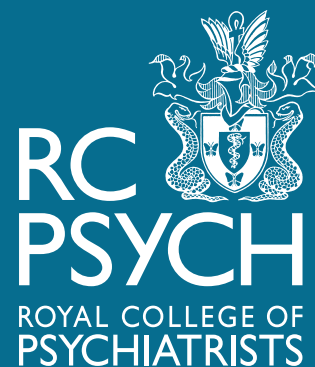


Faculty of Psychiatry of
Intellectual Disability
Newsletter

September 2026



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Editorial



Dr Unsa Athar

Resident Doctor (ST4), Psychiatry of Intellectual Disability

Editor – in – Chief

I have been involved in the Faculty Newsletter for more than a year now. And I have been a witness to the changing of the guards at the faculty. This process taught me how passionate all faculty members are about the work they undertake. Every action taken on clinical and non-clinical grounds is to advocate for the patients we take care of and to improve the quality of their lives. And in this age of misinformation and rapidly evolving communication platforms, critical thinking, reading and writing should become dearer to us than ever. As Elif Shafak says in her essay 'How to Stay Sane in an Age of Division'

"We live in an age in which there is too much information, less knowledge and even less wisdom. That ratio needs to be reversed."

My hope is to use this platform as a way to disseminate wisdom. And mind you, wisdom does not come with age. It comes with experiences and willingness to engage in meaningful conversations. And with this dream in my mind, I ask of all my colleagues to write for

the newsletter. I appreciate that not everyone would be experienced in writing. And might sometimes wish to rely on Artificial Intelligence for jotting down their thought processes. My personal views on that aside, I think it is important to remember to use Artificial Intelligence (AI) mindfully. If your prompt to the large language model lacks nuance, the output would be generic and lacklustre. If you do use AI for organising your thoughts or creating an image, please declare that you have done so.

For resident doctors looking for further incentive to write for the newsletter, I have now confirmation from the **Dean of Royal College of Psychiatrists Dr. Nandini Chakraborty** that writing up an audit/quality improvement project or reflection etc would attract a minimum score of 1 (*I have published one or more abstracts or articles (including e-publications) or I have published a letter*) in the **Domain 9: Academic Publications** (undergraduate or postgraduate including publications written on behalf of a trainee led collaborative) for **higher training applications**. You may use this editorial as additional evidence when completing your **self-assessments**. If you would like to discuss further or have any comments, questions or suggestions, please contact us at newsletter.psychid@gmail.com

In this particular issue, we have a very heartfelt obituary for our dear colleague Dr Bijil Simon Arackal. This is followed by a range of articles, from evidence in context to reflections and prize-winning essays. I shall let you peruse. I would like to thank my dear friend and colleague Dr. Amna Hussain for the wonderful photograph you see on the cover, from the lovely Windermere.

If you have any talented patients that would love to showcase their work on the cover, please feel free to contact us.

I would also like to thank **Kitti Kottasz**, Head of Faculties and SIGs at the RCPsych for always being helpful! Happy Reading!



Messages from the Faculty

From the Chair – the first 100 days (or thereabouts!)

Professor Rohit Shankar MBE, FRCPsych

Chair, Faculty of Psychiatry of Intellectual Disability



This is my first address to you as Chair of the Faculty since taking up the role on 16 June. I want to begin by saying what an honour it is to be entrusted with leading this Faculty at such a consequential time for our specialty. I want to thank Dr Inder Sawhney for her leadership and for the platform she and the outgoing executive members leave for us to build on. Inder is a hard act to follow. The faculty's achievements under her tenure, especially given the pandemic years, are a cause of both slight envy and immense pride for me!

I want to formally welcome **Dr Jana DeVillers (vice-chair)**, **Dr Samuel Tromans (finance officer)** and **Dr Rory Sheehan (academic secretary)**, along with the members of our new Executive Committee, several of whom are joining for the first time alongside colleagues continuing in post. Their energy, expertise and commitment to people with intellectual disability will be essential to the work ahead. You

can find the full committee list, and details of how to get involved, on our [Faculty webpage](#).

I regret to also be announcing the sad demise of a valued friend and colleague, Dr **Bijil Simon Arackal**. Many, like me would have met Bijil who gave a lot to the Faculty by serving on its executive on multiple occasions. A feature on him further in the Newsletter gives an in-depth insight of the work he did and the lives he touched in his typical unassuming uncomplicated way. RIP dear friend and colleague!

As you all know, this Faculty exists because people with intellectual disability continue to face some of the starkest health inequalities in our society, and because psychiatry has a distinct and necessary role in addressing them. Over the next three years, I hope to build on the faculty's reputation for combining strong clinical leadership with a robust academic and evidence base, and to make sure that reputation is matched by a membership that feels genuinely connected to the work being done in its name.

Although I am new to the Chair, the Faculty has not paused for breath. Indeed, it has felt rather like changing spark plugs in a car engine while the vehicle is not only running but galloping down the motorway! The last few months have seen several national developments that are already affecting, or will affect, our work and our patient population, not least the continuing re-alignment of health systems in England. I outline a few of these below.

The publication of the **Muckamore Abbey Hospital Public Inquiry** report was a defining moment. My view is that Muckamore should be read not as an isolated scandal but as a warning about how health systems lose the capacity to recognise deterioration, challenge poor practice and respond to risk. It is a clarion call for what clinical leadership particularly by psychiatrists, rights-based care and robust governance must look like if we are serious about preventing a cycle of repeats. I would encourage every Faculty member to read the report summary



and to reflect on what it means for their own service.

