Mental Health of Learning Disabilities Unit

Providing assessment and treatment for people with learning disabilities and complex mental health problems.
» It’s felt like a long year, but there’s light at the end of the tunnel. What I really hope is that the good work will carry on and stand him in good stead for the future. « Sandra, carer
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Service overview

We offer evidence-based assessment and treatment for adults with learning disabilities who present with complex or atypical mental health needs and require inpatient support.

We address specific clinical referral questions affecting people’s health and related quality of life issues. These include future service requirements, risk assessment and management, clarification of diagnosis and evaluation or initiation of prescribed medication.

Our treatment is offered within non-secure accommodation and has been proven to bring significant long-term care and cost benefits for referrers, as people are allowed to recover in less restrictive settings. This is designed to avoid lengthy hospital admissions and the need for readmission.

King’s Health Partners
Our service is part of the Behavioural and Developmental Psychiatry Clinical Academic Group. SLaM has joined with King’s College London, Guy’s and St Thomas’ NHS Foundation Trust, and King’s College NHS Foundation Trust to establish King’s Health Partners, an Academic Health Sciences Centre. King’s Health Partners involves bringing clinical care, research and education much more closely together. Our aim is to reduce the time it takes for research discoveries and medical breakthroughs to become routine clinical practice. This will lead to better care and treatment for patients.

Visit www.kingshealthpartners.org for more information.
Our philosophy

Our aim is to promote the values of empowerment, inclusion, rights, control and independent living for people with learning disabilities, including those with complex mental health needs.

We are committed to facilitating and promoting mental well-being, to allow our patients to return to a life in the community. We help people to fulfil their aspirations, whilst providing the support they need to achieve this.

Our service is also committed to promoting research and providing evidence to influence clinical practice and service provision in the future. We are committed to providing training and education locally and nationally to ensure that the mental health needs of people with learning disabilities are met by health, social care and third sector providers.

» We may have lived with him for his whole life, but the team has helped us to understand his autism better. They’ve been wonderful. « Sandra, carer
Who is our service for?

Our specialist service is for adults with learning disabilities who present with complex or atypical mental health needs.

We help people resolve their mental health difficulties and build their skills and capacity to deal with difficulties they may face in the future.

We identify a person’s strengths as well as their treatment needs. The person’s capacity to consent to an admission and treatment is regularly reviewed and the necessary safeguards are put in place.

Eligibility

› 18+ years
› Male or female
› People with learning disabilities who require specialist assessment and treatment of their mental health needs, and whose needs cannot be met by their local service provider
› Both informal patients and those detained under the Mental Health Act
› Local services must remain involved throughout the admission and attend regular meetings

Exclusion

› Clinical appropriateness for inpatient treatment is determined at the initial assessment, with all referrals assessed prior to admission

» I like the walking and occupational therapy activities. « John
Interventions

Our interventions are designed to address a range of mental health needs including co-morbid neurodevelopmental and physical health problems. Our interventions are evidence-based and person-centred.

**Specialist assessment**
Our assessment includes an in-depth review of psychiatric, medical, psychological and social history as well as previous treatment, with input from the referring team, family and carers and scrutiny of historical records. We assess each person’s strengths and difficulties with the aim of understanding their current distress and providing support that can be replicated in the community. The assessment covers mental health, neurodevelopmental disorders, physical health and social needs.

**Cognitive or neurocognitive assessment**
A specialist cognitive or neurocognitive assessment may help to understand the person’s particular cognitive profile or to differentiate between specific cognitive deficits which impact on a function.

Behavioural observations are undertaken to establish baseline measures of behaviours and measure the degree of behavioural change. Formal observational systems are used, like momentary time sampling. This allows our team to formulate an understanding of the person’s behavioural difficulties and to sequentially test out hypotheses with interventions and re-evaluation. This enables the development of management strategies to deal with difficult behaviours.

**Communication assessment**
People with learning disabilities often have communication difficulties that impact on the assessment and delivery of therapy for their mental health needs. This is sometimes associated with autistic spectrum disorder. A specialist assessment may facilitate communication skills and strategies, or allow for a more communicative environment to be put in place either on the unit or in the community.

**Assessment of daily living skills**
This includes social, domestic and life skills, and the use of standardised assessment tools like HALO (Hampshire Assessment for Living with Others). This supports the person’s needs assessment by identifying their strengths and areas which require development and support. It contributes to their overall clinical formulation, care plan, discharge plan and placement profile.

