occupational groups with defined responsibility in the criminal justice system together (police, prison, probation services, public prosecutor, habilitation services, mediation services) and establish some practice and routines that secure better information and adapted services to offenders or alleged offenders with learning disabilities. Finally the perspectives from the different occupational groups will be collected in a 'handbook' for treatment of people with learning disabilities in contact with the criminal justice system. The British project 'No One Knows' (Prison Reform Trust) has been an important reference to the Norwegian project.

**W205 - EMANCIPATION - 4 SEPTEMBER 2009 - ROOM 9****How to train family caregivers of people with intellectual disability - the carers EU-project***C.O. Oppenauer, Faculty of Psychology, University Vienna, VIENNA, Austria**E.Z. Zeilinger, Faculty of Psychology, University Vienna, VIENNA, Austria**G.W. Weber, Faculty of Psychology, University Vienna, VIENNA, Austria**B.B. Brehmer, University of Vienna, VIENNA, Austria*

In spite of the increasing need for caregivers, standardized education and training as well as official approval of competences in family members who provide care for their relatives are still missing in Europe. Although it is well known that care is mostly done by family members there have been so far hardly any activities in order to provide knowledge and training for family carers. In cooperation with the Leonardo da Vinci EU-Project 'ECL-European-Care Licence' the CARERS EU-Project aims to develop a learning and training program in order to assure basic knowledge and competences for informal caregivers and thus increase their emotional well-being. Target groups are caring family members and informal and voluntary caregivers. Further, experts in the field of care, social work and psychology will be trained as tutors within the training program for family carers.

According to the project goals different training modules will be developed. In this workshop the training module for family carers of people with intellectual disability will be presented. At first, the module's content will be introduced and the significance of the different issues and connected group exercises and pay roles will be discussed and demonstrated to the workshop participants. Finally, experiences from the pilot training courses and implications on the final training module will be reported.

**Do opposites really attract? - Exploring the borders of emancipation and control***C. Claes, University College Ghent, Ghent University, GENT, Belgium**F. Morisse, De Steiger en Polikliniek, P.C. Dr. Guislain, GENT, Belgium**D. Reynaert, University College Ghent, Ghent University, GENT, Belgium**J. Andries, Psychiatrisch Centrum Caritas, GENT, Belgium**S. Vandevelde, University College Ghent, Ghent University, GENT, Belgium*

The field of intellectual disability (ID) is strongly influenced by the Quality of Life paradigm. This framework supports the equality of persons, which is reflected by concepts including self-determination, emancipation, inclusion and empowerment. In daily practice however, in which concepts should be translated into actions, professionals are often confronted with the borders of these leading principles. This seems especially true when working with specific populations, such as persons with ID and mental health problems. The application of QoL-principles, which should - in ideal conditions - lead to a better mental health, seems to be at risk, as accounts from professionals indicate that emancipation is sometimes replaced by 'actions aimed at controlling' or 'regulating clients'. This workshop aims at stimulating a debate on whether these two - on the first sight opposite - concepts ('autonomy & self-determination' vs. 'controlled regulation') are really excluding each other. After a general introduction, tracing back the educational and philosophical roots of autonomy and control/regulation, current scientific insights from the QoL-paradigm will be contrasted with more practical case-driven accounts from professionals. Different topics will be covered, including dilemma's such as 'needs vs. wants'; 'self-determination vs. control'; and 'rights vs. obligations'. The two different perspectives will be illustrated by two presentations in which the above mentioned topics will be systematically compared and contrasted with each other. The systematic juxtapositioning of relevant insights from science and practice reveals that the concepts of self-determination/autonomy and control/regulation can be regarded as more complementary than opposite.

An integrative paradigm offers a framework to consider both concepts as essential elements of a holistic view on supporting clients with ID and mental health problems. Instead of giving definite answers, the presenters hope that this workshop will stimulate participants to critically reflect on theoretical findings and own practical experiences.

