Faculty of the Psychiatry of Intellectual Disability

Newsletter

December 2025

Contents

Editorial

Dr

Unsa Athar

ST3 Psychiatry of Intellectual Disability

Editor – in – Chief

"Psychiatry was one of the first fields to practise precision medicine – an extension of tailoring treatment to the individual. Now, we must take this further. Our years of training enable us to personalise care in ways that no algorithm or guideline can replicate. By reclaiming the full scope of our expertise, we can improve patient outcomes and safeguard the future of our profession. Let us not fall into the trap of letting our medical identity be reduced to medical prescriptions. Our role is far greater, and, at times, we need to remind both others and us of that fact."

Reading these words from the College Officers in *Insight (Spring 2025)* left me with a deep sense of relatability. In my training so far, I have seen psychiatrists function as leaders, prescribers, clinicians, and mentors. My second placement was in Psychiatry of Intellectual Disability (ID), where I witnessed the profound impact of clinical excellence through leadership and containment by the consultant psychiatrist. One and a half years later, I now find myself leading the Editorial Committee of this Newsletter. As Editor-in-Chief for the 2025–2026 term, I hope to make this platform a space of expression for all who contribute to advancing the field of Psychiatry of Intellectual Disability. Our patients deserve clinicians who are not only skilled but also advocates and leaders.

With this vision, the Editorial Committee proudly presents the Winter 2025 edition. This issue begins with messages from our Chair, Academic Secretary, and Higher Training Representative. We include a heartfelt obituary for John Anderson Oliver Russell. Professor Rohit Shankar and esteemed colleagues summarise their recent work in shaping conversations about the future of Psychiatry of Intellectual Disability. Dr. Carmody contributes the second article in her series, inviting us to explore the breadth of careers in ID psychiatry.

In our Reflections section, Raena Swami – our PsychStar Medical Student – shares her journey of discovering a passion for ID psychiatry. Dr. Turner follows with a thought-provoking reflection on end-of-life care in ID settings. The pressing topic of Artificial Intelligence also finds its place here, with leaders at Cygnet demonstrating how virtual reality is being harnessed to benefit patients.

Our Audit section highlights important work from Scotland on reforming epilepsy training needs within ID psychiatry. We also have an audit on STOMP (Stopping Over-Medication of People with a Learning Disability, Autism, or Both). As leaders, we will continue to champion STOMP until it becomes second nature in clinical practice. We conclude with a colourful article that talks about the good, the bad and the ugly of autism depiction in media.

A special thanks to Dr. Maruf Mustapha for guiding me through my first experience as a chief editor!

I hope you enjoy reading this edition as much as I enjoyed compiling it. On behalf of the Editorial Committee, I wish you a Merry Christmas, a Happy New Year, and joyful holidays.

Chair's Message

Dr Inder Sawhney

Chair of Faculty of Psychiatry of Intellectual Disability

Dear Colleagues,

I hope this message finds you well.

Faculty Executive Committee Elections

I would like to bring to your attention the upcoming Faculty Executive Committee elections in 2026, for the vacancies of the three Officer roles (Chair, Vice Chair, and Finance Officer) and seven Elected Member positions. Please note the nominations opened on 1 December and the closing date is 6 February and voting commences from 18 March.

Nomination information has been sent to all eligible Faculty members on 1 December.

I strongly urge you to consider putting your name forward and to encourage colleagues in doing the same; it is a valuable opportunity to serve our wider fraternity.

Health inequalities: Ethnic minority survey

It is well established that people with intellectual disability from ethnic minority backgrounds have poorer outcomes compared to their white counterparts. To understand and explore the barriers people with intellectual disability from ethnic minorities face in accessing treatment in intellectual disability services; we have developed a survey to ascertain clinicians' perceptions and experiences regarding ethnic disparities. I would be incredibly grateful if you could spare a few minutes, it should take no more than 10 minutes to complete the survey. Please also do share the link with your wider multidisciplinary team (MDT), as everyone's insights will be invaluable in shaping future improvements in access and equity.

SURVEY LINK

Mental Health Act Reform

The Mental Health Act Bill is now in the House of Commons for its third reading, where it will be considered for amendments before receiving Royal Assent. It is anticipated the implementation of the Act will be phased out over a period of time. Whilst implementation of the Act pertaining to people with learning disabilities is expected to take several years, as a faculty we remain concerned about its ramification and unintended consequences on this cohort. We are actively discussing how best to equip services to proactively prepare for the changes in the Act, put in safeguards and monitor and evaluate its impact on the population we serve.

Down Syndrome Act

I wanted to bring to your attention the consultation on the draft statutory guidance under the Down Syndrome Act 2022 has been launched. The consultation will close on 28 January 2026.

Individuals can respond to the consultation via this link: Down Syndrome Act 2022 draft statutory guidance - GOV.UK. Please do share this widely to ensure that the communities you represent are aware of the consultation and they can contribute and share their views.

Terminally Ill Adults (End of Life) Bill for England and Wales

The bill is now in Parliament for further scrutiny and amendments. The College has submitted written evidence to the members of the House of Lords. The submission focussed on the impact of proposed legislation on people with, mental disorders, intellectual disabilities & neurodevelopmental conditions and made several recommendations. One of the key recommendations specified the role of psychiatrist in the proposed legislation and for there to be no professional obligation for psychiatrists to raise AD with patients (as in not deemed to be a treatment) and there needs to be a central, opt-in register established for psychiatrists who are eligible and willing to undertake assessments for the purposes of assisted dying/assisted suicide.

UK Learning Disability Professional Senate

I wanted to bring to your attention the recent Learning Disability Professional Senate | bill briefing. The Senate has made several key recommendations aimed at sustainably addressing the implementation gap for people with learning disabilities. These changes promise broader benefits for individuals with learning disability, their families, and society at large.

Spring conference

A date for your diaries well in advance, the Faculty Spring Conference is on **24 April 2026** at RCPsych, London.

If the recent Autumn Conference in Leicester was anything to go by, this promises to be another outstanding event. Our Academic Secretary, Dr Samuel Trumans, supported by Dr Ezhil Anand have already started working on an exciting and impactful programme, and I strongly encourage you to save the date and join us. It was absolutely wonderful to connect with many of you at our recent Annual Residential Faculty Conference in Leicester.

Winter is on its way, stay safe, keep warm, and do not let those seasonal bugs catch you off guard!

Warm regards,

Inder Sawhney
ID Faculty Chair

A Message from the Academic Secretary

Dr Samuel Tromans

Academic Secretary and Executive Committee Member, Faculty of Psychiatry of Intellectual Disability

RCPsych Faculty of Psychiatry of Intellectual Disability Conference: 7th to 8th October 2025

I would like to thank all the psychiatrists across the faculty who attended our Faculty of Psychiatry of Intellectual Disability Spring Conference event, held as an in-person event at Voco Hotel, Leicester.

The event was an enormous success, with a fantastic selection of speakers discussing clinical practice, research, and their lived experience. I would like to thank all of our speakers and workshop presenters for their invaluable contributions to the event and giving their time to prepare and deliver such excellent talks and workshop sessions. I would also like to thank the Singing for the Soul Choir, who provided their wonderful singing talent at the end of day one of the conference. The conference feedback was incredibly positive, with a mean average rating of 8.20 out of ten among attendees.

I would also like to extend my congratulations to all of the Faculty Prize winners from this year's event, including James Hulme, Sarah Pape, Thomas Rourke, Moira Walker, and Oksana Zinchenko. The standard of submissions for Prizes this year was excellent, and it is wonderful to see how much academic talent exists within our faculty. Many thanks also to colleagues who kindly agreed to judge for these Prizes.

Finally, I would also like to give my thanks to the Faculty Executive Committee and Royal College of Psychiatrists colleagues who were also heavily involved with the organisation of this year's conference, including Ezhil Anand, Mahesh Odiyoor, Rohit Shankar, Inder Sawhney, Michelle Braithwaite, and Rhianne Haresign.

I look forward to many of you joining us for our Faculty Spring Conference, the details of which will be announced in early 2026.