**Cognitive behavioural and other psychotherapeutic treatment**
These interventions include family and systemic work. CBT is recognised as one of the most promising treatments for a range of mental health problems. We adapt the therapeutic process to make CBT accessible and meaningful for people with learning disabilities, helping to identify emotions and linking emotions to events or difficult behaviours. Other psychotherapeutic approaches are similarly adapted using the most recent evidence base.
» The team has invested a lot of time in his diagnosis. They’ve been able to shed a different light on things and it’s good to be able to link behaviour to the diagnosis rather than to him. « Sandra, carer

**Medication review**
Our expert pharmacists and psychiatrists monitor and review the use of pharmacological treatments and place an emphasis on optimising mental and physical health whilst minimising side-effects.

**Specialist nursing care**
Our nursing team offers care, that promotes physical and mental well-being. Care plans are designed and delivered with input from psychologists, occupational therapy and other professionals as required.

**Physical health and well-being**
People with learning disabilities often have high physical health needs that may have gone unrecognised and untreated. Our service develops and maintains good relationships with primary care and secondary physical healthcare professionals. We advocate for and promote physical health screening, healthy lifestyles and well-being.

**Risk assessment and management plans**
People may be referred to our service because they exhibit behaviours that put themselves or others at risk. A formal assessment of the person’s risk is a key component of the multidisciplinary assessment and team interventions. Our service adopts a risk adverse approach in order to promote, support and enhance independent daily living skills. Risk assessment and management is integral to the care programme approach.

**Placement assessment**
Our service works with the referring team to develop a placement profile, with recommendations about accommodation, staffing needs, continuing psychiatric and psychological treatment and support. If necessary, we work with new service providers, allowing a positive transition from our service back into the community.

**Discharge planning**
Our discharge planning begins early in the admission and involves the patient, carers and family as well as the referring team. As part of the care programme approach we assess relapse indicators, work on relapse prevention, offer training in the home and to community support workers or family, and agree on a crisis plan. We help identify a suitable placement in liaison with the referring team, should this be required. A comprehensive discharge plan is shared with the GP and other professionals. The patient is offered an accessible copy of their care plan and is encouraged to be actively involved in its development.
Weekly programme

<table>
<thead>
<tr>
<th>Time</th>
<th>MONDAY</th>
<th>TUESDAY</th>
<th>WEDNESDAY</th>
<th>THURSDAY</th>
<th>FRIDAY</th>
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<tr>
<td>10.00 – 10.30</td>
<td>Morning meeting</td>
<td>Morning meeting</td>
<td>Morning meeting</td>
<td>Morning meeting Medication awareness</td>
<td>Morning meeting</td>
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<tr>
<td>10.30 – 12.00</td>
<td>Free time</td>
<td>Shopping and budgeting trip or community centre 10.30 – 11.30</td>
<td>Relaxation 11.00 – 11.45</td>
<td>Art 10.30 – 11.45</td>
<td>Community centre 10.30 – 11.30</td>
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<td>12.00 – 13.00</td>
<td>Lunch</td>
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<tr>
<td>13.00 – 16.00</td>
<td>Circuit training at the gym 14.00 – 15.00</td>
<td>Games in the lounge 13.30 – 15.30</td>
<td>Woodwork 13.30 – 15.30</td>
<td>Healthy eating 14.00 – 16.00</td>
<td>Community meeting 14.00 – 15.00</td>
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<tr>
<td>16.30 – 18.00</td>
<td>Walking group 16.30 – 17.15</td>
<td>Cookery group and dinner 16.30 – 17.45</td>
<td>Free time</td>
<td>Men’s therapy group</td>
<td>Free time</td>
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<tr>
<td>18.00 – 19.00</td>
<td>Dinner</td>
<td>Dinner</td>
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<td>19.00 – 21.00</td>
<td>Patient protected therapeutic time 19.00 – 19.30</td>
<td>Free time</td>
<td>Club night at the community centre 18.30 – 21.00</td>
<td>Free time</td>
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» As a family taking part in these kinds of processes, you sometimes wonder whether you’re heard, but they seem to think we have a lot to contribute, which is nice. It’s been a really empowering process. «  Sandra, carer
Our care model

**ASSESSMENT**
- Evidence-based
- Co-ordinated multidisciplinary approach
- Functional assessment of behaviour
- Multidisciplinary formulation
- Ongoing evaluation and feedback