**W206 - MULTIPROFESSIONAL APPROACH - 4 SEPTEMBER 2009 - ROOM 9****Psychodynamic frameworks in psychopathology in persons with intellectual disability; diagnostics and clinical interventions based on cases studies***J.K. de Groef, VZW Zonnelied, ROOSDAAL, Belgium**A. Došen, Katholieke Universiteit, NIJMEGEN, The Netherlands*

Based on different psychodynamic theories, phenomenology and cultural anthropology an introduction to the 'anthropopsychiatry' will be given. This framework is called 'anthropopsychiatry' because psychopathological phenomena reveals in an extreme way what is working as grounddynamic in daily life. Anthropopsychiatry deals with the psychodynamic of four existential themes corresponding to the four main psychiatric categories: The theme of contact and mood referring to the different mood disturbances and attachmentproblems. The theme of pleasure/displeasure and passivity/activity referring to the perversions. The theme of rules, law and order and the social referring to neuroses. The theme of identity articulated with the conjunction of the verbs 'be and have' referring to psychosis.

This introduction does not presupposes foreknowledge. The framework will be built up with the help of clinical cases if possible brought in by the participants themselves.

Antopsychiatry has added values because it provides a developmental (congruent with the model of Došen) and a structural interpretation of the psychodynamic features of a person with ID and mental health problems. More specifically it emphasises a hermeneutic ordering of all the observational issues in relation with the four main existential themes of anthropopsychiatry. It thus provides an understanding of the client's mental health problems as well as suggestions for treatment and care. This inclusive framework can function - because of his pluridisciplinarity - as a common grid for reflection and discussion for all professionals working with such people and this as in a diagnostic as well as in a therapeutical phase regarding the client him/herself and his/her family and institutional context.

This framework does not substitute existing classification models or classical psychiatric diagnosis although it is compatible with them. It corresponds to the guidelines' and results in a comprehensive interpretation of mental health problems and mental health as such.

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#### **W207 - SUBSTANCE USE / MISUSE - 5 SEPTEMBER 2009 - ROOM 10**

##### **Substance use and misuse in intellectual disability - practical guidelines for social services**

*M. Kiewik, Aveleijn SDT, BORNE, The Netherlands*

*J.E.L. van der Nagel, Tactus, ENSCHEDE, The Netherlands*

Providing tools to workers in social services to detect and assess Substance Use and Misuse in Intellectually Disability (SUMID) in daily care situations

Developing a therapeutical climate, best practices on education of caregivers, adaptation of organization policy, cooperation with addiction medicine care

Education caregivers: The results of the study of Campbell, Essex and Held (1994) indicate a lack of experience and training among addiction care workers on issues related to learning differences. Training needs include information on disabilities; how a disability affects a person in treatment; stereotypes and prejudices; and communication and learning styles. On the other hand, the learning disability professionals identified their competencies and confidences in effectively communicating with this population, but stressed that they lacked the knowledge and skills needed in assessing, treating and managing people who misuse substances. This workshop provides an overview about education of caregivers.

Adaptation organization policy: In recent years, there has been an increasing interest in substance use and misuse in people with intellectual disabilities. Organizations must have a clear policy among people with intellectual disabilities and substance use. This policy is necessary for commitment to provide better care. This workshop will focus on good management and the possibilities workers will have to facilitate the management.

Cooperation with addiction medicine care: To facilitate treatment programs or to provide qualitative care, professionals from both areas (addiction care workers and intellectual disability workers) need to share information. Cooperation between different professionals is needed to ensure access to services. This workshop provides several solutions regarding to a successful cooperation and shows what the possibilities are.

##### **Asking crucial questions in interviewing abused clients with intellectual disability**

*H.H. Hofstede, Bascule, AMSTERDAM, The Netherlands*

Interviewing skills will be offered and common mechanisms such as 'evading the hot topic' will be analyzed and discussed. Asking direct questions to abused clients with ID is necessary, but where do they cross the small borderline between direct questions and leading questions? A very concrete workshop based on 20 years of experience in interviewing clients with ID about physical, sexual and emotional abuse. In 20 minutes do's and don'ts are presented with focus on asking crucial questions directly. The need for 'explicit lyrics' is even greater in interviewing sexually abused clients with ID, when feelings of shame, guilt and confusion are involved. Also included: a non-orthodox method of quickly establishing contact and a working relation with abused clients with intellectual disability!