With best wishes,

Samuel Tromans
Academic Secretary

Higher Trainee Rep Update

Dr

Dr Irshad Hussain

Higher Training Representative Faculty of Psychiatry of Intellectual Disability

Dear colleagues,

I hope you have all had a positive start to this autumn. If you managed to read the last newsletter, you will be aware that I have taken the role of Higher Trainee Representative from Dr Abigail Swift, and I would like to begin by thanking her for her dedication and all the work she has done in representing trainees at national and Faculty level. It is a real privilege to take on this role, and I look forward to building on her excellent work in the months ahead.

I am particularly pleased to share that this year's Higher Trainee Welcome Event was successfully held on 10 November 2025. This yearly online programme is designed to welcome new, higher trainees, and this year we saw strong engagement from both new and continuing higher trainees in Intellectual Disability Psychiatry, as well as participation from several regional representatives. The agenda this year featured a range of sessions, including an overview of the ID Faculty, the history of Intellectual Disability Psychiatry, research opportunities and ongoing projects within the field, and genetic services relevant to ID psychiatry. Overall feedback was very positive; trainee colleagues found the programme both engaging and informative. I am grateful to Dr Indermeet Sawhney, Prof Rohit Shankar, Dr Peter Carpenter, Dr Jo Doherty, and Dr Mischa Mockett for contributing their time to the event. Trainees were also especially appreciative of Dr Liam Embliss's presentation on sustainability in intellectual disability practice and Dr Sophie Heywood's reflections on organising the ID Psychiatry trainee conference in November 2024. Last but not least, I would like to thank Dr Abigail Swift and Dr Maruf Mustapha for sharing their experiences and perspectives from their higher training journey. The event also offered me an opportunity to reflect on constructive feedback, particularly the suggestion to include a future session on navigating the training portfolio. For those who attended, I hope you found the programme meaningful, and please feel free to email me with any further ideas or suggestions.

Beyond the welcome event, there are a number of ongoing discussions within the faculty about issues that continue to affect training in Intellectual Disability Psychiatry across the UK. These include the availability and structure of special interest sessions, consistency in supervision standards across regions, and ensuring that training opportunities reflect the breadth of modern ID practice, including community, inpatient, forensic, and neurodevelopmental pathways.

The next ID Faculty Executive Committee meeting is scheduled for 15 January 2026 (Thursday), and I plan to facilitate a meeting with all the regional trainee representatives before then. The aim will be to gather feedback from each region on current training experiences, highlight areas of good practice, and identify challenges that need to be raised with the faculty. If you are a regional trainee representative and have not yet received my recent message through our WhatsApp channel, please do get in touch so I can ensure you are included in our next meeting.

I would also like to take this opportunity to acknowledge the continued enthusiasm shown by trainee colleagues across the country. This was evident at the recent Faculty conference in

Leicester, where, I understand, there was excellent trainee participation, including a number of poster submissions. Despite the challenges we face, such as service pressures and variable access to academic opportunities, there remains a strong and growing sense of community among ID trainees. The passion for improving the lives of, and advocating, people with intellectual disabilities, and for advancing the quality and visibility of our specialty, continues to be the defining feature of our training community.

Over the coming months, I will continue to work closely with the Faculty Executive, regional trainee representatives, and our academic and clinical leads to ensure that trainee voices are heard and reflected in Faculty discussions. Please don't hesitate to get in touch if there are issues you would like me to raise at the next meeting, or if you have suggestions for how we can improve communication between trainees nationally.

With best wishes,

Irshad Hussain

Higher Trainee Representative

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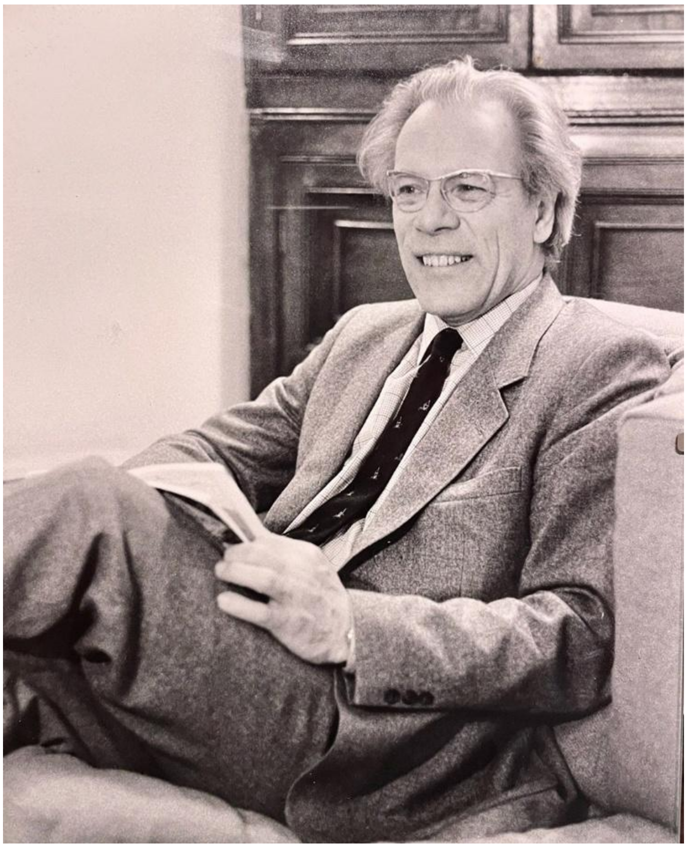
Obituary

John Anderson Oliver Russell MA BM BCh DPM FRCPsych (18 January 1936–25 July 2025)

Written by

Sheila the Baroness Hollins



Oliver attended Merchant Taylors' School in London, studied human physiology at St John's College, Oxford, and did his medical training at the Middlesex Hospital, London. His career spanned forty years as an NHS consultant psychiatrist, and a Reader in Mental Health at the University of Bristol, combining clinical practice and leadership with a strong applied research programme. He was a passionate advocate for closing extended stay mental handicap hospitals where he had started his career in psychiatry. In 1976, Oliver was appointed to the Department of Health's National Development Team, reporting on services for people with learning disabilities around the country.

At a local level he helped to transform services, giving people with learning disabilities the chance to live an 'ordinary life' in the community. The Wells Road Service was established in Bristol to assist in the resettlement of people from Farleigh Hospital, many of whom had been admitted as children at a time when 'mentally handicapped' children were not entitled to education.

In 1988, Oliver co-founded the Norah Fry Research Centre in Bristol, which undertook an extensive and very practical research programme on services for people with a learning disability, including how to improve primary care and supported housing provision. He travelled widely, taking his expertise to Australia, Canada, Slovakia and the USA and sharing the best of what he had learnt abroad on his return home.

In 1998 his last major post was a 3-year secondment as Senior Policy Adviser in Mental Health to the Department of Health, a position that I took over in 2001. His major achievement in this role was to shepherd the development of the Valuing People White Paper. This was the first government policy co-produced by people with personal and family experience of learning disability. One of these self-advocates was Jackie Downer, who had been training medical students at St George's with me, and accompanied me to an international Policy Academy arranged by the President's Committee on Mental Retardation in Washington DC. Oliver met Jackie there and used the action plan that emerged from this event to inform the development of 'Valuing People.' Jackie became his advisor when he was Chair of the Board of Trustees of the British Institute of Learning Disabilities and says of him that she "felt confident in this role because he always showed respect for me and listened carefully to my contributions." Jackie gave a tribute at Oliver's funeral.

Throughout his professional career including after his retirement, he was active in trying to improve the lives of people with learning disabilities through numerous voluntary organisations and professional advisory roles. Among these he was, at various times, an advisor to the government of Wales and its National Assembly, a trustee of Circles Network and later Honorary President, an advisor to the Foundation for People with Learning Disabilities and a Board member at the National Development Team.

Oliver was a 'gentle giant' in our field, always smiling, always optimistic despite facing many challenges. He was widely respected in the communities of people and families who really matter.

Oliver was a loyal friend to so many people and will be much missed. Especially of course by his wife for over 60 years, Rosemary, their three sons and eight grandchildren

Debates

The future of Psychiatry of Intellectual Disability and its importance amidst NHS policy omission

Professor Rohit Shankar MBE FRCPsych

Professor in developmental neuropsychiatry (Peninsula Medical School)

Consultant psychiatrist and clinical director for the adult intellectual disability services Cornwall Partnership NHS Foundation Trust

Associate Dean for Academic training Royal College of Psychiatrists

Psychiatry for people with intellectual disability in the UK stands at a crossroads. It has evolved into a mature, evidence-driven specialty central to addressing mental and physical health inequalities but now faces marginalisation within national policy most notably in the 2025 *NHS Fit for the Future 10-Year Health Plan* [1]. The juxtaposition between the specialty's progress and its omission from strategic national vision underscores a dangerous policy gap one that risks eroding decades of advancement toward equitable, rights-based care.

