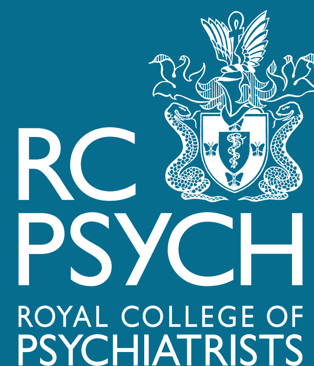
Faculty of Psychiatry of Intellectual Disability

Newsletter

March 2026



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Editorial

Dr

Unsa Athar

Resident Doctor

Editor – in – Chief

As I write this, the sun shines outside! We survived yet another winter and are marching into Spring. It feels like a particularly fitting moment for this edition of the Faculty of Psychiatry of Intellectual Disability newsletter as we, as an editorial team, are experimenting with new sections and ideas. I would love to hear the readers' thoughts on this edition. Please drop in an email with your thoughts and comments at **newsletter.psychid@gmail.com**.

As a new member of the Royal College of Psychiatrists and an International Medical Graduate, I have been feeling the 'othering' effect in these trying times; the us vs them chaos. I am a part of the picture but am I really welcomed? I sat with Dr. Regi Alexander with this feeling in my heart. His story was not only inspiring but also served as an important reminder; You can claim a seat at the table if you keep harnessing resilience. With his reflections on migration, mentorship, leadership and change, he challenged me to think more expansively about the future of intellectual disability psychiatry and our place within the wider neurodevelopmental field. I also learnt about the difference between a professor and a honorary professor. Who would have realised how nuanced academia is?

I hope you enjoy reading the interview as I much I enjoyed experiencing it!

In the spirit of new beginnings, I bring to you Research at a Glance. The aim for this section is to make innovative and relevant research palatable for our readers, especially the resident doctors. This is followed by an audit on access to genetic testing from Malta. It highlights how revisiting what we think we already know can open the door to better, fairer care for adults with intellectual disability. The ever-inspiring Dr. Mary Barrett has kindly shared with us a snapshot of her work on New principles for shared clinical practice in neurodevelopmental conditions for all doctors.

I hope you share my excitement for the first ever (I believe. I might be wrong but please let me have this) poem in our newsletter. The editorial team is ecstatic to see our doctors using different art forms to express their thoughts. The poem pays a well-deserved ode to all carers and workers supporting those suffering with Mental Illness. I am also extremely pleased to announce our first ever winner for best article for resident and specialty doctors. Many congratulations Dr. Prakash! I hope you find this token to be encouraging and continue to put pen to paper. Her article reminds us to slow down, remain curious, and keep dignity and understanding at the centre of risk-focused environments.

It has been an absolute pleasure putting this issue together. I (gracefully) beg you all to continue using the Arts and Science of Psychiatry. Keep writing, keep reading, keep thinking critically!

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Message from the Faculty

Meet your candidates for the Chair: Read their candidate statements

Professor Rohit Shankar MBE

I stand for the psychiatry of intellectual disability that listens to lived experience, leads with science and an evidence base and delivers accountable care, values championed by my clinical-academic leadership.

As Specialist Registrar, I witnessed Cornwall's intellectual disability services fail catastrophically. Inpatient units closed and patients were sent hundreds of miles from home. We re-built services grounded in evidence and transparency with professional/patient organisations. I founded an academic unit-Cornwall Intellectual Disability Equitable Research (CIDER) and established the Peninsula ST4–ST6 intellectual disability training rotation, becoming its first Training Programme Director. Our services were recognised as RCPsych Team of the Year for Intellectual Disability (2022), Digital Mental Health (2023), and became first to achieve RCPsych CCQI Community Accreditation for Intellectual Disability (2024).

Importantly, these changes delivered tangible patient benefits, including psychotropic rationalisation, premature mortality reduction and repatriation of all out-of-county placements. Our work informs national and international guidance. I served as Faculty Academic Secretary and Vice-Chair. I delivered four national Faculty Conferences, led key College Reports CR203/CR206 (epilepsy-intellectual disability), CR226 (mental health services for intellectual disability), contributed to CR230 (ADHD-intellectual disability), CR240 (outcomes), CR242 (asylum mental health), represented the faculty on major clinical, legal and policy issues, and advise on national programmes on epilepsy/mental illness/behaviours that challenge/medicines safety. As South-West Division Chair I represented 1000+ psychiatrists. As Associate Dean (Academic Training) I am launching the RCPsych National Academic Strategy. I would prioritise delivering ***four pillars*** assimilating the College Values.