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#### **W208 - SERVICES - 3 SEPTEMBER 2009 - ROOM 7**

##### **Evaluating service practices for persons with serious behavioural problems**

*A. Lapointe, G. Sabourin SQE-TGC, MONTRÉAL, Canada*

After publishing 'Practice Guidelines for Diagnostic, Treatment and Related Support Services for Persons with Developmental Disabilities and Serious Behavioural Problems', featuring contributions from internationally renowned experts from Europe, Canada and the U.S. (2006), and after its contents were adapted to Europe in 'Practice Guidelines and Principles for the Assessment, Diagnosis and Treatment of Persons with Intellectual Disabilities and Problem Behaviour', we worked to develop a method for evaluating current service practices used with people presenting problem behaviours.

Our method provides a picture of the practices used in a given service area. The results have been used to develop practice enhancement projects, with goals related and prioritized in a rational overall manner.

After this presentation, the attendees should have a clear idea of the method used to evaluate services practices and of its applications for planning services. This workshop will present the evaluation method and contents. The evaluation process we use brings together people familiar with the delivery of services within each specific department of an organization. Data is collected through networked computers, thus allowing each participating team to obtain immediate, step by step feedback on their practices. Based on this feedback, teams are invited to recommend strategies to improve their practices that need it most. A more detailed analysis on global as well as detailed profiles for groups of teams (e.g. children services) or for each specific participating team is then completed. Based on this report and on the improvement strategies put forward by each team, the evaluation report presents a plan for the development of practices for this organization.

Persons in attendance will be invited to assess some of their practices using our methodology. Finally, we will present the content of a typical evaluation report and discuss steps meant to improve practices.

#### **Customer survey on enhancement of service quality**

*J.J. Jussila, The Special Welfare District of Southwest Finland, NASKARLA, Finland*

*L.M. Matikka, University of Tampere, TAMPERE, Finland*

*S.A. Aaltonen, The Special Welfare District of Southwest Finland, NASKARLA, Finland*

In order to be responsive to customers' needs and expectations, the Special Welfare District of Southwest Finland developed a customer survey. It is a part of the organization's quality management system based on The EFQM Excellence Model. The survey was directed to the relatives of persons with intellectual disabilities.

The postal questionnaire included 31 questions concerning categories like 'assessment of service quality, communication, living conditions, daily activities, self-determination and satisfaction on reports, as well as benefits of services. The questionnaire could be returned anonymously, or the answers could be submitted electronically by the internet. 110 persons replied (45 % of those who were included in the sample). The data of 2009 will be collected in May and the results will be compared in order to find out, if the quality of care has improved.

In 2008, services were considered as important and useful. In addition, most of the informants felt that the services had been improving during the last five years. Special satisfaction was expressed about the tenderness and appropriate attitude of the personnel as well as safety and stable care conditions. Weaknesses were for example communication, excessive medication and shortage of stimulating activities. Results from 2009 and their comparison to the results in 2008 will be presented.

A lot of useful information helped to focus on various improvement measures. The survey was carried out together with the advisory board in special care consisting of relatives, personnel and people with intellectual disabilities. Experiences from this co-operation were promising.

#### **W209 - CHALLENGING BEHAVIOUR - 4 SEPTEMBER 2009 - ROOM 10**

##### **The approach of aggressiveness in challenging behaviour and prevention of seclusion on a clinical ward for people with id and psychiatric problems**

*M. van den Berg, D. Postmus, Tj. van der Heide, J. Plantinga, De Swaai, BEETSTERZWAAG, The Netherlands*

In Friesland in the Netherlands people with ID and psychiatric- and/or behaviourproblems can be hospitalised if necessary in a specialised hospital of de Swaai. During treatment and their stay on the clinical ward things may get out of hand because of escalating aggressiveness due to diverse stimuli, confrontation and interaction. Sometimes this can only be interrupted by putting the patient in a seclusion room. Though their stay in there is as short as possible the aim should be to prevent seclusion and de-escalate aggressiveness in a direct approach.