Drawing from two recent papers [2,3], we outline the developmental trajectory, current challenges, and future priorities for psychiatry of intellectual disability, and analyse the consequences of its exclusion from the NHS's strategic vision.

A century of transformation

Psychiatry of intellectual disability has evolved from a predominantly custodial model to one which is holistic, community-based, and person-centred. From the 1970s, deinstitutionalisation and legislative reforms redefined psychiatrists' roles, to one focusing on mental health assessment and management, overseeing management of comorbidities (autism, ADHD, epilepsy, dementia), through multidisciplinary collaboration.

The creation of the Faculty of Psychiatry of Intellectual Disability at the Royal College of Psychiatrists formalised training and leadership, positioning psychiatrists at the forefront of tackling the above complex matters.

Contemporary challenges

Persistent challenges remain such as fragmented service provision, heterogeneity of inpatient care, lack of outcome standardisation, challenges in psychiatric recruitment and training pathway delivery, as well as systemic underfunding. Specifically, there are challenges outlined in the more ideological and arguably less scientific approach to changes in the Mental Health legislation, issues of Long-Term Segregation (LTS) and Seclusion, Assisted Dying, ad hoc inpatient specialist psychiatric bed reduction and a monochromatic focus on *inappropriate* medication prescribing as opposed to *appropriate* medication prescribing [2-7].

Transforming Care agenda (2015), Building the Right Support (2015) as well as NHS Long-Term Plan (2019) all had a strong focus on improving community provisions for people with intellectual disability including better mainstream access [2]. but the parallel reductions in specialist inpatient beds have had challenges and consequence. It is also true that community services remain under-resourced and inconsistent, creating “new vulnerabilities” of crises, placement breakdowns, and avoidable deaths. The perception of inpatient admissions of people with intellectual disability being a “failure” rather than an opportunity to receive high quality care has been unfortunate [2,4-6]. A lack of investment in suitable psychiatric research in this disenfranchised population to understand best evidence has led to clinical practice being more dominated by anecdote and opinion rather than science [2,8].

Psychiatrists working with people with intellectual disability manage some of the most complex clinical presentations in medicine, i.e. people with physical and mental problems and communication difficulties. Yet systemic pressures continue to undermine care quality.

Prescribing practices of psychotropics remains a particular concern. Despite NHS England’s STOMP and STAMP initiatives to reduce inappropriate psychotropic use, implementation has been uneven often due to a lack of non-pharmacological alternatives.

Data from LeDeR shows that people with intellectual disability die, on average, two decades earlier than the general population. The psychiatrist’s unique role at the interface of neurology, neurodevelopmental disorders, mental illness, and physical medicine is therefore vital not only for treating illness but for identifying systemic risks and advocating for equity in healthcare access and outcomes.

A future vision: advocacy, genomics, digital health, co-produced systems, and training

- Advocacy: Strong psychiatric advocacy for evidence-based safeguards is needed to keep people with intellectual disability safe in the ongoing politico-legal issues of the Mental Health legislation, Assisted Dying Bill, LTS/Seclusion, medication optimisation, and specialist inpatient psychiatric bed reduction [2, 3-7].
- Genomics and Precision Medicine: Genetic testing reveals shared pathways between intellectual disability, autism, ADHD, epilepsy, and dementia. Integrating these insights enables proactive care. Psychiatrists must interpret results ethically, considering stigma and consent [2,3,8].
- Digital Health and AI: Digital phenotyping and AI can detect early signs of health deterioration, e.g., wearables identifying seizure or behavioural changes. Yet digital innovation must be co-designed for accessibility, as people with intellectual disability are among the most digitally excluded [2,3,8].
- Outcome measurement and co-production: Future systems should value autonomy, participation, and quality of life as much as clinical outcomes. Validated tools such as HoNOS-LD should be embedded in routine care [2].
- Integrated Multidisciplinary Systems: Psychiatrists must act as advocates and connectors across primary, community, and specialist care, replacing the “postcode lottery” with locally resourced, person-centred services and strengthening partnership working with social care partners and specialist commissioning [2].
- Increasing training opportunities / exposure to psychiatry of intellectual disability for resident doctors including opportunities for taster sessions/personal development sessions, increasing placements within foundation training, consideration of post expansions within core and higher training and developing/updating a psychiatry of intellectual disability recruitment strategy in partnership with RCPsych [9].

The NHS 10-Year Plan: A silence that speaks loudly.

The 2025 NHS Plan outlines three major shifts: toward community care, digitalisation, and prevention and yet people with intellectual disability are almost entirely absent in its content [3]. The 2019 *NHS Long Term Plan* mentioned intellectual disability forty-seven times while the 2025 version does so only once [2]. This silence potentially erases one of the NHS's most disadvantaged populations from its future vision. Critical omissions include:

1. No strategy for specialist inpatient or community pathways despite ongoing inappropriate detentions.
2. No mention of addressing polypharmacy.
3. No safeguards related to Mental Health Legislation reforms or Assisted Dying legislation.
4. No inclusion framework for genomic or digital health research, risking "invisible exclusion."
5. No evidence of co-production or accessible versions for service users.

Why the omission matters

Omission from the NHS Plan is not symbolic, it has tangible consequences. Without recognition and funding, workforce pipelines will erode, research will stagnate, and specialist expertise will dissolve into generalist systems unable to meet this cohort's needs.

The Plan's own aims of prevention, precision, and digital empowerment cannot succeed without including people with intellectual disability, those most at risk of psychiatric and physical illness, premature mortality, multimorbidity, and digital exclusion. As the authors conclude: "Policy without inclusion is inequity by design."

Reclaiming the future: policy and practice

Despite its gaps, the *NHS Plan's* principles could still support inclusion if implemented intentionally. Key issues include -

- Embedded health leads for intellectual disability in community centres
- Mandatory accessibility and reasonable-adjustment training
- Data monitoring to track health inequalities.
- Inclusivity in any health/social AI and genomic tool design
- Co-produced services and lived-experience-led research.
- Safeguards around Mental Health Act and Assisted Dying reforms
- Evidence-based approaches to inpatient care and Long-Term Segregation
- Strengthened training pathways across all medical levels [9]

These measures would operationalise inclusion and position psychiatry of intellectual disability as a leader for ethical, multidisciplinary reform.

Conclusion: A Future to Be Claimed

Our specialty stands as a microcosm of what an equitable health system could be: multidisciplinary, preventive, technologically informed, and co-produced. To ignore it is to deny the NHS's founding principle, that healthcare must serve those in greatest need first.
The nation's health will be measured not by technology, but by its commitment to those most often at risk of being left behind.

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ID Career Opportunities

Moving to the Other Side of the Table: An Independent Safeguarding Role – From ID Consultant to Second Opinion Appointed Doctor (SOAD)

Dr Elizabeth Carmody

Consultant Psychiatrist

In this second of two related articles. I describe my reflections on the transition from consultant ID psychiatrist to Second Opinion Appointed Doctor (SOAD), a role I hold on to a fee-paid basis, along with that of Tribunal medical member outlined previously.

Of the two new roles, I had greater anxieties about the SOAD role. My impression as an ID consultant had been that I used a narrower range of psychotropics, and at lower doses than was the case in other mental health areas. The number of times I had prescribed ECT or high dose neuroleptic medication was in single figures, even after more than 20 years of consultant practice. However, as I will demonstrate extensive pharmacological knowledge is only one facet of the role and one that is readily refreshed and maintained with peer support and focussed CPD.