Workforce and services

I will maintain College-level focus on inpatient closures, workforce pressures, training fragility and the realities faced by psychiatrists. I will collaborate with CAMHS Faculty to improve quality and delivery of CAMHS-ID services. I will develop evidence-based clinical pathways to support coherent job planning, meet training needs and provide psychiatric leadership across NHS and private sector to reduce burnout and improve job satisfaction.

Advocacy and influence

I will champion the interests of people with intellectual disability/carers, and faculty members in emerging political, legal, and clinical challenges, including Mental Health Act reform and assisted dying legislation by advocating for a *coalition of the willing* of other College stakeholders (e.g. forensic faculty/NDD-SIG) and patient/professional organisations to deliver safeguards and accountability.

Role and vision

I will update the faculty report (2011) on *role of psychiatrist in intellectual disability*, co-producing a vision addressing patient needs, role in MDT, leadership in reducing psychiatric and physical-health inequalities, improved training experience and parity of esteem for devolved nations.

Evidence building

Current clinical practice is largely risk informed and/or ideological, unsupported by evidence. I will drive systematic implementation of outcome measurements (CR240), genetics (CR237) and digital tools aligned with the NHS 10-Year Plan. Using the College academic strategy, I will embed faculty-level research awareness/engagement, strengthening our evidence-base.

The *pillars* will reignite grass-root participation in our faculty being inclusive across ethnicity, gender, grade, private sector and other specialities. As Chair, my ambition is to position us as a *faculty for many* and a national and international exemplar of an evidence-based, inclusive, future-ready faculty of psychiatry of intellectual disability.

Professor Sujeet Jaydeokar

I graduated from the University of Mumbai (1994) and trained as a psychiatrist in India before entering core training in the UK (1998). I gained my CCT in Psychiatry of Intellectual Disability in 2001. In my consultant career I have worked in forensic-ID services, Adult Community ID Service in London, and currently in a NHS Community Service for adults with ID in Cheshire.

I am a parent-carer of my son with intellectual disability and other neurodevelopmental conditions. As a professional and parent-carer, I understand at first hand the pressures on colleagues and on family-carers.

I held the roles of Academic Secretary and Finance Officer on the Faculty Executive Committee. Currently, I am the CQC National Professional Advisor for ID and Autism. I led the creation of CANDDID, an innovative academic centre in my Trust in the Northwest of England.

My Priorities

Fit for purpose: NHS 10-Year Health Plan

We need to ensure the implementation of the Plan in England reverses health inequalities and relieves the workload pressures on Faculty members. As your Chair, I will advocate for improved clinical services nationally that truly support people to live meaningful lives.

Legislation

Changes to Mental Health legislation in England and in Scotland will bring substantial challenges that we must address constructively and collaboratively. I will ensure the Faculty is actively involved in influencing the implementation of legislative changes.

Clinical Services

Reducing reliance on in-patient care has been good for innovation in clinical services. All psychiatrists value high-quality, safe, in-patient care in the NHS and Independent Sector. As Chair, I will promote high-quality in-patient and community services to deliver excellent care for people.

Workforce

Resident doctors are the future of our Specialty. We must ensure appropriate career pathways and opportunities are established to support colleagues. I will actively advocate for and support innovations in addressing workforce challenges. Leadership by Doctors is vital for sustainable clinical services.

Children with Intellectual Disability

As a psychiatrist and parent-carer, I know well the challenges to CAMHS-ID services and their under-resourcing. I will collaborate with the Faculty of Child and Adolescent Psychiatry to make a difference in children's lives.

Education and Training

The Faculty supports the RCPsych in setting high standards in training and clinical practice. As your Chair, I will promote the richness of the Specialty in its clinical and academic achievements setting standards for others to follow.

Professionalism

High standards in professional practice are essential for high-quality services. I will promote the profession at every opportunity illustrating the value of what Psychiatrists in ID bring to services that benefit people and their families.

The Faculty must reflect and represent all its members in the UK and internationally in all clinical services. We must ensure the Faculty continues to influence internally in the RCPsych and externally with policymakers through collaboration with key stakeholders and people with lived experience.

Interview

A Seat at the Table: Dr. Regi Alexander on Resilience, Mentorship, and Change

Q: You've had a long and distinguished career in psychiatry. Could you tell us the story behind your move from India to the UK and how that journey began?