As many of you are aware, the future of the **Learning from Lives and Deaths (LeDeR)** programme in England, in its current form, is uncertain. The faculty executive feels that LeDeR, for all its imperfections, remains the world's only national mortality review system for people with intellectual disability, and that losing it would make preventable deaths less visible rather than less frequent. The question, as we argue, is not whether England can afford to keep LeDeR, but whether it can afford not to. In the meantime, do acquaint yourself with the latest LeDeR report findings.

Many, if not all of you would be aware that the **Assisted Dying Bill** failed to get passed in the House of Commons. It is an important piece of legislation which undoubtedly will be revisited. It is imperative we ensure as a Faculty we advocate for suitable robust safeguards for our vulnerable patient group. Thus efforts need to continue with other stakeholders to build the evidence base in this key area.

There is no shortage of work for the faculty executive on the horizon. We are diligently working with the wider College team on the ongoing Mental Health Act reform and its practical consequences for our patients and services. We are also tracking the developing implications of the overruling of the Cheshire West "acid test" for deprivation of liberty safeguards and its impact on intellectual disability settings, an area that continues to generate real uncertainty for clinicians on the ground. In response, we have joined forces with the Old Age Faculty to lead a college-supported survey gathering members' insights on this impact. Please do respond when it lands in your inbox!

I would also be grateful for your engagement with three further surveys, if you have not already contributed:

1. **PROTECT-ID**, which looks at violence and aggressive behaviour by inpatients towards staff on psychiatric wards for people with intellectual disability (https://docs.google.com/forms/d/e/1FAIpQLSdOknVTMAPsdqca5Vc_nzsUckKYhaE53AxHnwKjGkFf6ch48A/viewform).
2. A survey exploring **ethnic disparities** in access, assessment and outcomes across specialist intellectual disability services in the UK (<https://forms.cloud.microsoft/pages/responsepage.aspx?id=isSqdaspmEKtrGnT5-0-dzxmJEW23uxGokEcScwNYO5UQkwwSkhJWVFaNEXtIdPNloyWThRUIZGUC4u&route=shorturl>).
3. A survey on awareness and management of **epilepsy** in intellectual disability (<https://forms.gle/KrokMwfwPoEo7boJ7>). If you have not yet engaged with them, I would urge you to as it all helps us build a rounded picture from across the faculty membership.

I am also pleased to announce that the **College Report on Psychotropic Medication Optimisation** will be launched in early October at the Annual Residential Conference, alongside the **NHSE/DHSC STOMP** update. My thanks to my deputy editors, **Dr Samuel Tromans** and **Professor Shoumitro Deb**, and to the working committee for their diligent efforts in helping deliver this.

I am keen to bring a sharper focus to the evidence base for intellectual disability policy, examining the evidence behind decades of health strategy, from bed reductions to mainstreaming to changes in mental health legislation. This underscores the need for balancing towards evidence-based service design, sustained research investment and the maintenance of specialist expertise. With this in mind, I have set up an academic oversight committee, led by Dr Samuel Tromans and Professor Angela Hassiotis, to strengthen how the faculty supports and coordinates evidence-based practice across the faculty membership. We are planning to include a summary of their work on a regular basis in the newsletter.



Similarly, I am delighted to confirm that the faculty is establishing a new **CAMHS-ID working group**, responding directly to emerging concerns about access to, and quality of, mental health services for children with intellectual disability. Led by Dr Heather Hanna, the group will develop a position statement on the current state of CAMHS-ID provision across the UK and make best-practice recommendations.

Both groups reflect a thread running through this newsletter: that good intentions are not enough, and that services for people with intellectual disability need dedicated leadership, robust governance and a genuine evidence base if they are to improve. I hope to set up similar working groups to deliver key position statements and guidance in the coming months.

I would like to highlight the role of the Newsletter, and to thank **Dr Unsa Athar** and her editorial team. They have given the newsletter a fresh look, with the aim of delivering relevant Faculty news and signposts to best practice, to your inboxes regularly. Please support this effort by contributing your own perspectives, the friendly editorial team is always just an email away!

Finally, may I urge you to consider attending at least one, if not both, of our faculty conferences each year? We are a small Faculty, and it is imperative that we meet, discuss, debate ideas and new developments together. I believe, being visible and present in person is not just desirable but essential to fostering a genuine sense of professional belonging. I look forward to seeing you in **Cardiff in early October**, if not next year!

Again, I reiterate, it is a privilege to take on this role at a time when the faculty's voice is needed as much as it has ever been. I look forward to working with you all over the coming months, and I welcome your thoughts, involvement and challenge as we take this agenda forward together.

Message from Resident Doctor Representatives

We are delighted to be your higher trainee representatives for the ID faculty.

Through our role, we are passionate about raising the profile of ID psychiatry amongst resident doctors including advocating for trainees, promoting the specialty and supporting initiatives that enhance education, engagement and career development within the field.

If you wish to raise any training issues or ideas, we encourage you to speak to your local trainee representatives, who can bring these to our regular meetings. You can also contact us directly via our emails included below.