**EDUCATION, WORK AND OPPORTUNITIES**
- Psychosocial education
- Self advocacy
- Self-esteem
- Self management
- Positive programming
- Communicative environment

**RISK MANAGEMENT**
- Risk assessment
- Risk reduction strategies
- Positive risk-taking
- Drug and alcohol awareness
- Appropriate sexual behaviour
- Discharge planning
- Strategies to support a capable environment
- Appropriate use of MHA, MCA and DOLs legislation

**FAMILIES AND CARERS**
- Support and interventions to understand the needs of the patient
- Information to access community resources
- Facilitating and developing new coping strategies
- Local support networks

**THERAPIES**
- Psychological therapies
- Occupational therapy
- Speech and language therapy
- Behaviour interventions and management
- Development of coping strategies
- Positive behavioural support
- Creative therapies

**PATIENT**
- Promoting mental well-being
- Promoting physical well-being
- Physical safety
- Person-centred approaches
- Speaking up for yourself
- Skills development
- Healthy living
- Understanding of rights

**PHYSICAL HEALTH AND PHARMACOLOGY**
- Evidence-based practice
- Review, rationalisation and initiation of medication
- Physical health checks
- Healthy lifestyle review
- Health promotion
Our care pathway

- Referral received and funding approved
- Assessment
- Recommend treatment package
- Treatment
- Review
- Discharged with care plan approach

Criteria not met, recommendation for alternative referral
Further treatment required
Outcomes

Our service helps people resolve their mental health difficulties and enables both patients and carers to develop an understanding of any mental health problems, their likely causes and consequences.

Outcomes may include:

- Rigorous assessment of learning disability and level of functioning
- Treatment plan for co-morbid disorders
- Decreased challenging and forensic behaviour
- Decreased risk to self and others
- Decreased vulnerability
- Optimum function and improved quality of life
- Future care needs identified in a placement profile
- Discharge planning with the referrer
- Person placed in a less restrictive environment
- Staff training and ongoing support via our outreach service
- Positive working relationships between local services, national services and families or carers

Patient Experience Data Intelligence Centre (PEDIC)

Our service uses the PEDIC system, which helps us evaluate our treatment. PEDIC measures patient satisfaction and enables our team to develop and improve our interventions to best suit the needs of our patients.

**Graph 1** PEDIC results showed that 94% of our patients thought the information they received prior to admission was good or very good.

**Graph 2** shows that 82% of our patients feel the way they are involved in their care plan is good or very good.

**Graph 3** 96% of patients responded positively when asked about being well-occupied during their admission, which aids social inclusion and recovery.
His autism diagnosis has always felt a bit vague and one thing they’ve done is explain to us more clearly what his condition looks like day-to-day, and how it relates to his learning disability. « Sandra, carer
Research

Our service has strong links with the Estia Centre, which is a national and international research centre specialising in the mental health of adults with learning disabilities.

Our research focuses on understanding the issues that are faced by people with learning disabilities who have a mental health problem and reflecting our findings through the development of future treatments.

Our research projects have informed a number of evidence-based academic and training publications which are used worldwide.

We also work closely with the forensic and neuro-developmental science department at the Institute of Psychiatry, King’s College London, whose research aims to better understand human brain development, functioning and abnormalities.

www.estiacentre.org

» The staff are wonderful and he gets on very, very well with his psychiatrist. «  Greg, carer
Our facilities

Our inpatient unit is based at the Bethlem Royal Hospital. The hospital offers the perfect therapeutic environment for promoting recovery, set in 270 acres of green space, with woodland and meadows that are designated as a ‘site of importance for nature conservation’.

Our facilities include a gym, swimming pool and an onsite art gallery. An extensive occupational therapy programme includes activities like computing, creative art, sewing and textiles, aikido, drumming, drama, gardening, community art projects, woodwork, digital photography, karaoke, an organic kitchen garden and pottery. Our patients also have the use of the community centre, chapel and museum.

Our recently refurbished unit is on the ground floor and has wheelchair access. Patients are encouraged to make choices for themselves throughout their stay, like choosing the colours of the soft furnishings they would like in their bedrooms.

Facilities on the ward include:

- Separate areas for men and women
- A modern sitting room and dining area
- Space for intensive support, which can also be used to trial independent living
- Designated therapy rooms
- An off-the-ward family room for visitors
Our team

Our clinical team includes psychiatrists, nurses, psychologists, occupational therapists and behavioural support specialists, who bring together a range of skills that benefit each patient.