Dr. Regi Alexander: My journey began with a disappointment, which, in many ways, is where most growth stories begin. As a student in India, I used to learn with a certain passion for subjects, history and mathematics, particular favourites. However, about halfway through my medical training, that passion seemed to fade. I found myself simply studying to pass exams rather than feeling truly engaged with the subject. At one point, I even began exploring alternative career paths, including the civil service.

It was during this period of uncertainty that I first encountered psychiatry in a meaningful way. I worked in de-addiction with a psychiatrist who became an important role model and encouraged me to consider a career in this field. I wrote the entrance examination for the National Institute of Mental Health and Neurosciences (NIMHANS) in Bangalore, an institution modelled after the Maudsley Hospital in London. After completing the DPM there, I faced a major disappointment when I did not secure a place in the MD program. Instead, I spent a year working as a research fellow. That year turned out to be formative and instilled in me a desire to follow a career pathway that many others in similar positions there had followed. That is how I came to the UK with the aim of not just further training in psychiatry but also to start a new chapter of my life.

Q: What was the experience of arriving in the UK in the mid-1990s like, especially as an immigrant doctor?

Dr. Alexander: I arrived in August 1994 through the Overseas Doctor's Training Scheme (ODTS) and was allocated to St. Mary's in London. It felt as if I was a brave new world and I often reminisce about how our unit was almost opposite the building where Alexander Fleming discovered penicillin. It was a time when I was still thinking in my mother tongue and translating into English, a cognitive process that became faster over time but never truly changed.

I never felt any overt discrimination or disadvantage and in fact, people around me were particularly helpful and encouraging. Having said that, there was something you could not help but notice particularly when you went to academic conferences. You would see an audience of doctors that looked like me, but a stage that looked completely different. That was seen as a fact of life existing alongside the kinship, kindness, and genuine warmth of a psychiatry community.

Q: You've moved into significant leadership roles. How did you manage to get a "seat at the table" when you were often the only person of colour in the room?

Dr. Alexander: As I said in reply to your earlier question, I did not face any overt discrimination. I was also fortunate to have clinician academics who were generous with their time- Professors Priest, Montgomery, Tyrer, and Schmidt at St Marys and consultants like Drs Lambert, Katz,

Murray who often helped by letting me tag along to management or academic meetings. I have never thought too much about how exactly I ended up with a seat at the table, but I guess a capacity to do the "boring work" of distilling long documents into clear summaries at a time when neither google or indeed AI was well developed, did help. It was a skill that leaders appreciated and that reliability opened doors to represent colleagues on committees and build key connections.

Q: You are quite vocal about the MRCPsych exams and "differential attainment." What is your perspective on why International Medical Graduates (IMGs) often struggle more with the CASC exam?

Dr. Alexander: The usual explanation is to stress communication differences or racial disadvantage. While these explanations have the advantage of simplicity, this is an issue that needs much more careful thought. The examiner profile has changed beyond recognition and yet there is some persistence of this attainment gap including a puzzling "intergenerational disadvantage," where even UK-born, UK-educated second-generation immigrants anecdotally perform worse than their peers. I also think that the current secrecy around the content of exam stations need re-evaluation. If one uses the driving test analogy, it is possible to be fully aware of what route you are expected to drive on and still be tested effectively.

Q: How has the nature of mentorship in psychiatry changed since you were a trainee?

Dr. Alexander: Mentorship has moved from informal, warm relationships to a much more structured but bureaucratic system. When I was a junior doctor or in the early years of my consultancy, mentoring was the freedom to pick up the phone and ring a senior colleague for advice when you were stuck. I sometimes worry whether the very structured systems of appointed mentors lose the spontaneous encouragement and role-modelling that helped me feel like I belonged in the room.

Q: On a personal note, how did your family and parents influence your resilience during these career transitions?

Dr. Alexander: There is sometimes a stereotype about ambitious Indian parents, and mine certainly wanted me to be a professional. But the key point was that this did not extend to undue pressure. As a child, I was never scared to share disappointments at home. My father, an engineer, was the type who would say "never mind" and then, thirty minutes later, sit down to analyse exactly what went wrong and offer constructive suggestions. That gave me, from the very start, a cloak of security. When we moved to the UK, my wife and daughter and a son who came a few years later, continued not just as the nucleus of the family but also a source of security that feeds your resilience.

Q: Looking to the future, what is your vision for Intellectual Disability (ID) psychiatry?