Warm wishes,

Dr Fergus Lewis,

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(London)



Dr Ibrahim Younes,

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(Northwest England)



The Establishment of the Academic Oversight Committee

Samuel J. Tromans and Angela Hassiotis

As part of the Royal College of Psychiatrists' Faculty of Psychiatry of Intellectual Disability's commitment to promoting evidence-based practice, we have established an Academic Oversight Committee to review clinical guidelines, policy documents, and other key publications relevant to the people we serve.

As Committee Chairs, we will work with a group of academic intellectual disability psychiatrists from across the United Kingdom to undertake structured reviews of these documents using a standardised appraisal framework. Our focus will be on assessing the extent to which recommendations are supported by the available evidence, identifying areas of uncertainty, and highlighting important gaps in the evidence base.

The Committee will meet regularly and report to the Faculty Executive Committee. We will also share our findings with relevant stakeholders, including organisations responsible for developing guidelines and policy documents. Where appropriate, we hope to disseminate our work more widely through presentations, publications, and other academic outputs.

It is essential that psychiatrists have a strong voice in shaping clinical practice and future research. By critically evaluating the evidence underpinning key recommendations, the Committee aims to support high-quality care while helping to identify priorities for further research and evidence generation.

We are due to hold our inaugural meeting in September and look forward to updating Faculty members on our progress in the months ahead.

The **members** of the committee include

1. Afia Ali (Queen Mary University of London)
2. Satheesh Gangadharan (Leicestershire Partnership NHS Trust and Loughborough University)
3. Sujeet Jaydeokar (Cheshire and Wirral Partnership NHS Foundation Trust and University of Chester)
4. Iain McKinnon (Newcastle University and Cumbria Northumberland Tyne and Wear NHS Foundation Trust)
5. Jane McCarthy (Sussex Partnership NHS Foundation Trust)
6. Raja Mukherjee (Surrey and Borders Partnership NHS Foundation Trust and University of Salford)
7. Sarah Pape (King's College London and Oxleas NHS Foundation Trust)
8. Bhathika Perera (University College London)
9. Rory Sheehan (King's College London)
10. Andrew Stanfield (University of Edinburgh)
11. Lance Watkins (Swansea Bay University Health Board and University of Plymouth).



Obituary

In Loving Memory of Dr Bijil Simon Arackal, DPM, FRCPsych (1st August 1970 – 21st July 2026)



Dr Bijil Simon Arackal (affectionately known as “Biji”) was a Senior Psychiatrist with the Intellectual Disabilities Service in Chichester, West Sussex, and passed away surrounded by the enduring love of his family. His life was celebrated on August 7, 2026, at St. Mary’s Church, Bosham, Chichester.

Early Life & Roots:

Born to Simon C. Peter (retired Chief Engineer, Kerala Water Authority) and the late Mrs Accamma Simon, Bijil grew up in Kerala alongside his brothers, Vineeth and the late Dr Arun. His youth was filled with cherished memories, from swimming across the Thodupuzha River to sharing made-up stories, building bonds that spanned continents.

Academic Excellence & Professional Leadership:

A brilliant mind and voracious reader, Bijil completed his MBBS at Calicut Medical College, earned his Diploma in Psychological Medicine at NIMHANS, and moved to the UK in the year 2000. He completed his CCT in Intellectual Disabilities via the Charing Cross Training Scheme.

For nearly 18 years, Bijil served as a Consultant Psychiatrist in Chichester and, for a time, as Clinical Lead. A Fellow of the Royal College of Psychiatrists, he served as an elected member of the Executive Committee of the Faculty of Psychiatry of Intellectual Disability and as a college examiner, encouraging several friends to become examiners alongside him. He remained deeply engaged in the College’s work and thoroughly enjoyed being a psychiatrist.

Bijil was also an active, dedicated pillar of the UK Calicut Medical College Alumni organisation, serving as its Treasurer for many years.

A Cherished Colleague & Mentor:

To his peers and trainees, Bijil was an extraordinary mentor and friend. Known for his deep knowledge base, wisdom, and approachable nature, he was always ready with sound guidance, honest advice, or a listening ear. He had a knack for using funny stories to lighten difficult clinical situations, inspiring core and higher trainees alike with his quiet integrity and unwavering dedication to his patients.

A Devoted Family Man:

Above all, Bijil adored his family. He was the glue holding the Arackal family together, tracking milestones and writing detailed Christmas chronicles. To his wife, Sandhia, he was a steady partner; to his daughters, Taniya, Amanda, and Anjali, he was an anchor, mentor, and greatest advocate. Whether debating global politics, driving at dawn for airport drop-offs, or cheering at dance and gymnastics displays, his world



revolved around his family, including his son-in-law, Hormis.

Legacy:

Bijil brought warmth, humour, and resilience to every space he entered, loving vibrant gatherings filled with good music, fine whisky, and spirited conversation.

Bijil is survived by his father, Simon; his wife, Sandhia; his daughters, Taniya, Amanda, and Anjali; his son-in-law, Hormis; his brother, Vineeth; and a wide network of family, colleagues, and friends. As per Bijil's wish, at his funeral, his daughter Amanda sang this song as a tribute to her dad:

*"Shepherd me, O God, beyond my wants,
beyond my fears, from death into life.*

Reflections from Colleagues in Sussex:

Bijil worked in Sussex as a Consultant Psychiatrist in Learning Disability Service based in Chichester, West Sussex for nearly 18 years, he was the Lead Psychiatrist for the Service during that time and was a trainer inspiring many core and higher trainees over the years. Bijil was also committed to the work of the Royal College of Psychiatrists and served as an elected member on the Executive Committee of the Psychiatry of Intellectual Disability Faculty.