Analysis of the challenging behaviour to understand why the patient is likely to show aggressiveness is demonstrated. Methods of approach in communication and sometimes physical approaches for the de-escalation of aggressiveness and prevention of seclusion are also shown. The result will be that with these tools the staff is more confident and able, also to establish a safe climate on the ward.

##### **The definition and measurement of severe behaviour disorders in persons with an intellectual disability: results of five years of research carried out by the sqetgc in Quebec**

*G. Sabourin, A. Lapointe, FQCRDITED, SQETGC, MONTREAL, Canada*

As soon as our program was created in 2000, the lack of consensus on the definition and measurement of severe behaviour disorders (SBDs) posed numerous problems, with several authors raising this crucial difficulty for researchers and providers of services to persons with an intellectual disability (Emerson, 2001; Thompson, McGrew and Bruininks, 1999). This workshop will review the different steps taken to resolve the problem in Quebec, including four independent studies conducted between 2003 and 2008.

The initial study developed a first valid instrument intended to screen for the presence of behaviour disorders using psychometric indicators. Then, with the same instrument, another study used a clinical sample made up

of persons known to present challenging behaviours to specify critical thresholds for ruling on the presence of SBDs. This work was inspired by a new operational definition, one that includes the personal impact of the problem behaviours presented by the person with an intellectual disability, as well as the impact on others. Given the innovative character of this operational definition, we were intent on scientifically validating it, together with certain more objective parameters for measuring SBDs. This was achieved using the DELPHI method with about 60 specialists throughout Quebec. The measurement instrument we were able to develop as result of this initiative was used with a first validation sample.

Throughout the presentation, participants will be asked to use the two psychometric assessment tools for behaviour disorders stemming from this work. The computer-based compilation of results from these two assessment instruments will be demonstrated, and the clinical interpretation of the weighted scores will be carried out with the participants. The workshop will also allow participants to appropriate methods relevant to the expert consensus, to the measurement of SBDs and to their proper classification.

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#### **W210 - MENTAL HEALTH IN WOMEN WITH ID - 4 SEPTEMBER 2009 - ROOM 10**

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##### **Women wise: a health promotion programme targeting women with intellectual disabilities to improve their emotional well-being**

*L.T. Taggart, University of Ulster, COLERAINE, United Kingdom*

*J.S. Schofield, Compass Advocacy Network, BALLYMONEY, United Kingdom*

*L.M. McKendry, Compass Advocacy Network, BALLYMONEY, United Kingdom*

The workshop aims to share information about the development and delivery of a gender specific health promotion programme for women with intellectual disabilities (ID) focusing upon improving their emotional well-being. The workshop we will demonstrate the specific need for a gender sensitive health promotion programme, highlighting gaps in government policy and service provision across the UK (Dept. of Health, 2002, 2003, 2006, 2007).

The purpose and nature of the programme will be explained as well as the programme's content.

The results of a preliminary evaluation of the study will be shared. Moreover, some of the women who are engaged in the course will provide personal accounts of the success of this health promotion programme and how this programme has impacted upon their emotional well-being and life style choices.

The workshop will encourage ID staff to think about the potential for delivery of a similar programme within their current service and the value attached to health promotion for other women with ID. We aim to empower the workshop participants and enable them to deliver similar programmes throughout the world.

##### **Sexual support and learning disabled women in New Zealand: taking gender difference into account**

*C.A. Hamilton, Waikato University, HAMILTON, New Zealand*

Up to 15,000 adults in New Zealand require assistance due to intellectually disabling conditions. Life-long support is necessary and can include significant health, communication, mobility, literacy and social interaction needs. What intellectual disability' means has undergone a major change of focus in the last fifty years in this country. Since the 1970s, it has come to refer to the assistance people with an assessment of functional limitation require to live an ordinary life in their local community. This change has highlighted the need to resolve the many environmental and social barriers that compromised people's life-chances in the past. Many have been overcome, yet people in this group still experience many difficulties accessing the support needed to engage in intimate relationships.

This paper explores data about sexuality and intimacy support practice in New Zealand taken from interviews with direct support workers.