Dr. Alexander: We must stop thinking only in terms of the "service" we work in and start thinking about our professional expertise. Our true expertise is in neurodevelopmental disorders, which affect 10-20% of the population. We are specialists in how these conditions affect the presentation of psychopathology, the nuances of treatment and the disparity in treatment outcomes. By defining ourselves only in terms of our service, we run the risk that our sphere of action will progressively narrow from learning disability alone to only moderate to severe learning disability and so on. Focusing on the whole neurodevelopmental disorder group will allow us to be true pioneers not just in clinical practice but also newer technology and research.

Q: You often say that "academia is everyone's business." Why is this such a central part of your ideology?

Dr. Alexander: I reject "mental health exceptionalism", the idea that psychiatry is too complex for the outcome frameworks used in other fields of medicine and surgery. Every good clinician should be a clinician academic. You don't need to be a lead researcher, but you must have an interest and curiosity to find out if your treatment works. Some of our most significant findings come from routine clinical databases and observational studies, not some research 'ivory towers'.

Dr. Regi Alexander is a consultant psychiatrist with Hertfordshire Partnership University NHS Foundation Trust and the clinical lead for Forensic Learning Disability services within the NHS East of England Provider Collaborative, working across both in-patient and community services. An international medical graduate, he is a Fellow of the Royal College of Psychiatrists and a Visiting Professor at the University of Hertfordshire's School of Life & Medical Sciences. He also served as President of the Royal Society of Medicine's Intellectual Disability Section from 2020 to 2025 and continues to convene RADiANT (Research in Developmental Neuropsychiatry), a UK-wide network bringing together NHS Trusts, academics, service users, families, and community leaders.

Previously, he chaired the Royal College of Psychiatrists' International Congress (2014–2019), served as Associate Dean for Conferences, CPD and Advanced Learning (2019–2022), and directed the National Autism Training Programme for Psychiatrists (2022–2025). A full-time practising clinician with extensive experience in both the NHS and independent sectors, his work focuses on the interface between neurodevelopmental conditions, psychiatric illness, and challenging or offending behaviour. He has authored around 100 publications and edited four major texts: *Oxford Textbook of Psychiatry of Intellectual Disability* (2020), *Forensic Aspects of Neurodevelopmental Disorders* (2023), *Psychiatry of Intellectual Disability Across Cultures* (2024), and *The Frith Prescribing Guidelines for People with Intellectual Disability*, 4th ed. (2024). In recognition of his contributions, he received the Royal College of Psychiatrists' President's Medal in 2018.

Research at a glance

Organising care for complexity: a pathways model for adult community intellectual disability services

Shankar, R., Sawhney, I., Tromans, S. J., Perera, B., Korb, L., Sheehan, R., ... Hassiotis, A. (2026). Organising care for complexity: a pathways model for adult community intellectual disability services. *International Review of Psychiatry*, 1–12. https://doi.org/10.1080/09540261.2026.2624620

In a recent article published in the *International Review of Psychiatry*, a multi-author team led by Rohit Shankar proposes a generalisable pathways model designed to modernise adult community intellectual disability services in the United Kingdom. The model addresses a persistent structural challenge: delivering specialist, evidence-based care for individuals with complex needs while minimising restrictive practices and reducing reliance on inpatient provision.

The Case for Change

Despite decades of policy aimed at community-based, person-centred care, many services remain fragmented, operating in professional silos or relying on crisis-driven responses. People with intellectual disabilities continue to face significant health inequalities, including higher rates of multimorbidity and a life expectancy roughly two decades shorter than the general population. The authors argue that a structured pathways approach provides a pragmatic framework to reconcile these issues by replacing episodic referral models with proactive, formulation-led intervention.

Core Components of the Model

The proposed architecture is built upon several theoretical foundations, including **biopsychosocial formulation**, systems theory, and a life-course perspective. Key components include:

- **Universal Interface:** Supporting access to mainstream health services through specialist liaison and reasonable adjustments.
- **Care Navigation:** A central shift from bureaucratic "care coordination" to a clinically grounded "care navigator" role, ensuring continuity across the patient journey.
- **Single Point of Access:** Multi-disciplinary triage to ensure proportionate responses based on risk and complexity.