Bijil will be remembered as a special man to the many who were fortunate to know him. He was admired, respected and warmly appreciated by patients to whom he was committed. Bijil was an amazing colleague, always available, ready with sound advice and guidance (especially to those of us juniors). Bijil was approachable, kind, generous with his time and always had wise thoughts and advice for colleagues. He was very committed and supportive to his trainees.

Bijil always had a story to tell, often a funny one that lightened tricky situations. He was a highly regarded and respected peer who not only offered honest and valuable advice but always went the extra mile in providing a listening ear. His strong knowledge base, wisdom and desire to constantly learn instilled inspiration. Nothing

was ever too much, and he was always there for his colleagues and patients.

Moreover, he will be remembered as a devoted friend and a kind human being.

His love for his family was clear from the stories he kindly shared. He will above all be remembered as a devoted husband and a father who adored his girls.

"Rest in eternal peace, Biji. Your light, wisdom, and laughter remain forever anchored in our hearts."

Evidence in Context

Cancer prevention and screening for people with intellectual disabilities in Europe: a systematic review and recommendations for policy and practice

REVIEW article

Front. Public Health, 20 August 2026

Sec. Public Health Policy

Volume 14 - 2026

| <https://doi.org/10.3389/fpubh.2026.1925665>

This systematic review, *"Cancer prevention and screening for people with intellectual disabilities in Europe,"* maps the extent to which European cancer policies, guidelines, and recommendations address the needs of people with intellectual disability. The authors highlight that people with intellectual disability experience significant inequalities across the cancer care continuum, including *"lower screening participation, later-stage diagnosis, and higher cancer-related mortality."* Despite these disparities, it has been unclear whether European cancer prevention and screening policies explicitly include this population.

The review searched academic databases and grey literature up to August 2025, using the PCC (Population, Concept, Context) framework. Although 2,394 academic records were screened, *"all database sourced records were excluded at title and abstract screening."* The entire evidence base came from grey literature sources such as Google, organisational websites, and policy portals. Out of 141 full-text documents assessed, only 16 met inclusion criteria.

These 16 documents came from just five jurisdictions: the United Kingdom (n=9), the Netherlands (n=4), Belgium (n=1), Denmark (n=1), and the European Union (n=1). Most were national-level recommendations or guidelines, with screening overwhelmingly dominating the focus. Fifteen documents addressed screening;

only one addressed prevention, and two addressed clinical monitoring. No documents addressed treatment, survivorship, or palliative care.

The review found that adjustments for people with intellectual disability were concentrated on breast, cervical, and bowel screening. These adjustments fell into several recurring categories:

- **Accessible information:** Easy-Read invitations, pictorial guides, videos, and clear explanations were widely recommended.
- **Appointment adaptations:** Flexible scheduling, extended appointments, pre-visit familiarisation, and sensory accommodations such as quiet environments.
- **Carer involvement:** Support persons were recommended across all screening types, including assistance with communication, positioning, and home-based bowel test completion.
- **Consent and capacity:** Many documents emphasised supported decision-making, individual capacity assessment, and avoiding exclusion based solely on disability.
- **Alternative screening modalities:** For example, CT colonography under general anaesthetic, HPV self-sampling, or acceptance of imperfect mammography images.
- **Workforce training:** Several documents highlighted the need for staff training in communication, consent, and reasonable adjustments.

The review also identified two syndrome-specific monitoring documents: one for Cowden syndrome and one for Down syndrome. These provided detailed surveillance protocols for cancers such as thyroid, renal, melanoma, uterine, and testicular cancer.

A major finding was the uneven geographic distribution of guidance. The UK and Netherlands accounted for 81% of all included documents. No eligible guidance was found for most EU member states, including high-



expenditure countries such as Germany and Ireland. The authors note that this likely reflects a genuine policy gap rather than a search failure, because native-language reviewers conducted searches in each country.

The review also highlights that screening dominates the policy landscape, while prevention, treatment, survivorship, and palliative care are almost entirely absent. For example, *“No specific guidance was identified on smoking, alcohol reduction, diet, physical activity or HPV vaccination.”* Similarly, there was no guidance on managing positive screening results or ensuring accessible diagnostic follow-up.

The authors argue that focusing solely on screening access is insufficient. People with intellectual disability often present with late-stage cancers, and diagnostic overshadowing remains a major barrier. Because organised screening only covers breast, cervical, and colorectal cancer, earlier detection of other cancers depends on symptom recognition yet policies rarely address this .

The review concludes with recommendations for EU-wide coordination, national development of ID-inclusive cancer screening guidance, legislative strengthening of reasonable adjustments, and embedding adjustments as standard practice rather than optional accommodations. The authors emphasise that the current evidence base is fragmented, largely invisible in academic literature, and in need of systematic expansion.