The most obvious area of expertise that an ID clinician brings to the SOAD role is that of capacity. The recent report on the MHA [1] shows that SOAD requests due to lack of capacity to consent to treatment, as opposed to refusal of medication, are much more common and in excess of 90% Whilst capacity assessment is part of every psychiatrist's training and practice, ID clinicians arguably have more experience and often in very nuanced and disputed cases as evidenced in capacity case law. As a result, we are accomplished at putting the wishes and feelings, beliefs, and values of the individual at the centre of our assessments. We are also familiar with the extra effort it takes to identify those aspects of an individual, including a need to engage with other informants / carers which is not routinely required in SOAD assessments but can be advisable or necessary in complex or contested cases. Modern psychiatric services can be fragmented at times and complex patients in particular frequently access numerous inpatient facilities and services. This can make it difficult to access an individual's history and personal circumstances, crucial contextual information in ascertaining whether proposed drug treatment is appropriate and necessary. We should not underestimate the skills we develop in tracking down such information in everyday ID practice.

Another specialty that deals extensively with capacity issues and relies heavily on informant history is that of older people's mental health and completing SOAD assessments in this field has been the most familiar, after ID assessments. There are other drug-related similarities such as the paucity of specific research in the patient group, use of smaller doses and propensity for side-effects. Of particular resonance is NHS England's 2022 [2] guide to appropriate prescribing for behavioural and psychological symptoms of dementia (BPSD). There are many parallels with the STOMP-LD programme, and an ID clinician is well-placed to scrutinising the rationale for prescribing psychotropic medication in BPSD by exploring non-pharmacological approaches, clarity of outcome measures and plans for deprescribing where appropriate. The same skills can also be applied in other clinical areas, for example when reviewing the use of benzodiazepines, promethazine, and hypnotics for symptomatic relief of agitation in mental disorder. Exploring the purpose and utilisation of pro re nata (prn) medication is a well-developed and extensively researched area in ID practice which is not necessarily always the case in some areas of practice where it can seem to be prescribed as a routine, “one size fits all” regime.

Another area in which ID clinicians are well-equipped to assess treatment plans is when there are significant physical co-morbidities. Such co-morbidities, particularly epilepsy, are quite common in ID and we have extensive experience in liaising with general medical colleagues, even developing joint guidelines for assessment and management. Senior ID clinicians will therefore find it remarkably familiar territory to consider psychotropic treatment plans in the context of other management priorities.

The relative ease of applying the skills and expertise of an ID clinician across specialties has been such that I now do far fewer ID specific SOAD assessments than non-ID. Inpatients without ID and / or autism do not have Care (Education) and Treatment Reviews (CTR / CETRs) scrutinising their treatment and whether it is appropriate. The SOAD mechanism, together with that of the Mental Health Tribunal, is therefore a crucial independent safeguard that protects those patient’s rights.

One benefit of SOAD work is that it gives assessors the opportunity to pick up work in a wide range of services in different clinical and geographical areas. It gives direct experience of front-line practice, whether that be a ward or a community team. By talking to and meeting patients and professionals in this way, ID clinicians can gain insights into the whole spectrum of mainstream mental health practice including the prevailing pressures and changing multidisciplinary and multiagency roles. Such knowledge can be useful in a Tribunal setting where such issues are not necessarily as evident.

It is particularly useful for ID clinicians who no longer have a substantive post but also potentially for those who still practise but are less embedded in mainstream mental health services.

In summary then, SOAD work both uses and builds on the expertise gained in ID practice and senior ID clinicians are in an excellent position to contribute to the safeguarding of the rights of people detained under the MHA by means of this role.

(You can read the first part of this series in the July 2025 Edition)

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Reflections

Discovering a Passion for Psychiatry of Intellectual Disability

Raena Swami

Psych Star

From the very beginning of my journey into medicine, I knew that intellectual disability was something I was passionate about. It was one of the main reasons I wanted to become a doctor. I wanted to learn how to make a real difference for people with intellectual disabilities, not just through treatment, but by advocating for them and making sure their voices are heard.

During the Christmas holidays at school, I wanted to do something meaningful, so I volunteered at a day centre for people with intellectual disabilities. I had never worked with anyone with intellectual disabilities before, and I remember feeling quite anxious at first because I did not know how to interact with the service users, or what to expect. But within days, those worries faded. The people I met there welcomed me with such openness and kindness that I soon felt part of something incredibly special. I was moved by the sense of community and genuine care everyone in the facility showed one another. Every day in that place taught me something new about patience, understanding, and connection. I went in hoping to help, but I left feeling that I had learned far more than I had given. That experience changed the way I saw others and myself, and it made me realise that supporting people with intellectual disabilities was not just something I cared about, but something I wanted to dedicate my future to.

When I started medical school, I learned about psychiatry of intellectual disability as a career option. The idea of combining psychiatry with supporting people with intellectual disabilities fascinated me. I reached out to a consultant in the field, and he kindly organized a taster week for me. That week turned out to be one of the most valuable experiences I have had so far, and it only deepened my passion for this specialty.

Learning from the team

During the week, I joined a group of people who shared the same passion for inclusion and enthusiasm for advocacy. Watching psychiatrists and the multidisciplinary team at work was inspiring. They used different communication strategies and reasonable adjustments to make sure every patient could be heard and understood.

I also learned about important ideas like STOMP (Stopping Over Medication of People with a learning disability, autism, or both) and diagnostic overshadowing, where a person's symptoms are mistakenly attributed to their disability [1]. I realized that psychiatrists working with intellectual disability are not only doctors. They are also advocates, fighting for patients and challenging the inequalities they face.

The multidisciplinary team impressed me as well. Psychiatrists, nurses, psychologists, occupational therapists, and speech and language therapists all worked together, each bringing their own perspective, but all focused on the same goal, to provide the best care possible.

Seeing patients as people first

One of the strongest lessons for me was understanding that each patient has their own story. No two people are the same. When I spent time in a day centre for adults with special needs, I was touched by how well the staff knew each person- from the food they liked, to the way they preferred their plate to be arranged, to where they felt most comfortable sitting. That attention to detail reminded me what truly person-centred care looks like.

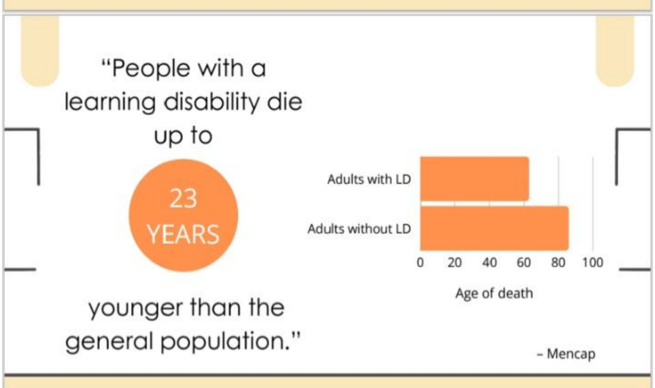
I also saw how psychiatrists adapted their approach to each patient. For example, one person with mild intellectual disability spoke confidently and gave a clear and detailed history. Another patient was non-verbal. The psychiatrist first spoke directly with them, then with their carer, and then returned to the patient again. It showed me that this specialty is all about inclusivity, patience, and making sure every voice is valued.

Many of the people I met could not communicate with words, which could easily make their symptoms harder to understand. But I saw how psychiatrists combined verbal and non-verbal approaches, noticing subtle expressions, gestures, and behaviours to piece together what was happening. The patients themselves taught me a powerful lesson: all communication might not be verbal, but all communication is definitely valid.

Confronting inequalities

Another part of the experience that stayed with me was seeing the health inequalities that people with intellectual disabilities continue to face. It was upsetting to learn that people with intellectual disabilities still die, on average, up to 23 years younger than the general population. Many of these deaths are avoidable. They are linked to diagnostic delays, lack of reasonable adjustments, and diagnostic overshadowing [2].

These statistics were disheartening but also gave me a sense of urgency. I realized that this is something I want to do something about. As future doctors, we cannot allow disability to be a reason someone receives poorer care.



Looking ahead

The patients I met during this week taught me more than I ever expected. They showed me the value of patience, empathy, kindness, and paying attention to detail. They reminded me that as doctors, we should not only teach but also learn, and often, our greatest teachers are the patients themselves.

I ended the week with a clear feeling: I need to do something about the inequalities I had seen. That motivation led me to apply for the Psych Star role in the Faculty of Psychiatry of Intellectual Disability. I was fortunate to be selected, and I look forward to learning more from patients and colleagues.

