Editorial

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Welcome to the final edition of 2016. Our first article covers an area that is often not discussed or acknowledged. That is, the reactions of people with profound intellectual disabilities (ID) to loss and bereavement. It is in living memory that people assumed that everyone with ID was incapable of experiencing feelings, emotions and poor mental health like those without ID. People with profound ID who experience separation and loss, are unlikely to respond in a way that is considered typical by the general population. There is an assumption by many that they are immune from suffering following loss due to difficulty in conceptualising, therefore protected from poor mental health. Currently there is a lack of knowledge into the mental health of people with profound ID and how they respond to and deal with issues such as separation and loss. As a result there is a lack of therapeutic direction and understanding of those who present with the most complex needs. This state of affairs means that the needs of people with profound ID can often be overlooked or not even acknowledged. The paper examines the evidence and puts forward recommendations of interventions for bereavement support and helping people with profound ID dealing with loss or separation.

Since the publication of a number of influential reports such as the Confidential Inquiry into the deaths of people with ID (Heslop *et al.*, 2013), equal treatment: closing the gap: a formal investigation into physical health inequalities experienced by people with learning disabilities and/or mental health problems (Disability Rights Commission, 2006), Healthcare for All (Michaels, 2008) and Death by Indifference (Mencap, 2007) that have highlighted inequalities trying to access healthcare; and the increased risk people with ID face in hospital, the need for increased awareness by clinicians and the public has been identified as a priority. As a result there has been an increased demand for training to address this issue. A fast emerging area is simulation training which is being increasingly used to improve awareness and skills of staff. The next two papers offer an insight into how simulation training is delivered in practice and has developed. These papers illustrate the use of simulation to different audiences and some of the developments in this area since the journal published "Using a simulation exercise to develop staff competence in a specialist inpatient service" (Hardy and Chaplin, 2010). The first article describes a training programme that was designed to increase awareness by improving knowledge and confidence of clinicians. This was part of a two phase educational strategy, in which the first stage sought to map to existing programmes at undergraduate and post graduate level and identify how improvements to the patient experience could be made. The second phase concentrated on the delivery of training across a number of organisations as part of a cross-agency partnership. The simulation was used in conjunction with eLearning, which was also used to target large numbers of staff outside of simulation to increase awareness and also help to prepare clinicians and staff undertaking the simulation-based training. The training was coproduced and facilitated with people with ID and feedback was sought at the time of training and also three months post training. Currently the project is undergoing evaluation, however, the authors offer us an insight into the feedback so far and illustrate the power of training delivered by people with ID to shift opinion on what people with ID can achieve and are capable of. Changes in attitude through increased awareness is also apparent in the second simulation article. This second offering examines a training pilot to medical students that was produced and run by people with ID with support from advocates. Often it is still the case that training focussing on ID is run solely by clinicians and when it training does involve people with ID there is often little input from people with ID in its production. This paper provides an important message. That is, not only does training from people with ID provide a better context to the problems and issues they face, but it changes attitudes and shifts opinions for the better, by letting the trainee focus on what people can do. Whilst acknowledging the anxiety of trainees who may harbour negative stereotypes about people with ID pre-training. It is these shifts in opinion and increased awareness that improves confidence whilst helping build a competent and capable workforce.

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The fourth article offers a perspective from clinical psychology, and examines the potential role and contribution from psychology following the Francis Report and Winterbourne View. In setting the scene the paper does not dwell on the tragic recent past but looks to the future and the discussions within the profession on the need for psychological responsibility. The paper is inspired by discussions and reflections within a local psychology team who examined current practice and asked the question what they could offer the compassion agenda and begin to shift opinion and improve practice across professional groups.

For the final paper we present a short case study which highlights the potential vulnerability of people with Aspergers syndrome. Although Asperger's syndrome is not an ID, this group due to lack of funding are often referred to ID or MHID services I the absence of specialist provision. Often clinicians feel unequipped to work with this group as many of them come to the attention of services when in crisis. This case study offers a brief overview of Aspergers and offending and looks at an issue that a number of clinicians struggle with, i.e. separating fantasy from reality and the difficulties faced by people with Asperger's syndrome in hospital.

References

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