References

Vukovic V, Knapp P, Sykes K, Denny M, Kowalczyk O, Denieffe S, Wells J, Cuypers M, Tyner B, Lima KY, Popa AE, Ibrahim DI, Hansford R, Allerslev Horsbøl T, Milutinović D, Güvenç Tuna B, Şahin EB, Ilgaz A, Banda A, Sarac E, Doğan S, Akbulut SCY, Aksoy B, Tadić D, Merzah MA, Soylar P, Doğan A, Simin D, Mušanović J, Altin D, Topkaya MS, Kassymbekova F, Trajkovski V, Tar Bolacali E, Lynch L, Burke E and McMahon M (2026) Cancer prevention and screening for people with intellectual disabilities in Europe: a systematic review and recommendations for policy and practice. *Front. Public Health* 14:1925665. doi: 10.3389/fpubh.2026.1925665



Media

“Assume That I Can”: Expectations, Dignity and the Quiet Harm of Low Assumptions



Dr Mandeep Gill

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

World Down Syndrome Day is celebrated annually on March 21st. This year, I am reminded of a short campaign video titled “Assume That I Can” that had been widely shared online in 2024 (Tevlin, 2024). At the time, I was a CT1 doctor in psychiatry training, and I had minimal experience of intellectual disability and so this video had really struck me. Madison Tevlin features in this video, she is a Canadian woman who is an actor, broadcaster, advocate and content creator and uses her platform to challenge misconceptions about people with Down syndrome. She often says that her diagnosis is “the least interesting thing about me,” emphasising that her personality, talent and ambitions are what truly define her. In the ‘Assume that I Can’ video, Madison Tevlin looks directly into the camera and challenges the viewer with various statements. She asks us to

assume that she can work. She asks us to assume that she can live independently. She asks us to assume that she can learn Shakespeare. She asks us to assume that she can have sex. She confronts us to assume that she can, so that maybe she will. The message is simple but deeply confronting.

I have just started my rotation in intellectual disability, and my mind still casts back to the ‘Assume That I Can’ video and the message Madison Tevlin had conveyed to me. It made me think that societal attitudes profoundly influence the lives of the people we support. Yet the video invites a more uncomfortable reflection about how often our own assumptions, even well-intentioned ones, shape the trajectories of our patients?

Low expectations rarely announce themselves as prejudice. They often present as protection. We may hear phrases such as “he wouldn’t manage that,” “she’s not able to cope,” or “it’s too risky.” These statements are usually motivated by care. But when assumptions are made before assessment, before discussion, and before exploration of support needs, they risk quietly limits the autonomy of the patients we care for.

The Mental Capacity Act reminds us that we must begin with a presumption of capacity. This principle is foundational, yet in practice it can be challenging. In busy services, decisions are sometimes made quickly, particularly when risk is perceived. However, presuming incapacity without careful assessment contradicts both the law and the spirit of person-centred care. The Act also reminds us to take the least restrictive option. That principle requires us to balance safety with autonomy and not to default to restriction because it feels more comfortable.

Nowhere is this tension more apparent than in conversations about relationships, sexuality, employment and independent living for our patients with learning disabilities. In clinical meetings, safeguarding concerns are often at the forefront and appropriately so. But when



protection becomes the dominant lens, opportunity can recede into the background. The concept of “dignity of risk” recognises that a meaningful life inevitably involves some degree of uncertainty. For people with intellectual disability, this principle is sometimes applied inconsistently. We would rarely consider removing all risk from the life of a neurotypical adult. But for our patients, the threshold for concern may be lower.

In multidisciplinary settings, language matters. How we describe someone in ward rounds, case discussions and documentation shapes the narrative around them. Are we describing deficits, or are we identifying strengths alongside needs? Are we asking the person what they want, or primarily speaking about them? Small shifts in language can signal larger shifts in culture.

adopt limiting narratives. The video serves as a mirror not to accuse, but to prompt reflection.

There is also a broader societal dimension. Employment rates for people with intellectual disability remain significantly lower than the general population. In the UK, just around 5% of people with a learning disability are in paid employment, despite the overwhelming majority wanting to work. Health inequalities persist and social isolation is common. While many of these factors are structural, expectations play a role. When families, educators, employers and clinicians collectively assume reduced capability, opportunities shrink. Conversely, when high but realistic expectations are combined with appropriate support, outcomes improve (Bloomer, 2025).



As resident doctors, many of us are still forming our professional identities within ID services. We inherit systems, practices and risk frameworks that predate us. Reflecting on our assumptions is not about self-criticism, but about growth. It requires humility to recognise that even compassionate clinicians can unconsciously

The role of the intellectual disability psychiatrist is unique. We sit at the intersection of medicine, ethics, law and social care. We are often involved.

in complex decisions about capacity, risk and best interests. Our assessments can open doors



or close them. Recognising the power of that responsibility is essential.

The video's message "*Assume that I Can*" does not advocate recklessness. It does not deny vulnerability or support needs. Rather, it asks us to shift the starting point. Instead of assuming limitation and then allowing possibility if proven otherwise, it invites us to assume potential and then identify the support required to realise it safely. It is a professional challenge. It asks us to begin from a position of belief in the person's potential, to assess capacity carefully rather than reflexively, to balance protection with empowerment, and to remain alert to how our language shapes possibility.

Perhaps the most powerful aspect of the video for me is its directness. It does not ask for sympathy. It asks for expectation. In Intellectual Disability Psychiatry, that shift, from protection alone to protection alongside possibility, may be one of the most important contributions we can make. Our role is not to decide the limits of a person's life. It is to create the conditions in which possibility can be explored safely, respectfully and lawfully.

References

1. Tevlin, M. (2024) *Assumptions Become Reality | Assume That I Can | World Down Syndrome* [Online Video], YouTube. Available at: <https://www.youtube.com/watch?v=4fHGsLuA76w>
2. Bloomer, A. (2025) *Only 5% of people with learning disabilities in employment, finds landmark Mayfield review*, *Learning Disability Today*, 6 November [Online].