The patients I met during this week reminded me why I chose medicine: to listen, to learn, and to care. They showed me that not every form of communication is verbal, but all are valid, and every person deserves to be understood and cared for with dignity. This simple truth has shaped the way I see medicine, and it will guide me as I continue my journey in psychiatry of intellectual disability.

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Raena is a third-year medical student at Queen's University Belfast and the current Psych Star for the Faculty of Intellectual Disability Psychiatry. She has a strong interest in psychiatry and is particularly enthusiastic about improving care in intellectual disability psychiatry.

Providing End-of-Life Care in an Inpatient ID Setting

Dr Oliver Turner

ST5

Psychiatry of Intellectual Disability

Palliative Care in ID Psychiatry

Supporting someone approaching their end of life is a complex and emotionally charged experience. Doctors are trained to prevent death by treating, and the concept of Palliative Care, not curing, but accepting the terminal diagnosis and providing comfort in various forms, can feel much more uncomfortable. This being said, compared to the wider medical field, Psychiatry shares similar approaches to the field of Palliative Care as there is an emphasis on a biopsychosocial approach to care - supporting the service user as a whole.

While approaches to care are similar, palliative care for those with intellectual disability remains challenging. Health inequities experienced by our service users are found through all clinical fields, including Palliative Care. Amongst other challenges, diagnostic overshadowing, absent reasonable adjustments, communication difficulties, and assumptions made about wishes, all may impact on their End-of-Life Care. Questions related to the concepts of end-of-life, afterlife, and purpose, can be challenging to address.

But with our similar approach to care, we are well placed to advocate for End-of-Life patients, support them with their distress and symptoms, and ensure where possible that they have a good death. Here, I describe and reflect on our experience of providing Palliative Care to a service user on an intellectual disability inpatient unit.

Summary of Care

We supported a gentleman in his forties who had been in inpatient services for over ten years, diagnosed with terminal cancer. When I first met this gentleman, he was aware of his diagnosis, but not its terminal nature. Our initial focus was ensuring a shared understanding, including of prognosis, and the treatment plans. Careful consideration was needed for how information was presented with Easy Read documents, and over several sessions, allowing time for him to express his distress. Giving one key piece of information a day was a helpful approach that we adopted.

Clear, considered Advanced Care Planning was a key next step, allowing for better involvement in his care. We became aware early on that the service user stated his preference to remain on the ward through his End-of-Life Care, and did not wish to be discharged to a care home or hospice, and we could therefore plan how this would happen early on.

Care began to slowly shift, from treatment to symptom management. Ceilings of care were reviewed regularly, with fewer admission to hospitals, and a DNACPR was completed. Medication was regularly reviewed, and rationalised. Distress was addressed pharmacologically and through regular psychology sessions. Care plans were made in close liaison with primary/secondary care specialists, which outlined clear plans for complex physical health issues, for professionals who ultimately were not specialists in End-of-Life Care.

We arranged fortnightly professional meetings to ensure all aspects of his care were addressed, as well as frequent reflective practice sessions. Most importantly, we sought to address his quality of fife wherever possible, including regular family visits and trips out. In a particularly heart-warming day, when unable to visit a local animal sanctuary due to illness, the animals were brought to the courtyard outside the ward.

After 5 months, the service user passed away. He did so in his room on the ward, with family members with him, appearing comfortable and settled. Support was given to family and staff, his funeral was arranged as per his requests, and his Will was followed.

Reflections

The care provided to this gentleman took a significant emotional toll on staff involved; however, when able to reflect, we were proud as a team and felt he had as comfortable a death as possible. Granted, an inpatient setting allowed more time/input into his care than what a community team could offer. But it did feel that clear communication, early and thorough advanced care planning, regular addressing of emotional needs and a holistic, MDT approach improved his end-of-life care.

Sadly, this is not always the reality for our service users. A retrospective cross-sectional study into ID Palliative Care by Hunt et al. highlighted that compared to the general population, those with intellectual disability were less likely to be aware of being End of Life, and a smaller proportion had chosen a preferred place of death [1]. This, and a mortality gap of 19.5 years between people with intellectual disability and the general population noted in the recent LeDeR report [2] suggests a higher mortality rate for people with ID in an acute hospital setting. Hunt et al showed that the experience of care at End of Life is worse in an acute hospital when compared to other settings, including home and care homes.

We are in a privileged position to support and advocate for patients at their End of Life and can be effective if we use our skills as Intellectual Disability specialists to consider all aspects of their care. This case has given me personally a blueprint for how to approach such care in the future.

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Clinical Updates

Revolutionising Autism Care: The Clinical Promise of Artificial Intelligence

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The field of mental health is witnessing a dramatic transformation, particularly in Autism Spectrum Condition (ASC) care. Artificial Intelligence (AI) is emerging as a powerful tool to address long-standing diagnostic and therapeutic challenges. Understanding these innovations is crucial for improving patient outcomes. This article explores current and future AI applications in autism care, with particular focus on a pioneering initiative at Cygnet Harrow.

AI in Diagnostic and Therapeutic Applications

Artificial intelligence is transforming autism care across multiple domains. Current ASC diagnostic pathways are often lengthy, relying on extensive behavioural observations that can delay intervention for months. AI offers solutions using machine learning algorithms to analyse complex datasets with speed and precision, reducing assessment time significantly whilst maintaining high accuracy [1]. Eye-tracking technology combined with deep learning and AI-powered wearable devices that monitor physiological indicators are among the emerging tools enhancing diagnosis and enabling personalised interventions [2]

Beyond diagnostics, AI supports therapeutic applications through robotic therapy systems and virtual reality programmes that create safe environments for practising social interactions. Generative AI tools produce structured, customized social stories and images that help individuals prepare for unfamiliar events or understand social cues [3]. Mobile-based screening applications and AI-driven chatbots extend support beyond clinical settings, providing continuous guidance to families between appointments and offering coping strategies and crisis support [4].

Innovation in Clinical Practice: A Case Study from Cygnet Harrow

The theoretical promise of AI-enhanced therapy is becoming clinical reality across NHS and independent healthcare settings. At Cygnet Harrow's locked autism rehabilitation unit, a pioneering virtual reality programme demonstrates how innovative technology can transform patient care when thoughtfully integrated into clinical practice. This case study illustrates both the potential and the practical implementation of AI in real-world autism care.

Origin and Clinical Rationale

The clinical team at Cygnet Harrow recognised that emerging technologies offer promising opportunities for stress management in autism care. With rapid advances in virtual reality and growing evidence from international research demonstrating that individuals with autism spectrum disorder learn more effectively and achieve better self-regulation through immersive environments, the team sought to develop a structured Virtual Reality (VR) -based intervention. The decision to implement this programme reflected both the growing evidence base and the clinical need for more effective stress management tools that could accommodate the sensory sensitivities and preferences of individuals with autism.

Programme Structure and Delivery

Using Meta Quest 3 headsets in partnership with XR Health—a leading organisation with experience in virtual reality therapeutics—the unit provides patients with immersive therapeutic experiences ranging from tranquil beaches and peaceful cartoon landscapes to natural settings such as waterfalls and forests. These virtual landscapes complement the hospital's existing therapeutic interventions, such as nature walks and outdoor exposure, which are already part of standard care. The VR programme specifically targets stress reduction and relaxation, offering an accessible alternative for patients who may be unable to participate in physical nature-based activities or who require additional support in managing anxiety and stress responses. The VR therapy programme is structured as a focused 6–8-week intervention, with patients attending two sessions per week. Each session employs guided imagery and progressive muscle relaxation techniques delivered within the therapeutic virtual environments.

The VR sessions are facilitated by a multidisciplinary team comprising occupational therapists and psychologists, ensuring clinically informed delivery that integrates psychological expertise with occupational rehabilitation principles. This human-centred approach ensures that technology remains a tool to enhance clinical care rather than replace it. The implementation process began with comprehensive training for therapy and medical teams, ensuring seamless integration into existing treatment programmes and demonstrating the importance of preparing staff for technology adoption.

Technology Integration and Data Collection

What makes this programme particularly innovative is its integration of artificial intelligence and machine learning capabilities, specifically tailored for stress management applications. An AI-driven tracking system monitors patient responses during VR sessions, whilst machine learning algorithms analyse this data to generate detailed progress reports for clinical staff. The software's intuitive AI-powered command system allows for real-time customisation of virtual environments based on individual patient preferences and responses, ensuring each therapeutic session is optimised for the person's unique needs and sensory sensitivities.