Specialist Clinical Pathways

The model identifies several **exemplar clinical pathways** for high-impact areas where coordinated intervention can materially improve outcomes:

- **Mental Illness & Neurodevelopmental Conditions:** Focused on reducing diagnostic overshadowing and managing co-occurring autism or ADHD.
- **Behaviours that Challenge:** Grounded in functional assessment and **Positive Behaviour Support** to reduce restrictive interventions.
- **Epilepsy & Dementia:** Addressing the high prevalence of epilepsy and the increased risk of dementia in populations such as those with Down syndrome.
- **Forensics & Transitions:** Managing the narrow boundary between challenging behavior and offending, and ensuring stable moves from children's to adult services.

Oversight and Implementation

The model integrates with existing frameworks like **Dynamic Support Registers (DSRs)** and Care (Education) and Treatment Reviews (C(E)TRs) to identify those at highest risk of community breakdown. While evidence

suggests pathway models can improve efficiency and reduce hospital costs, the authors caution against **rigid over-standardisation**. They emphasise that pathways must remain flexible enough to provide personalised care for individuals who do not fit neatly into a single category.

Conclusion

The authors view this model as the first stage of a national programme to innovate service design. Future steps include developing a **practical implementation toolkit** and conducting further research into the cost-effectiveness and lived experience of pathway-based care. Ultimately, the model aims to provide a coherent, ethically grounded structure that supports consistent, high-quality care across the UK.

You can read the full article here:

https://www.tandfonline.com/doi/10.1080/09540261.2026.2624620?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed#d1e709

Audit

Improving Access to Genetic Testing for Adults with Intellectual Disability

Dr Nicole Mifsud

Understanding the cause of a health condition can be life-changing. For individuals with an intellectual disability (ID), identifying a genetic cause can improve healthcare planning, clarify associated risks, and support families in making informed decisions about the future.

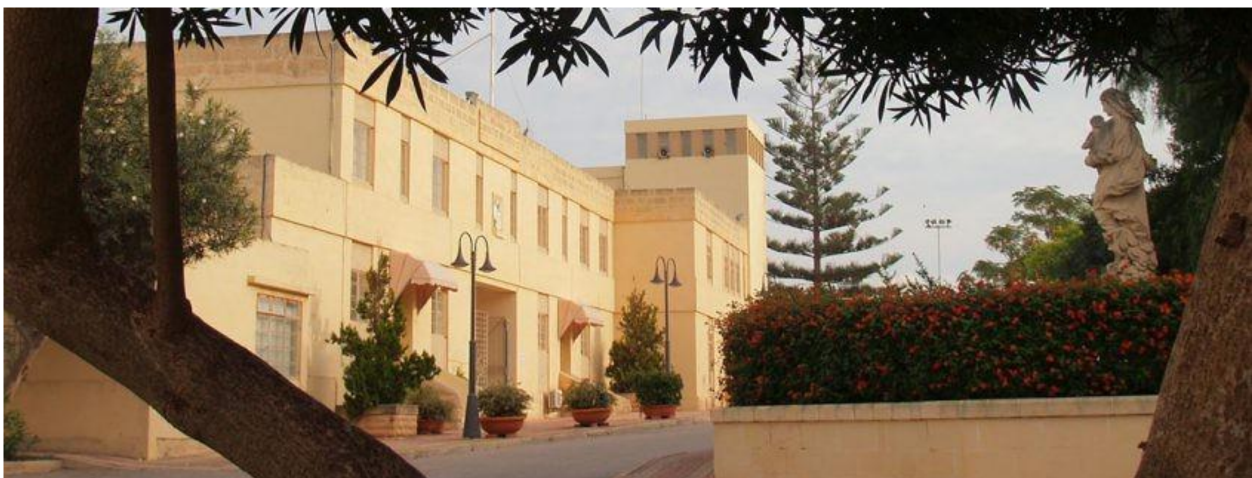
At Dar tal-Providenza, a Maltese residential home providing individualised services for persons with disabilities, we asked a simple but important question: ***Are adult residents receiving the genetic testing recommended by international guidelines?***

This article summarises our recent audit, key findings, and the steps we are taking to improve practice.

Why Does Genetic Testing Matter?

International organisations including the American College of Medical Genetics and Genomics (ACMG), the European Society of Human Genetics (ESHG), and NICE recommend genetic evaluation for individuals with ID or autism, particularly when additional features such as epilepsy, congenital anomalies, dysmorphic features, or a significant family history are present.

A confirmed genetic diagnosis clarifies prognosis, guides long-term surveillance, informs management, and supports family and reproductive counselling. Genetic testing remains valuable in adulthood, influencing ongoing care and relatives' risk assessment. Although access in Malta has expanded, referrals remain indication-driven, requiring clinician awareness of appropriate criteria.