Service personnel's comments suggest that initiating support is not based on levels of assistance deemed to be required, but on whether the learning disabled individual concerned is 'capable' or 'not capable' of sustaining a sexual relationship. A key measure of entitlement is having been involved in a prior sexual experience. In relation to this adjudication, unsurprisingly learning disabled men are more often judged capable than women. Issues of gender difference underpinning the double standard involved in this process means that women are less likely to be pro-actively supported or that assistance for greater involvement in this area will be considered necessary.

These findings raise a number of questions for support practitioners. These include: what different best practice outcomes are needed so that clinicians and service personnel can engage more fully and openly with the nature of gender relations, sexual prejudices and oppressive practices that currently compromise learning disabled women's positive sense of sexual self.

**W211 - CHILDREN/YOUTH - 5 SEPTEMBER 2009 - ROOM 6****Child psychiatry and the care for mentally disabled children***A.P.J. Geelhoed, GGZ Friesland, DRACHTEN, The Netherlands**W.J. Vos, Bosman GGZ, ERMELO, The Netherlands*

Invitation for those involved in working with mentally disabled children having (possible) psychiatric problems or disorders. Parents and professionals are trying to improve the development of children with mental limitations. Child psychiatrists are at the moment gradually being involved in this specific area of child care and development.

Latest research results show clearly that mentally limited or disabled children very often combine mental handicaps with specific psychopathology. Therefore there is an increasing demand for psychiatric screening.

At the moment different forms of cooperation are developing between psychiatry and mental care. This cooperation, though basically a good thing, can also create ambiguity about availability, organisational aspects and responsibility for diagnostics and treatment. In other words. Which of the disciplines is leading. In other words is there basically a medical problem (psychiatry) or not (care)?

In this workshop we will describe the present situation in the Netherlands and start a discussion on how child psychiatrists in Europe are involved in this field of care.

After presenting the results of a survey held under Dutch child and youth psychiatrists and institutions for mentally disabled children the following questions will be addressed:

How many child psychiatrists are working with this specific group;

How is this psychiatric care organised and in what way are institutions cooperating.

Do the different professional participants cooperate well enough;

Are the various responsibilities recognised and organised;

What are the pitfalls.

After the presentation there will be plenty of time for discussion by the participants from the different attending European countries.

Aim of this workshop will be to create a platform for the different experiences in Europe and discuss the best ways of organising and providing childpsychiatric care to this specific group of mentally disabled children.

**Washington State Aggression Replacement Training (WSART) for youth with an intellectual disability***M. Bouaoud, A. Sluys, De Bascule, UTRECHT, The Netherlands*

To demonstrate the use of a modified version of the WSART (Goldstein, Glick, and Gibbs, 2000; Barnoski, 2004) for youth with intellectual disability (ID) and behaviour problems. The WSART content three parts: social skills, anger control and moral reasoning.

Although literature shows that youth with an intellectual disability have more emotional and behaviour problems than normal youth with a higher risk to develop psychiatric problems, delinquent, and criminal behaviour, evidenced based treatments for this population is sparse. Therefore we have adapted the WSART for youth with behaviour problems and ID.

The WSART was executed three times. In general, pupils find the training both intensive and instructive. The results will be presented with several case studies.

A modified version of the WSART is promising for the treatment of behaviour problems in youth with ID.

**W212 - DEMENTIA / DUAL DIAGNOSIS - 5 SEPTEMBER 2009 - RED ROOM****Good practice guidelines for the assessment, diagnosis, treatment and support of people with learning disabilities and dementia***K.D Dodd, Surrey & Borders Partnership NHS Foundation Trust, EPSOM, United Kingdom**A. Bush, Sheffield Health & Social Care Trust, SHEFFIELD, United Kingdom*

This presentation will explore the work undertaken by representatives from the Learning Disability Faculty of the British Psychological Society and the Royal College of Psychiatrists to develop guidance on the assessment, diagnosis, treatment and support of people with learning disabilities and dementia. The workshop will outline the process of development of the guidance and explore the content. Standards for the evaluation of local services have been developed and will be presented.