XR Health provides the underlying technology that enables this personalisation, operating under a yearly licence that encompasses behavioural tracking, AI-driven environmental adaptation, and dedicated stress management resources. What is particularly noteworthy is that this sophisticated technological implementation remains cost-effective; the investment in both hardware and software represents a practical approach to enhancing patient care quality without requiring prohibitively expensive infrastructure. This demonstrates that meaningful technological innovation in mental health can be achieved through pragmatic resource allocation, making it feasible for healthcare institutions to adopt similar approaches.

Importantly, the VR intervention functions as a dedicated stress management tool. Data collected from VR sessions informs the progression and refinement of the VR therapy itself, optimising the virtual environments and techniques for maximum therapeutic benefit. However, these data are not currently being used to direct or modify other interventions provided to patients—the VR programme operates as a focused, standalone stress reduction intervention within the broader treatment ecosystem at Cygnet Harrow.

To ensure effectiveness and measure outcomes systematically, a standardised assessment is conducted before the programme begins and again upon completion at the 6–8-week mark, allowing clinicians to track measurable changes in stress levels and therapeutic progress. Data collection is conducted using standardised stress assessment scales provided by XR Health, ensuring objective measurement of intervention outcomes. This systematic approach to evaluation distinguishes the Cygnet programme as a clinically rigorous implementation of VR technology in autism care.

Outcomes and Clinical Impact

Early outcomes suggest that patients find these immersive experiences both engaging and therapeutically beneficial, with pre- and post-intervention assessments demonstrating measurable improvements in stress management and emotional regulation. The programme's success lies not just in its technological sophistication, but in its ability to provide controlled, predictable environments that are particularly valuable for individuals who may find traditional therapy settings overwhelming. The AI-powered personalisation ensures each session meets individual sensory profiles and preferences, supporting the broader goal of individualised, evidence-based autism care.

This real-world application exemplifies how AI can enhance rather than replace human therapeutic relationships. The technology provides objective data collection and personalised experiences, whilst skilled clinicians interpret this information and maintain the compassionate care that remains central to effective treatment. Supporting the broader goal of individualised, evidence-based autism care.

Ethical and Implementation Challenges

While AI offers significant promise for autism care, its integration into sensitive mental health contexts is accompanied by several important challenges that must be addressed to ensure equitable and effective implementation.

Data Privacy and Security: AI systems necessitate the collection, storage, and analysis of large volumes of sensitive patient data, including behavioural patterns, communication styles, and health history. This increases the risk of breaches and unauthorised access, demanding robust protective measures [5].

Maintaining Clinical Oversight: There is a critical need to mitigate the risk of over-reliance on algorithmic decisions without clinical oversight. AI tools should augment clinical capabilities rather than replace them, with clinicians able to understand, validate, and potentially override AI recommendations based on their professional expertise [6].

Implementation Barriers: Practical challenges include prohibitive costs for infrastructure, training, and service integration, which may be beyond the means of healthcare institutions with limited resources. Additionally, clinicians must be trained, and these systems must integrate seamlessly with existing healthcare workflows [7, 8].

Validation and Bias: Prior to widespread adoption, there is a critical need for robust validation across diverse populations, encompassing various ethnicities, genders, and socioeconomic backgrounds. Datasets must be representative to avoid algorithmic bias and ensure the generalisability of AI tools across different geographical and cultural contexts [5].

Equity and Access: Failure to ensure universal access raises equity issues if access becomes limited to well-resourced settings, exacerbating existing health disparities and global inequalities, particularly affecting low-income families and those in low- and middle-income countries [6].

Practical Implementation in Clinical Settings

Beyond specialist centres, AI can be integrated across healthcare services through mobile-based screening applications that perform initial assessments in community settings, reducing waiting times and improving access. AI systems also streamline administrative tasks, optimising clinical workflows so professionals can focus more on direct patient care [9,10]

Conclusion

Artificial intelligence offers genuine potential to address longstanding challenges in autism diagnosis and intervention. The technology promises more accurate, efficient, and personalised approaches to care, extending support beyond traditional clinical boundaries. Projects like the VR programme at Cygnet Harrow demonstrate that this potential is already being realised, with AI-enhanced interventions providing measurable benefits to patients and valuable insights to clinicians.

The future of autism care lies not in replacing human expertise with artificial intelligence, but in creating synergistic partnerships that amplify the strengths of both. As these technologies evolve, we can expect more innovative applications that will transform autism care, making high-quality, personalised interventions more accessible to those who need them most.

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Audits

STEPS-ID: Meeting the epilepsy training needs of psychiatry of intellectual disability trainees in Scotland.

Dr Jennifer Mutch

Consultant Psychiatrist

Background

Epilepsy is the most common serious chronic comorbidity in people with intellectual disability (ID). People with epilepsy are commonly seen within ID services and by psychiatrists working within these services. Epilepsy, and the treatment of epilepsy, may impact behaviour, and can affect long-term mental and physical healthcare outcomes. Knowledge in the assessment and management of epilepsy is therefore essential for psychiatrists collaborating with people with ID.

Historically, there has been a lack of clarity regarding the role of the psychiatrist in the management of epilepsy, and there is variation in how services are set up across the country. The current curriculum for higher trainees in psychiatry of intellectual disability includes 'an understanding of the assessment and treatment of epilepsy in patients with intellectual disability' as a key capability. There had not however been any formalised training in epilepsy for ID higher trainees offered in Scotland, with most addressing this competency through 'special interest sessions' of varying duration, variety and intensity depending on trainee interest and local service arrangements, and attendance at conferences.

In May 2017, The Royal College of Psychiatrists (RCPsych) published College Report 203, "Management of Epilepsy in Adults with Intellectual Disability" (1). This document acknowledged the lack of clarity around not only training standards, but also pathways to achieving competency and the expected roles of psychiatrists working within ID services. The report clarified the RCPsych position on the role of the ID psychiatrist in the management of epilepsy and proposed a tiered model of competencies.

Aim and Methods

The aim of our work was to understand and address the epilepsy training needs of higher trainees in psychiatry of intellectual disability in Scotland. We established a working group with representation from epilepsy specialist psychiatrists from across Scotland as well as a higher trainee in psychiatry of ID. In December 2019, higher trainees in ID psychiatry from across Scotland (n=13) were invited to complete an online survey based on the competencies outlined in RCPsych College Report 203. Trainees were asked to rate how strongly they agreed or disagreed with statements relating to different areas of capability in epilepsy. They were also asked for free text responses in relation to their experience of epilepsy special interest sessions to date and any perceived gaps in their knowledge or training, as well as any challenges encountered in obtaining competency in this area. The baseline survey results, alongside the College guidance, shaped the development of the Scottish Training in Epilepsy for Psychiatry Specialty Trainees in Intellectual Disability programme (STEPS-ID). Following the establishment of the programme, and a period of programme delivery, we invited trainees to complete a follow-up online survey in April 2023 (with further invites sent in May 2024) to collect early evaluation data.

Result

Twelve trainees responded to the baseline survey. Ten responded fully and two only to Part 1 of the survey (up to and including Question 10). Questions elicited a wide range of responses indicating varying levels of confidence within the trainee group, likely in part reflective of the varying stages of training represented within the group. Despite this however, only 22% of trainees agreed that they have had.