Dr Jean O’Hara MBBS, FRCPsych
Clinical Director | Consultant Psychiatrist

Dr Jean O’Hara is the clinical director for the Behavioural and Developmental Psychiatry Clinical Academic Group, consultant psychiatrist at the Trust, and works with the Estia Centre as the clinical director.

She has been clinical director for both the mental health of learning disabilities division and the Estia Centre since 2008. She is also a visiting research associate at the Institute of Psychiatry, King’s College London.

Dr O’Hara is a fellow of the Royal College of Psychiatrists and holds an extensive postgraduate medical education portfolio with the London Deanery School of Psychiatry. She completed her Bachelor of Medicine and Bachelor of Surgery at the University of London in 1983.

Research
Dr O’Hara’s research interests include health service research e.g. service models, service evaluations and vulnerability. She has initiated research projects in ethnicity and developed training for carers on ethnicity and diversity.

Adults with learning disabilities: a practical approach for health professionals was published in 1997 and was the first handbook for primary care. Dr O’Hara also co-edited to Intellectual Disability and Ill-Health: a review of the evidence. Published in 2010, it was the first comprehensive world-wide literature review of health co-morbidity in learning disabilities.
Our team continued

Dr Shaun Michael Gravestock MBBS, FRCPsych
Consultant Psychiatrist

Dr Shaun Michael Gravestock is a consultant psychiatrist who specialises in the mental health of learning disabilities. He has overall clinical responsibility for the unit.

He is also an honorary senior lecturer at the Estia Centre. He is also an editorial board member of the Advances in Mental Health of Learning Disabilities journal.

Dr Gravestock is a member of the Royal College of Psychiatrist’s learning disability faculty and executive and project lead for the family carer strategy working group.

Research
Dr Gravestock is a co-author of the Diagnostic Criteria for Learning Disabilities (DC-LD 2001), published by the Royal College of Psychiatrists. He is also responsible for writing diagnostic criteria for eating disorders, personality disorders and problem behaviours.
Dr Colin Hemmings  BSc, MBBS, MSc, MA, MRCPsych
Consultant Psychiatrist

Dr Colin Hemmings is the service line leader and a consultant psychiatrist for Mental Health of Learning Disabilities in the Trust.

He is a visiting research associate at the Institute of Psychiatry, King’s College London.

Dr Hemmings has degrees in medicine, cellular and molecular pathology, psychiatric theory and research and medical anthropology. He is currently undertaking research towards an MD (Res) degree at the Institute of Psychiatry. He is a peer reviewer for several academic journals and member of the editorial board for the Advances in Mental Health and Learning Disabilities journal.

Research
His academic interests include psychosis in learning disabilities, mental health services for people with learning disabilities and the relationship between psychiatric symptoms and behavioural problems in people with learning disabilities.
Our team continued

Lynette Kennedy
Service Line Manager

Lynette Kennedy is the service line manager for the Mental Health of Learning Disabilities Unit. She is responsible for the effective daily running of the service, including the operational management of team leaders and professional heads.

Background
Lynette studied at Stoke Mandeville Hospital in Buckinghamshire and became qualified as a registered nurse for people with learning disabilities in 1996. She then moved to Leeds to work in a low secure mental health facility, before starting work for the Trust in 1997. Lynette first worked for the Mental Impairment Evaluation and Treatment Service, before she moved to the Mental Health of Learning Disabilities Unit. After five years, Lynette became the team manager, before being appointed to her current position of service line manager.

Other role
Lynette was part of the Royal College of Nursing’s mental health nursing of adults with learning disabilities guide steering group. She co-authored the *Improving services through partnership and consultation: a case example* article, published in *Advances in Mental Health and Intellectual Disabilities*, March 2011 and presented at the 5th and 7th *European Congress of Mental Health in Intellectual Disability* conferences in Barcelona (2007) and Amsterdam (2009).
Training and consultancy

An integral part of our work is our relationship with the Estia Centre, a training and research resource specialising in the mental health needs of adults with the learning disabilities.

The Estia Centre is a training, research and development resource for those who support adults with learning disabilities and additional mental health needs. The Estia Centre is an integral part of the local services for people with learning disabilities provided by the Trust.