Double diagnosis: Mental disability and psychopathology, a psychiatric hospital is this the place to be? Under what conditions?

**Do we need specialized units?**

*L.B. Baetens, Medisch Kabinet Dr. G. Baetens, UKKEL, Belgium*

We follow one of our patients during his therapeutic program at St-Bernard, a psychiatric institute in Wallonia, Belgium, which includes a specialized unit for double diagnosis, started in March 2007. We will guide you through our clinical practice and its effects and try to articulate it in more theoretical bases.

Our theoretical bases are Dr. D. Winnicott therapeutic sessions and explications with children; his squiggles and the motion of transitional objects are interesting to set up 'therapeutic group sessions'. Also, F. Dolto, Maud Mannoni and Melanie Klein, Bergs and Balbo, Eva Marie Golder, are interesting authors. Basics of institutional therapy: Dr. J. Oury in France. Most important is the organisation of the teamwork and our relationship as differentiated subjects with the patient's subjects in different contexts.

From a medical point of view, there is much complexity in the pathology on an internistic and neurological level. Therefore, we have a psychiatrist and a general practiser, to differentiate the positions which are important in this therapeutical context. The staying in the hospital is for our patients just one specific period in the therapeutic process. This is why we need a network with different possible residential or ambulatory approaches which will be documented by our colleagues. Zonnelied residential setting, SUZA: ambulatory therapy with autists, concerto: create meetings where every therapeutic setting involved with a patient (double diagnosis) is invited to discuss about possibilities for care: home, institute, combination, ...

We would like to share with you the topics of our daily work: this of a specialized multidisciplinary team at the congress here in Amsterdam.

**W213 - PSYCHO ANALYSIS / TRAINING OF STAFF - 4 SEPTEMBER 2009 - BLACK ROOM****Take Care of Contact in Autism**

*S.O. Oosterlinck, E. Verhoeven, VZW Zonnelied BORCHTLOMBEEK, Belgium*  
*W. van Rossem, E. Weyts, UPC Sint-Kamillus, BIERBEEK, Belgium*

In this workshop, we focus on the specific characteristics of contact in autism, in adults with intellectual disabilities. What services do we have to provide, to offer them, a good quality of life?

Our approach is based on a psychoanalytic framework. The description and interpretation of a personal developmental history and the hypothesis of a structural diagnosis plays a crucial role. Starting from the analytic literature of the Hungarian school (I. Hermann, L. Szondi) and referring to the attachmenttheory we will focus on the beginning of psychic life, the primary basal relationships and their disruptions. Specific fragments from our daily practice will sharpen up a number of theoretical questions.

It is remarkable to notice that in autism, subjects are used to 'grasp' other people (they come very close) unlike this, they relate also in a 'glimpse' way to others (they quickly flutter around). This opposition can be clearly illustrated using the 'contactvector' (from a Szondian perspective). The 'contactual' interrelated dynamics are an efficient indicator for our daily clinical practice (tuning, coaptation, defining distance-closeness, ...). A fine tuning between the environmental stimuli and the demands of the autistic subject asks a very accurate and careful attention.

According to our way of thinking about this population, we assume that 'holding' plays an important role. Especially we wonder how we can translate this in our clinical practice. Teambuilding that focuses on coaptation, defining distance and closeness, is in this work an elementary and basic topic.

**The authentic dialogue**

*P.J.A.M. van Loon, Pameijer, ROTTERDAM, The Netherlands*

Nowadays, the professional has often to deal with a very complex situation. He has to give an answer on difficult questions and he has to make decisions on moral dilemmas. Often he has to do that on his own. He wants to serve his client but he also knows that the organisation, he is working with, has its own goal: control the situation. That can give tension and it makes the professional vulnerable. Working with people means dealing with dilemmas. An organisation demands of its Staff to work fast and therefore the professional translates the questions of the client in services that can be offered by the organisation.

This way of providing services to clients will not satisfied nor the client nor the professional. He wants to listen to the real question of the client. If he wants to do that, he has to change his concept of professionalism. I am convinced that the philosophy of Levinas can offer a contribution to a new professional concept.