Our Aims:

1. Determine how many adults at Dar tal-Providenza have a confirmed genetic diagnosis.

2. Assess whether genetic discussions or referrals are documented in patient records.

3. Evaluate whether current practice aligns with international recommendations.

Who Was Included?

Our cohort consisted of 80 adults with a documented diagnosis of ID and/or autism. Mean age:

50.4 years, 49 males (61%), 31 females (39%). Clinical complexity was high. In addition to ID: 22.5% (n=18) had autism, 13.75% (n=11) had cerebral palsy, 6.25% (n=5) had epilepsy, 16.25% (n=13) already had a confirmed genetic syndrome.

What Did We Find?

Despite the clinical complexity, genetics referrals were rare. Only 6 patients (7.5%) had a documented referral to genetic services. Genetic testing was documented as discussed with the patient or carers in just 1 case (1.25%). Among the six referred patients: five had confirmed diagnoses, one was awaiting results and no documented follow-up plans were recorded. These findings reveal a significant gap between recommended practice and current documentation.

Several factors may contribute:

1. Perception that genetics is “paediatric”. Genetic testing is often associated with children, and its value in adults may be underestimated.

2. Limited awareness of evolving guidelines. Recommendations increasingly support genomic testing as a first-tier investigation in neurodevelopmental disorders.

3. Documentation gaps. Discussions may occur but are not consistently recorded, affecting continuity of care.

4. Unclear referral pathways. Psychiatrists and ID physicians may be uncertain about criteria or processes for referral to national genetics services.

Our Action Plan

To address these gaps, we developed a structured improvement strategy:

1. Standardised Documentation of Genetic discussions, Referrals, Results and Follow-up plans.

2. Clinician Education. In collaboration with the national genetics team, we will deliver targeted teaching sessions covering current NICE and ACMG guidance, practical referral criteria, and adult case examples demonstrating clinical value.

3. Clear Referral Pathways. We will work with the genetics service to develop a shared referral form, agree on clear referral criteria and establish multidisciplinary case discussions.

4. Re-Audit within 6–12 months.

Conclusion

Our audit identified a highly complex adult cohort with clear indications for genetic evaluation. Yet only 7.5% had been referred, and documented discussions with families were minimal. These findings highlight an important service gap, but also an opportunity for development. By improving documentation, increasing clinical awareness through education, and clarifying referral pathways, we aim to ensure fair access to genetic testing for adults with ID.

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Audit team

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Update

Treating Patients Well: New principles for shared clinical practice in neurodevelopmental conditions for all doctors

Dr Mary Barrett

An unmet need

All doctors will encounter patients with neurodevelopmental conditions in their clinical practice, however most medical subspecialty training does not explicitly cover the needs of this patient group. This leads to doctors feeling under-skilled and/or lacking in confidence to assess and manage patients with neurodevelopmental conditions. It also increases the risk of diagnostic overshadowing, adversely affecting health outcomes for patients with neurodevelopmental conditions.

This gap in training was highlighted by the General Medical Council (GMC) who commissioned the Academy of Medical Royal Colleges to provide all doctors with easily accessible information on learning outcomes for neurodevelopmental conditions. The Academy approached the Royal College of Psychiatrists to lead this work.

Developing key principles

The Royal College of Psychiatrists convened a working group of clinicians specialising in neurodevelopmental conditions; many members of this group were drawn from the Faculty of Intellectual Disability, along with the Neurodevelopmental Psychiatry Special Interest Group. Two sets of learning outcomes were drafted, one focussing on Intellectual Disability and one on wider Neurodevelopmental Conditions, including autism, ADHD, FASD and tics. The learning outcomes needed to align with the GMC's Generic Professional Capabilities and with Good Medical Practice. They needed to apply to all stages of medical training (From undergraduate upwards) and to all medical specialties. In addition, they were to be written in a way that could be embedded within any medical specialty's CPD framework. Given these parameters, the focus was on creating overarching key principles that could be widely applied.

Achieving publication

The draft learning outcomes were subject to review and challenge, firstly within the Royal College of Psychiatrists and then within the Academy of Medical Royal Colleges.