The Estia Centre supports the development of a competent workforce, from support staff to experienced managers and from a variety of services. By working in close collaboration with clinical services, we aim to improve the care of people with learning disabilities, especially those with additional mental health needs, through evidence-based practice. To discuss our training packages further, please do not hesitate to contact Steven Hardy on steve.hardy@kcl.ac.uk or on 020 3228 9744

For more information on the Estia Centre please visit www.estiacentre.org
My brother has autism and learning difficulties.

There was a breakdown in residential care. He’d been living somewhere for 18 years and had to be moved to a private clinic in Waterloo, which then closed down, so they were frantic to find him somewhere else.

To be honest, I was concerned when they suggested the Bethlem. I wasn’t sure it was the right placement for him because I only knew it as a mental hospital. What learning difficulties support did they have? I was worried he was being sent to the Bethlem just because they didn’t know what else to do. But, they told us that this was a specialist unit for learning difficulties and assured us he would be okay, so he moved there in May.

They have built a good rapport with him.

It can be difficult to get a sense of his inner world, because although he has some language skills, he can’t really process and express his feelings. I do think he felt a bit frightened about the move – and sad initially – autistic people like structure and this was a big change. He got on with it though.

The staff are definitely fond of him. And, although he doesn’t have the ability to connect with the other residents, they seem to be quite protective towards him. He has the lowest ability on the ward when it comes to looking after himself physically, so he could be vulnerable, but he hasn’t been, and the others have looked after him.

My mum, my dad and myself like to visit him two or three times a week, and what I really liked was that we were included in things from the very beginning – with all his processes and much of his care. He doesn’t like people taking his blood, for instance, so they asked me to come in to be with him.

The staff have been really supportive and respectful.

They are really caring and it’s been a really transparent process. We have always been made aware of any wobbles and, in these cases, the team has considered the triggers, looked at what they can perhaps do better for him and what we, as his family, can also do to help. He challenged the medication a bit at the start, but they were able to get support from the old placement.

We’ve always been invited to his care programme approach meetings and feel we have a voice. Though there are a variety of professionals in these meetings, our opinion seems to carry an equal weight and our suggestions are taken on board. As a family taking part in these kinds of processes, you sometimes wonder whether you’re heard, but they seem to think we have a lot to contribute, which is nice. It’s been a really empowering process.

They’ve helped us to understand his autism better.

We may have lived with him for his whole life, but the team has helped us to understand his autism better. They’ve been wonderful.
His autism diagnosis has always felt a bit vague actually and one thing they’ve done is explain to us more clearly what his condition looks like day-to-day, and how it relates to his learning disability. He can sometimes stand too close to people and they have helped us unpack behaviour like that – to realise that he doesn’t really have the usual awareness of space and social rules.

The staff have a lot of empathy too. At one stage, he didn’t look well when he started on new medication and we told them how worried we were. They took the time to tell us what was happening and explained that the side-effects would wear off. We’ve always felt comfortable to ask and they have always given clear explanations. We could even go home, do our own research and come back to them with questions if we wanted.

“**They’ve helped us through the daunting processes too.**”

He had a tribunal as part of the sectioning process and that felt a little daunting because of the cross-examination and panel. But the staff explained what was going to happen and it felt like we were respected at every stage. He had a solicitor in the tribunal and she was also very good.

I think they admire the support we give him actually. I feel we’ve been held in high regard in a way. They seem happy he has somebody – that his family is behind him.

So, this has been eye-opening for me because, like I said, I started from a place where I wasn’t sure if the Bethlem would be right for him. I wanted to get him in and out as quickly as possible, but the team hasn’t rushed the process, which is really good. They have wanted to be thorough so he won’t need to be re-admitted.

“**The team has invested a lot of time in his diagnosis.**”

They’ve been able to shed a different light on things and it’s good to be able to link behaviour to the diagnosis rather than to him. He has had enough labels thrust upon him and words like ‘difficult’ or ‘challenging behaviour’ can have consequences in the future.

At the end of the month, he’s actually moving out of hospital and into somewhere else, and it seems like a good time for him to resettle. Before that happens, the staff from the new place are coming to the Bethlem to work with him for a couple of days. So, the care planning process is a thorough one.

It’s felt like a long year, but there’s light at the end of the tunnel. What I really hope is that the good work will carry on and stand him in good stead for the future.


Claudia

“He suffered brain damage during pregnancy.”

I was only seven months pregnant when Thomas was born, so he was very premature. He weighed just three pounds and looked like a little doll. He was born in the middle of the night and the next morning I found out he’d suffered brain damage due to a lack of oxygen during pregnancy.