Author

Dr Mandeep Gill is an ST3 in Psychiatry of Intellectual Disability currently working in Berkshire Healthcare NHS Foundation Trust. Her article has won this edition's best article from Resident/SAS doctors.



Musings

If Intellectual Disability Psychiatry Were a Netflix Series



Dr Lisa Schomerus

If Intellectual Disability (ID) psychiatry were a Netflix series, I suspect I would already recognise many of the characters and storylines.

As a CTI with no prior experience in ID services, I've found myself imagining the themes, ethical dilemmas, and quiet plot twists that might define the specialty. The more I reflect, the more I realise many themes have already appeared throughout my training and daily life, including through the media.

The opening scene would not be in a specialist clinic. It would be in a diner, drawing from my own experience. The series would start here in everyday life, because that's where most assumptions are made.

One busy evening, whilst introducing myself as the waitress and asking about allergies, my eyes were drawn to a bright blue bracelet on one diner's wrist: *"I have an intellectual disability. Please be patient."* The restaurant was loud and fast-paced. Later, I brought a colleague on their first shift to take orders with me. The customer responded in a way that didn't quite match the rhythm of the room. Focused on efficiency and training my colleague, we instinctively turned to his family to "clarify". Only later did I reflect on

how quickly the conversation had shifted away from him. It was subtle, but these almost invisible



moments are where 'autonomy' begins to slip!

I was reminded of this experience when watching *Out of My Mind* (Sealy, 2024), an adaptation of Sharon Draper's novel which follows Melody, a girl with cerebral palsy who cannot communicate verbally. The audience hears her rich internal monologue, which powerfully dismantles the assumption that communication difficulty equals lack of understanding. Since watching, I now wait longer in consultations. I direct questions back to the person, even when answers take time. Episode one: assume competence first.

Another episode would explore romance and sexuality, and what autonomy and individuality mean within these relationships. Watching *Gabrielle* (Archambault, 2013), the French-Canadian film about a young woman with Williams syndrome navigating love and independence, made me realise how deeply society infantilises people with intellectual disability. Gabrielle sings, falls in love and wants independence. Her relationship with Martin challenges the idea that people with intellectual disability are less entitled to romantic and sexual lives. The power of Gabrielle's story lies in its ordinariness: she desires intimacy, pushes boundaries and negotiates risks like many young adults, yet the world struggles to see an adult with her own will.



The film made me reflect on how mental health professionals are trained to prioritise safety. Safeguarding is essential, as is ensuring dignity. *Gabrielle* reminds us that autonomy is rooted in individuality; every person has distinct preferences, goals, tolerance for risk, and strengths which means good decisions require nuance.

Crucially, Gabrielle's sexuality is not a side plot; it is part of who she is. Love, sex and intimacy are often overlooked when we think about people with intellectual disabilities. A 2025 systematic review (Moura, Franco and Minetto, 2025) found that people with intellectual disabilities often want romantic relationships, but are frequently overlooked in research and face barriers including societal expectations, lack of support and inadequate sex education.

Episode three would centre on grief and behaviour. While working in a Child/ Adolescent Mental health team, I encountered a referral of a young person with "challenging behaviour", with brief mention of ID. Sitting with the young person and their family, the story unfolded differently: a recent bereavement, change of carers, disruption in routine. The term "challenging behaviour" began to feel unsuitable, and I've since reframed behaviour as a sign to explore difficult emotions or unmet needs. It also reminded me that presentations in people with intellectual disability are rarely explained by one factor alone; communication difficulties, mental health, physical health, changes in routine and social context can all interact and lead to complexity. The behaviour may be the most visible part, but is rarely the whole story.

My series would be incomplete without the mention of inequalities and persistent health disparities that people with intellectual disability face. Reduced access to healthcare and diagnostic overshadowing continue to result in poorer outcomes (American Association on Intellectual and Developmental Disabilities, n.d.). These are rarely headline dramas, and in my opinion, representation of disparities facing people with intellectual disability is hugely

lacking in the media. This is important because the media shapes public attitudes and, subtly, clinical practice. If disability is framed as a personal tragedy, there is a risk of over-medicalising disability and focusing primarily on an individual's impairment rather than societal attitudes, inequalities and barriers that contribute to their experiences. Conversely, when disability is absent from representation altogether, there is a risk that it becomes overlooked within society. Even well-intentioned media can lead to gaps. I have noticed fewer portrayals of people with profound ID, or how disability intersects with ethnicity, gender and



socioeconomic disadvantage.

Dramas like *Then Barbara Met Alan* (Goodison and Sharma, 2022), following the story of disability rights activists in the UK, remind us that inclusion was fought for. The more I read, watch and observe, the clearer it becomes that advocacy in ID Psychiatry is an integral part of the role.

Now let's talk production. For me, authentic representation isn't just about casting, it's about authorship. My screenplay is still in draft form, as those with lived experience and those around them must help to write the narrative.

If intellectual disability psychiatry were a Netflix series, it has already started, and I now realise I hadn't just been watching. The series would not be a niche spin-off; it would show how intellectual disability is woven through everyday life - in diners, schools, workplaces, friendships and families. I've been an extra, seeing the narrative unfolding around me, sometimes missing the deeper plot.