Question Key: Q1. I feel confident in my ability to take a relevant history of epilepsy. Q2. I have knowledge of indications and limitations of investigations relating to epilepsy. Q3. I have knowledge of differential diagnoses, including non-epileptic attack disorder (NEAD). Q4. I have knowledge of the psychiatric co-morbidities in epilepsy. Q5. I have an appreciation of the association between challenging behaviour, epilepsy, psychiatric illness and intellectual disability. Q6. I am able to diagnose, address and treat any associated mental illness or challenging behaviour occurring alongside epilepsy. Q7. I have a basic knowledge of indications and side effects of first line anti-epileptic drugs (AEDs). Q8. I have knowledge of the psychiatric side effects of AEDs. Q9. I am aware of the interactions between AEDs and other drugs, especially psychotropic drugs. Q10. I am able to scrutinise a rescue medication protocol and ensure that one is in place if needed. Q11. I know the risks associated with epilepsy and have knowledge of epilepsy risk assessments. Q12. I am able to manage discussions about sudden unexpected death in epilepsy (SUDEP) with patients and carers. Q13. I am familiar with the local or regional pathway for epilepsy management.

opportunities in their training to date to gain the necessary skills in epilepsy management required as a consultant psychiatrist working in ID. Generally, trainees agreed that they would like more training in epilepsy (70% strongly agree)

The working group agreed on relevant capabilities on which to base the training programme, informed by the College Report (Box 1). These capabilities, supported by the baseline survey results, informed the development of the STEPS-ID programme. The programme consisted of the following:

- a national epilepsy teaching day for all trainees with input from psychiatry, neurology, epilepsy specialist nursing, occupational therapy.
- shadowing experience at The William Quarrier Scottish Epilepsy Centre.
- time with epilepsy specialist nurses, neurologists, neurophysiologists, and psychiatrists working in epilepsy.
- signposting to epilepsy educational resources; and
- quarterly case-based discussion sessions on MS Teams.

Discussion and Conclusion

It is well established that psychiatrists collaborating with people with ID should have knowledge and skills in epilepsy assessment and management. Survey of trainees in psychiatry of ID in Scotland revealed what was suspected; that they felt there were gaps in their knowledge and skills in relation to epilepsy assessment and management and that they felt there was a need for more training. Through drawing on the expertise available nationally and the formation of a working group, we were able to combine efforts and resources to develop the STEPS-ID programme. This programme has proven, in early evaluation, to support higher trainee psychiatrists to meet their expected competencies and increase confidence in this area of their practice. Further evaluation and development of the programme is planned. We would encourage those working in other areas of the UK to consider developing a similar programme for epilepsy and to consider which additional areas of trainee curricula may be addressed with a similar national or regional approach.

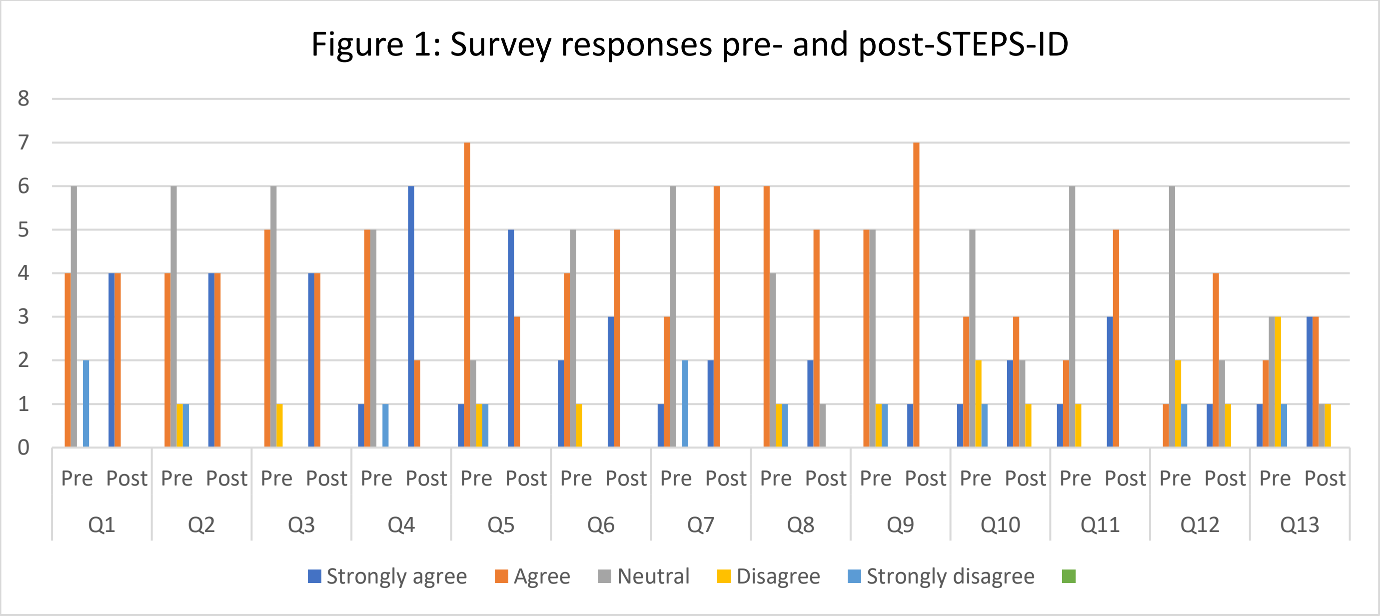

Figure 1: Survey responses pre- and post-STEPS-ID

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Clinical Audit of Adherence to STOMP Principles in CAMHS LD Services: A Comparative Review of Worcester and Hereford

Dr Tugba Kece

CT3

Introduction

Psychotropic over-prescription in individuals with learning disability and autism remains a pressing concern across healthcare systems. Inappropriate or prolonged use of psychotropic medication can result in adverse side effects, diminished quality of life, and poor long-term outcomes [1].

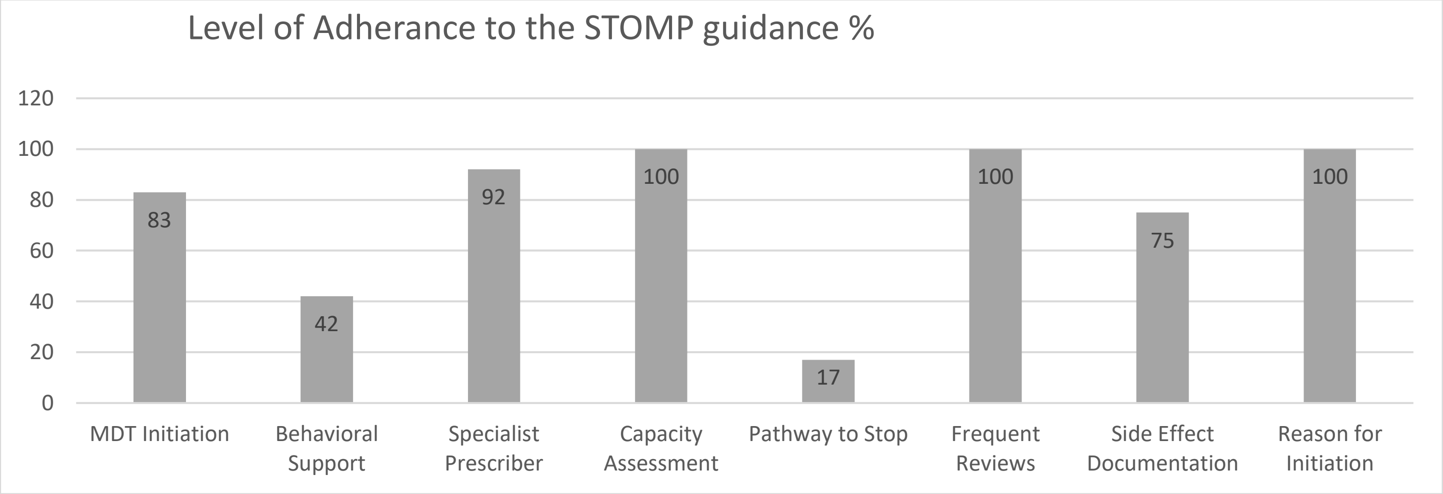

Figure 1

In response, STOMP (Stopping Over-Medication of People with a Learning Disability, Autism, or Both) was launched by NHS England in 2016 as a way to reduce the inappropriate prescribing of psychotropic medication to manage challenging behaviour in the absence of a licensed indication [2]. The program emphasizes the shortest duration of antipsychotic use at the lowest dose whilst maintaining regular reviews and ensuring non-pharmacological alternatives are in place prior to considering medication [3].

Aims

To assess the current level of adherence with the guidelines set by the Royal College of To assess the current level of adherence with the guidelines set by the Royal College of Psychiatrists (2021) Position Statement (4) as regards STOMP, within the two outpatient Community CAMHS LD Teams in Herefordshire and Worcestershire Health and Care NHS Trust.

To compare results between two counties to ensure the same quality of care following the merger of Herefordshire and Worcestershire under the same Trust in 2020, as both sites frequently operate separately.