An initial submission then went to the GMC, and after their review and feedback, further work was undertaken to shape the learning outcomes into a framework of principles of behaviour. GMC approval was received in March 2025 and the documents 'Treating patients well: principles for shared clinical practice in intellectual disabilities' and 'Treating patients well: principles for shared clinical practice in neurodevelopmental conditions' were published by the Academy of Medical Royal Colleges in April 2025 https://www.aomrc.org.uk/publication/treating-patients-well-principles-for-shared-clinical-practice/

Key highlights

Common principles of behaviour in both documents include:

Shared key principles of behaviour for ID/NDC
Clear & accessible communication
Flexibility, adaptability & reasonable adjustments
Patient at centre
Mental capacity, best interests & advocacy
Holistic approach
Comorbidity
Diagnostic overshadowing
Quality of life
Services, signposting & safety netting

Each principle of behaviour is underpinned by specific learning outcomes to help translation into clinical practice, for example:

Principle G.	Ensure clear and accessible communication between all relevant parties involved in the provision of care, ideally backed up with takeaway information
Learning outcomes	Be familiar with common communication systems used by people with ID/NDC and understand how they can support the medical consultation process
	Demonstrate the ability to adapt your communication style to the needs of persons with a range of ID/NDC presentations and abilities
	Produce appropriately tailored clinical correspondence for your patients with ID/NDC, their carers and other professionals

Implementation

Publication of the principles for shared clinical practice in intellectual disabilities and in neurodevelopmental conditions is an important step towards addressing a widespread gap in medical education and training. However, unless the principles become embedded into undergraduate curricula and postgraduate CPD frameworks across all medical specialties, their impact will be limited.

The Royal College of Psychiatrists has therefore agreed to work on **two initiatives,** to support implementation:

1. Awareness-raising of the published documents both within RCPsych and externally, for example sharing with the ND Academy group.

2. Development of a centralised list of learning resources relevant to the learning outcomes for each shared principles document, to allow effective signposting. The ID SAC and NDPSIG have been asked to lead on this for the intellectual disabilities and wider neurodevelopmental documents respectively.

How you can help

We also need support from all Faculty members, including Doctors in Training, SAS Doctors and Consultants to publicise the documents within their networks across medicine.

Secondly, incorporating the shared learning principles into education and training opportunities – both within Psychiatry and cross-specialty – is a valuable way of clinicians helping translate them into practical learning.

Thirdly, if anyone reading this would like to contribute to the collation of signposting resources – or knows of resources that would be of value to add to the lists – please get in touch with me at mary.barrett1@nhs.net

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Poem

Keepers of the Quiet Light

Dr Ebrahim A. Seedat

An Ode Dedicated to all Carers and Workers supporting those suffering with Mental Illness

Poet

Dr Seedat is SAS Doctor working for Skylight Psychiatry. He has a particular passion for neurodiversity and he is dedicated to creating a practice that celebrates different ways of thinking and being. He has recently written a mental-health related fictional novel which is soon to be published.

We are the Beacons of Beaming Light

Burning in watchful hours throughout the night.

We grasp the space where reason seems to fray,

Anchoring Souls adrift in disarray.

We learn the Maps of the Secrets within,

The Sacred, Silent Battle deep beneath the skin.

We hear the Fears no Language can truly declare,

Meeting the Hollow, overwhelming stare.

We know the Mind's garden runs wild—

Where Panic Blooms, and Sorrow covers unriled.

We do not judge the Thorn, nor curse the Weed,

Planting seeds of hope for desperate need.

We are the warm hands pruning with care,

The ones who brave the freezing chill of despair.

We offer shelter from the storm's harsh blast,

And make the present moment safe at last.

We traverse the Bridge with planks, loose or gone,

Helping with the Weary, frightened journey on.

We turn the soil, limiting the inner rain,

Trusting in dormant life to grow again.

We do not wield the manuals as law,

Instead with Compassion, Temper, what you saw.

We place the person first—the Infinite Whole—

The Timeless, Struggling, Beautiful Human Soul.

So let this Verse be, a Humble Grateful Beam,

Reflect the grace of this sustaining dream.

For in this Care, a Sincere Truth takes Flight:

The Greatest Strength is lending others Sight.

We are the Keepers of the Quiet Flame,

Who write, with daily Grace, Love's truest name.

Reflection

Intellectual Disability and Acute Psychiatry: Shared Lessons in Risk and Understanding

Dr Krishna Prakash

Winner of this edition's best article from Resident/SAS doctors.

Working in acute adult psychiatry, I have often reflected on how systems designed for safety can feel overwhelming for those who are already vulnerable. This tension becomes particularly visible when supporting individuals with intellectual disability (ID) within high-risk psychiatric environments.