Perhaps the real shift needs to be in perspective, recognising that intellectual disability was never a subplot but an integral part of the narrative all along.

Am I ready to play a bigger part as well?

References

- American Association on Intellectual and Developmental Disabilities (n.d.) *Health disparities and advocacy resources*.
- Archambault, L. (dir.) (2013) *Gabrielle* [Film]. Canada: micro_scope.
- Goodison, B. and Sharma, A. (dirs.) (2022) *Then Barbara Met Alan* [Television film]. UK: Dragonfly Film and Television Productions and One Shoe Films.
- Moura, N.M., Franco, V.D. and Minetto, M.F. (2025) 'Romantic relationships and sexuality of people with intellectual disabilities: a systematic literature review'.
- Sealy, A. (dir.) (2024) *Out of My Mind* [Film]. USA: Big Beach, Participant, Disney Branded Television and EveryWhere Studios

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Conferences

Reflections on the Child & Adolescent Intellectual Disability Psychiatry Network (CAIDPN) Conference (7-8 May 2026)



Dr Anjila Pradhan



Dr Olivia Campbell

The 2026 Child & Adolescent Intellectual Disability Psychiatry Network (CAIDPN) Conference was our first opportunity to attend this two-day event, held in London across two iconic venues: King's College London and the Science Gallery. As trainees with an interest in Child and Adolescent Mental Health Services (CAMHS) and Intellectual Disability (ID) psychiatry, we were keen to learn about current developments in research and clinical practice while connecting with professionals working in the field. We had heard of the CAIDPN network previously and about these welcoming, international conferences that offer a unique opportunity to collaborate and share knowledge with professionals within CAMHS-ID from all over the UK, Ireland and beyond.

The **first day of the conference** was titled "From research to practice: advancing early intervention, treatment and services for children

and young people with intellectual disabilities". The conference opened with a powerful presentation by Professor Caroline Richards highlighting the importance of early intervention to support behaviours that challenge in children with ID. This talk made us reflect on the importance of ensuring parents and carers have access to supportive communities, understanding their unmet need to feel connected and get practical advice from fellow carers about their own lived experiences. The importance of peer support and connection appeared to be a theme throughout the conference, not just in terms of the young people and their carers but for the professionals who work alongside them too.

There was a talk by Jenny Weston and Kayleigh Rodbard from Hertfordshire, where children and young people with autism and/or ID with complex needs and behavioural challenges were supported with a multi-disciplinary early intervention approach. We were particularly impressed by the emphasis on equipping families with strategies that could be sustained beyond discharge. Prof Vicky Slonims, consultant speech and language therapist, gave an overview of available evidence-based information about challenges faced by children with ID, the interventions and understanding how to gain and maintain the autonomy and independence for them. This was truly enlightening.

Listening to the lived experience of Mary Busk during the reflection panel discussion, whose child has severe intellectual disabilities and autism, provided a powerful insight into challenges families face to navigate through the system in order to make sure their children's voices and needs are heard. Hearing about the battles she had to fight to make a way for her son to be supported was quite emotional. It was inspiring to hear about her journey and where she now is involved in public sectors advocating about this topic and has been involved in a number of research opportunities. The importance of carers as voices for their loved ones should serve as a reminder to professionals that within healthcare systems, we too can act as advocates for our patients and service users.



The **second day of the conference** focused on genetics, ADHD, medications and catatonia. Day one featured discussion around non-pharmacological interventions whereas day two brought in more discussion around pathology and pharmacology.

The presentation of the clonidine case series and low dose medication survey helped us understand the importance of tailoring to the needs of patients and thinking beyond guidelines when needed. The varied discussion and perspectives around clonidine use following the talk served as an example of how helpful access to peer groups can be when working within this specialty.

The sessions on genetics highlighted how rapidly genomics is transforming clinical practice in CAMHS-ID services. It reinforced the importance of considering genetic referrals early and reminded us that timely diagnosis can significantly influence the support available to young people and their families. On top of that, it helped us understand the role of clinical geneticists and genetic counsellors. There is significant overlap between CAMHS-ID and clinical genetics so an opportunity to learn more about this other service was very welcome.

Discussion of a case presentation by Helen Simmons about a young person with autism, ID and catatonia highlighted the importance of multi-disciplinary teams. An interesting case of complex catatonia presented by Amy Blake gave us insight about thinking outside the box and the importance of advocating for our vulnerable patients to make sure that they get the best possible care.

One of the greatest benefits of the conference was the opportunity to make connections with the specialists from various disciplines across the UK and even overseas. Getting to know how the same things are done differently in their regions compelled us to compare how things are done in the area where we work and perhaps what we can improve on. Learning opportunities and possibilities available out there in this field which might not be easily available online, speaking to experts first hand,

listening to their life story, career journey, and words of wisdom were a truly amazing experience for us.

We would definitely recommend any trainees considering taking up this speciality to attend this conference. It gives an overall view from a trainees' perspective to the horizon of possibilities they can access when they move further in their career. We left the conference not only feeling inspired by the passion and dedication demonstrated by the speakers and attendees but with a genuine heartwarming feeling. We found everyone we interacted with at the conference to be approachable, friendly and genuinely willing to offer support and guidance within the field.