He came home at 12 weeks old weighing just five pounds and they told us his difficulties would probably become more obvious as he got older. He did seem to develop late with things like feeding, crawling, walking and talking, and he was rushed into hospital again with suspected meningitis while he was still a baby – something they think might have caused further brain damage.

He was at a special school until he was 16. But, apart from the regular teenager issues, there weren’t really many difficulties. A couple of times he’d bang his head against a wall, though this didn’t seem mysterious at the time.

“He spent seven years in his own flat before he became unwell.”

After school he got into college and started living on his own. He worked in a kitchen and got council accommodation because of his learning disabilities.

He couldn’t keep his food down and lost lots of weight, so he came to stay with us and after tests at the hospital he was put on insulin. He coped, but we saw significant changes. He didn’t seem his usual bubbly self. I can’t remember him having another job after that – he was 28 then and is 35 now.

Life went on, but I believe he started to get bored. He definitely stopped doing things he liked, like football and walking the dog.

“Things went downhill when his father and I split.”

Thomas is very family-oriented – he always felt we should be living as one family. He started telling us he had things wrong with him. He regressed, like a form of depression. And the more he lay on the settee at home, the worse he got.

One day, my daughter rang me at work because she was concerned about him. He was sat on his own singing nursery rhymes and when I came home he didn’t look good. He also mentioned he wanted to jump out of the window.

Within ten minutes of someone visiting from the local mental health team, Thomas ran out the door, down the street and threw himself in front of a moving van. Luckily he wasn’t injured and I took him straight to the GP surgery, where I literally sat on him to keep him there.

“He was admitted to the mental health unit at the local hospital.”
I was relieved because I thought he’d be getting the best help, but it wasn’t a nice experience at that hospital. When he rang me distressed one day, I went to see him and he’d been banging his head. He was very frightened; he’d been restrained and was badly bruised. I felt really guilty and got him transferred to the Bethlem.

He was detained at the Bethlem Royal Hospital under section 3, but we’ve never had occasion to be unhappy with him there. When he went for a member of staff and had to be restrained, they did it in the right way – not how it was done before.

“I can’t remember the first time he heard voices.”

After nine months, he was back in his flat. I can’t say he was the son I knew before, but he was a lot better. The Bethlem supported him, but he became ill again. There were episodes when he didn’t walk and when I was out he’d say he’d fallen down the stairs, even though there wasn’t a mark on him.

He told us voices had been telling him to do things. I’ve never heard him talking to them, but I have heard him telling them to go away. It does seem that a lot of what’s happened has come through the voices actually.

One time, he set fire to himself at home. He was on Christmas leave from the Bethlem – it had been a lovely Christmas – and he wasn’t happy about going back. We went out to the shops and left him with his sister, but while she was running a bath upstairs he put the gas burner on in the kitchen and laid his t-shirt on it. Of course, it ignited and he then tried to take it off and burned his hands and forehead.

His t-shirt was still alight when we got back. I still remember him on the stretcher... and the blue lights to the hospital. He went back to the Bethlem heavily bandaged.

“I’m hoping we can find him somewhere he can settle.”

People deal with depression in different ways, but my poor daughter was so upset by the fire incident. He seems to target me – when he’s suicidal, he always calls Mum. People have said it’s like a threat, but I don’t like to see it that way. I’ve taken him to the toilet with me because I couldn’t leave him alone. He has a personality disorder and behavioural issues so he’s crafty, but we’ve coped.

He’s been at the Bethlem for a couple years and he’s quite well, even though he doesn’t see it that way. The staff are wonderful and he gets on very, very well with his psychiatrist.

I don’t see an end to the story at the moment, to be honest, but his social worker is looking for placement opportunities. They found a supportive living facility recently and he didn’t last a week. She has a hard job really because his needs are split between mental health and learning difficulties. We’re working on it though, together with the Bethlem.
Referring to our service

Referrals are accepted from consultant psychiatrists, GPs and GP consortia.

Mental Health of
Learning Disabilities Unit
Fitzmary One
Bethlem Royal Hospital
Monks Orchard Road
Beckenham BR3 3BX

T: 020 3228 9742
F: 020 3228 9749
lynette.kennedy@slam.nhs.uk
www.national.slam.nhs.uk

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» People with learning disabilities present with complex symptoms, behaviours and needs. Understanding this is a complex task and requires a co-ordinated approach to assessment, which we provide. «

Dr Jean O’Hara