Acute wards and Psychiatric Intensive Care Units (PICUs) are structured around containment, rapid stabilisation, and risk management. Doors are locked. Observations are frequent. Documentation is detailed. These frameworks are necessary, particularly when patients are distressed or behaviourally unsettled. Yet for individuals with intellectual disability — who may already experience heightened sensitivity to environmental stressors — such settings can amplify confusion, fear, and loss of control.

Intellectual disability challenges psychiatry to slow down.

In busy clinical environments, communication can become task-focused. Risk assessments are completed efficiently. Medication changes are documented carefully. However, patients with ID often require adjustments that go beyond standard practice: simplified explanations, visual aids, repetition, additional time to build rapport, and close collaboration with carers and multidisciplinary teams. Without these adaptations, containment risks being experienced not as protection but as incomprehension.

One recurring observation in my clinical work has been how easily behavioural distress in patients with ID can be misinterpreted as deliberate non-compliance. Agitation may reflect sensory overload. Withdrawal may reflect communication difficulty. Resistance may reflect fear rather than defiance. When risk frameworks dominate our thinking, we may unconsciously prioritise behavioural control over understanding.

This is not a criticism of acute psychiatry — it is a reminder of its complexity.

The Faculty of Intellectual Disability has consistently emphasised reasonable adjustments and person-centred care. In practice, this means asking different questions:
Is this behaviour communicative?
Have we adjusted our language appropriately?
Have we involved family or support workers early?
Have we considered sensory needs?

These questions require time and reflective capacity — commodities that can feel scarce in pressured services.

Yet the rewards are significant. When adjustments are made thoughtfully, engagement improves. Distress reduces. Restrictive interventions become less necessary. Staff confidence grows. What initially appears as "challenging behaviour" often softens once understanding replaces assumption.

Intellectual disability psychiatry also invites us to examine power more closely. People with ID may be disproportionately subject to restrictive

practices across healthcare systems. Ensuring equity requires vigilance: are we applying the least restrictive principle consistently? Are we aware of diagnostic overshadowing? Are we balancing safety with dignity?

In my experience, collaboration is key. Joint formulation with ID specialists, speech and language therapists, occupational therapists, and carers can transform care planning. What begins as a risk management exercise becomes a shared attempt to understand vulnerability within context.

Perhaps the most important lesson ID psychiatry offers acute services is humility. It reminds us that behavioural disturbance is rarely simple, that autonomy may look different for different individuals, and that meaningful care sometimes requires us to pause rather than proceed.

As psychiatry evolves, cross-faculty dialogue becomes increasingly important. Acute psychiatry and intellectual disability psychiatry are not separate worlds; they intersect frequently. Building bridges between them strengthens both.

Ultimately, the question is not whether acute services can manage risk in individuals with intellectual disability. They can and do. The deeper question is whether we can do so while preserving clarity, dignity, and meaning.

When vulnerability meets risk, the measure of our practice is not how efficiently we contain — but how thoughtfully we understand.

Author

Dr Krishna Prakash is an ST4 resident doctor in General Adult Psychiatry at Leeds & York Partnership NHS Foundation Trus. Her clinical interests include acute psychiatric care, intellectual disability, and person-centred approaches to risk management in complex clinical settings. She is particularly interested in reflective practice and improving understanding of vulnerability within psychiatric services.

PRIZES AND BURSARIES

Prize for best article for resident doctors and SAS doctors

We will be awarding £50 for the best article in each newsletter.

Eligibility: resident doctors and SAS doctors. All articles submitted by psychiatric resident doctors and SAS doctors will automatically be considered for the prize. Please make sure you state your grade when you are submitting an article.

The prize winner will be announced in the newsletter and will be contacted a few days before publication.

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Faculty Executive Committee Elections

Please note voting has now commenced for Faculty Executive Committee Elections. If you are eligible to vote, you should have received a link unique to yourself at your registered email address. **Voting closes on 15 April at noon.** For further information, please see:

https://www.rcpsych.ac.uk/about-us/our-people-and-how-we-make-decisions/elections/elections-2026/2026-elections-timetable

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SUBMITTING ARTICLES

This is the ID Faculty members' newsletter, and we encourage submissions from clinicians, students, service users, carers, and members of the wider multidisciplinary workforce. We will consider any article that may be of interest to our readers.

For submissions, email to **newsletter.psychid@gmail.com**.