Methodology

A retrospective case-note review was conducted using a pro forma prepared by auditors, in accordance with STOMP criteria. Hereford data was audited in August 2024, whereas Worcester data was audited in March 2025, with the prospect of combining the data.

Only the patients with moderate–severe LD with or without autism who are on antipsychotic medication were selected.

Hereford sample: twelve young people (aged 8–17 years) from a cohort of twelve patients.

Worcester sample: twenty young people (aged 8–17 years) chosen with random sampling from a cohort of forty-eight patients open to the Worcester CAMHS LD Team to minimize the bias, given the smaller Hereford cohort.

Results

Level of Adherence to STOMP Guidance

Hereford: Figure 1

Worcester: Figure 2

Conclusion

The audit demonstrated several strengths across both services:

Most prescriptions were initiated by specialists and had a clear rationale, 92% for Hereford and 80% for Worcester.

Review intervals adhered to NICE guidance, 100% for Hereford and 78% for Worcester.

Monitoring completion was generally robust.

However, there are also areas requiring focused improvement:

Clear, initiative-taking discontinuation planning was lacking in most cases across both counties. Only a small proportion of patients had a discontinuation planning in place, Hereford 17% and Worcester 10%.

MDT involvement at the initiation stage was limited in Worcester with being 30%. It was higher in Hereford 83%.

A considerable proportion of patients had no non-pharmacological support in place in both counties, Hereford 58% and Worcester 35%.

Implementing targeted quality improvement measures will help ensure more consistent and safe psychotropic prescribing for young people with learning disabilities and autism.

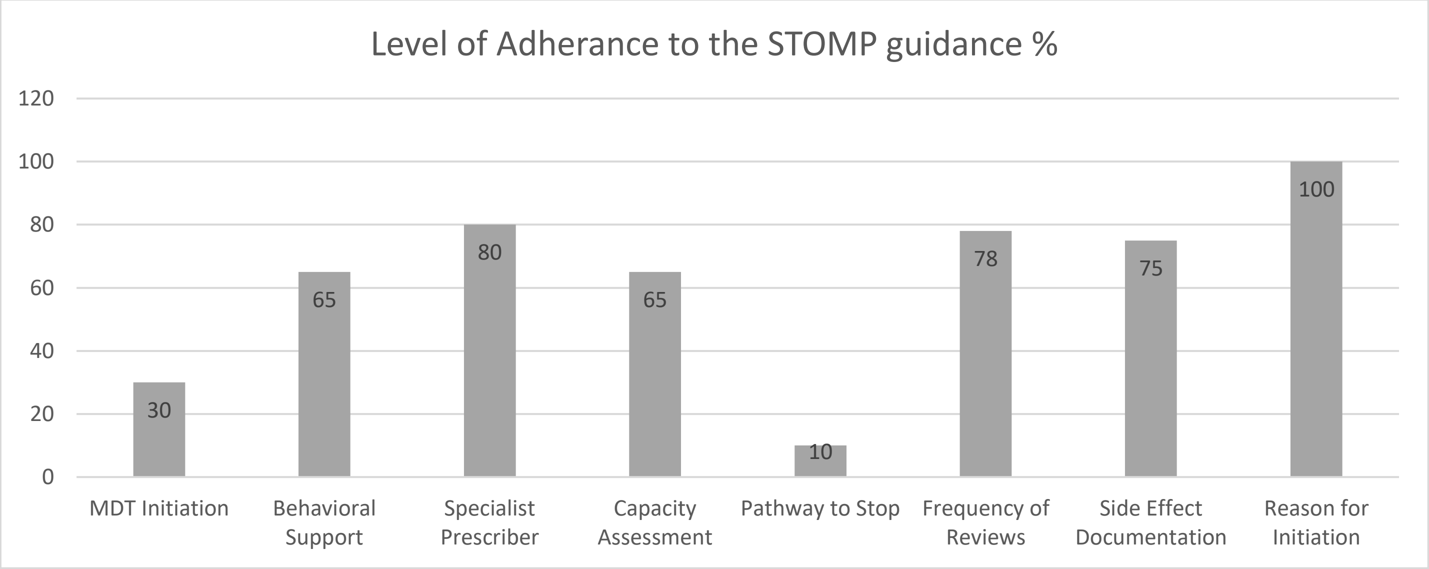

Figure 2

To improve the service, it has been agreed to disseminate findings across the CAMHS LD team and wider service whilst reflecting on current prescribing practices and documentation processes. Both services in Hereford and Worcester have been operating separately. It has been decided to arrange a session to present the findings to the LD Teams together to increase cohesiveness and reduce differences in service provision. We planned for a re-audit within the next 12 months to assess progress and impact.

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In the Media

Autism Spectrum Condition in Visual Media: Implications for Clinical Practice and Public Perception

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Autism Spectrum Condition (ASC) has steadily increased in prevalence in the UK over recent decades. A population-based study reported a 787% increase in autism diagnoses between 1998 and 2018 [1. This is not accounting for the longer waiting lists and backlog created by the COVID-19 pandemic, which contribute to a significant undiagnosed population lacking access to the support structures that a clinical diagnosis and NHS services provide.

In this context, popular media—including film, television, literature, and social media—plays an increasingly key role in shaping public perception and understanding of ASC. Many people engage with these portrayals as a point of identification and often as a step towards self-diagnosis; clinical accuracy and quality of representation are therefore crucial. For practicing clinicians, awareness of how ASC is presented in the media is important, as patients and families often arrive with expectations shaped by these depictions: what ASC looks like, who qualifies for diagnosis, and what level of support is appropriate.

Trends on social media are particularly difficult to track or regulate, given the significant variability in content across time, geography, and communities and the rapid pace of change in the social zeitgeist. Increasing public literacy about ASC through reading faces its own challenges: a 2024 study from The Reading Agency found that only 50% of UK adults read regularly for pleasure, down from 58% in 2015 and that in the same period, the proportion who never read for pleasure rose from 8% to 15% [2]. As such, this article will focus on portrayals of ASC in visual media, exploring both their benefits and their drawbacks.

There are clear advantages to raising public awareness of ASC through visual media. Public health literacy can often be advanced most effectively through the formats people consume in their daily lives. Television dramas about physical health, such as ER (1994–2009) and The Pitt (2025–ongoing), have both increased empathy for the pressures faced by healthcare professionals and provided audiences with at least a surface-level understanding of clinical decision-making and triage. While recent portrayals of ASC have had successes, they are not without pitfalls. Many rely on excess dramatization or one-dimensional stereotypes that fail to reflect the diversity and nuance of the autistic experience.

The Good Doctor (2017–2024) offers a widely recognised portrayal of a high-functioning autistic character, Dr Shaun Murphy. The series has helped reduce stigma by highlighting challenges such as sensory overstimulation and communication difficulties. At the same time, it continues a trend of linking ASC with savant abilities—seen previously in Raymond Babbitt in Rain Man (1988), Abed in Community (2009–2015), and Simon Lynch in Mercury Rising (1998). A longitudinal study of patients diagnosed with ASC at the Maudsley Hospital, London, found that while 48% of parents reported their child as having a savant skill, only 8.6% met criteria when formally tested [3].

Other portrayals have been more problematic. Rick in Rick and Morty (2015–present) is frequently shown as violent and callous, while Christian Wolff in The Accountant (2016) uses his mathematical savant skills to support a criminal career. Such depictions risk reinforcing "sociopath" or “psychopath” stereotypes that conflate communication difficulties with aggression and a lack of empathy, further contributing to stigma.

There are, however, examples of more responsible representation - Julia, a four-year-old autistic character introduced to Sesame Street in 2017 and is shown interacting with her peers and family in ways that educate both neurotypical children and those with ASC. The character was developed with significant input and support from the Autism Self-Advocacy Network and is performed by puppeteer Stacey Gordon who is herself a parent of a child with ASVC. Julia has been credited with supporting children and families while also promoting inclusion and reducing bullying in schools.

Awareness raised through popular media is often a double-edged sword. On one hand, it can empower autistic individuals and reduce stigma; on the other, it risks perpetuating stereotypes and misconceptions. Responsible representation—grounded in nuance and authenticity—remains key to supporting individuals and families affected by ASC, especially for those still waiting for diagnosis or struggling to access support structures.

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