Child & Adolescent Intellectual Disability Psychiatry Network (CAIDPN)

Overview by Dr Ashley Liew (Consultant Paediatric Neuropsychiatrist)

CAIDPN is an international network of more than 200 psychiatrists interested in improving the healthcare and lives of children with ID through peer support in the areas of clinical work, service development, training and research. We have an active online platform for discussions and sharing of resources; and organise 2-4 larger meetings annually. Check out our webpage: (<https://www.acamh.org/hub/caidpn/>) with details of how to join the network for free and look out for information about our next 2-day residential conference in May 2027 in Dublin. There are Trainee bursaries available to attend the conference (of which Dr Pradhan was a recipient this year).

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Audit

Use of STAMP Criteria in Children with Intellectual Disability and/or Autism at CYPS Malta



Dr Nicole Mifsud

Psychotropic medication can play an important role in managing mental health conditions in children. However, in children with Intellectual Disability (ID) and Autism Spectrum Disorder (ASD), prescribing must be especially careful, proportionate, and regularly reviewed (Matson and Neal, 2009).

The STAMP initiative (Supporting Treatment and Appropriate Medication in Paediatrics) promotes safe and appropriate prescribing, ensuring medication is not used as a substitute for behavioural or psychological support (NHS England, 2019; Swanepoel and Lovell, 2023).

At Child and Young People's Services (CYPS), St. Luke's Hospital, we carried out an audit to examine how closely current prescribing practices align with STAMP principles.



St Luke's Hospital building

Why Does STAMP Matter?

Children with ID and/or ASD are more vulnerable to medication side effects. They may struggle to communicate discomfort, and many have complex physical or neurological conditions such as epilepsy (Royal College of Psychiatrists, 2021; Matson and Neal, 2009).

National and international guidance, including NICE and the Royal College of Psychiatrists, emphasises that medication should not be used as a first-line treatment for behaviour alone. Behavioural and psychological interventions should be tried first. When medication is prescribed, it must have a clear clinical indication, be regularly reviewed, and involve families in shared decision-making throughout the process (NHS England, 2019; NICE, 2015; Royal College of Psychiatrists, 2021).

STAMP promotes these principles and supports responsible prescribing (NHS England, 2019; Swanepoel and Lovell, 2023).

Our Aims

1. Assess whether prescribing practices align with STAMP guidance.
2. Identify how many children were prescribed psychotropic medication and which types.



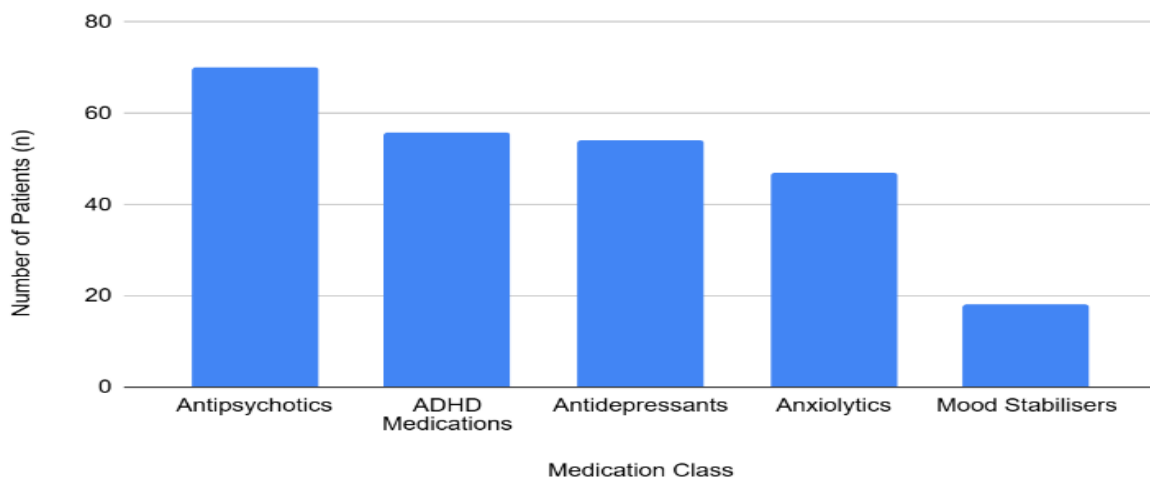
3. Review documentation of multidisciplinary input, behavioural strategies, medication reviews, and carer involvement.

Who Was Included?

We reviewed 120 children with ID. Mean age: 14.7 years including 86 males (72%), 34 females (28%), 75.8% (n = 91) of which had ASD. Common co-existing conditions included ADHD (60%), anxiety

carer involvement in care planning was recorded in all patients (100%). Medication reviews within the previous 12 months were documented for 117 patients (97.5%), and reduction or tapering plans were present for 81 patients (67.5%)

Number of Patients (n) vs Medication Class



What Did We Find?

113 patients (94.2%) were prescribed psychotropic medications. Antipsychotics were most commonly prescribed (n = 70, 58.3%), followed by ADHD medications (n = 56, 46.67%), antidepressants (n = 54, 45%), anxiolytics (n = 47, 39.17%), and mood stabilisers (n = 18, 15%). A clear clinical indication was documented in 100% of cases.

Non-pharmacological interventions were widely used (n = 115, 95.8%), with school-based support in 88 patients (76.5%), psychology assessments/referrals in 42 (36.5%), behavioural therapy in 35 (30.4%), occupational therapy in 28 (24.3%), and psychotherapy in 24 (20.9%). Multidisciplinary team (MDT) involvement was documented in 117 cases (97.5%), and parent or

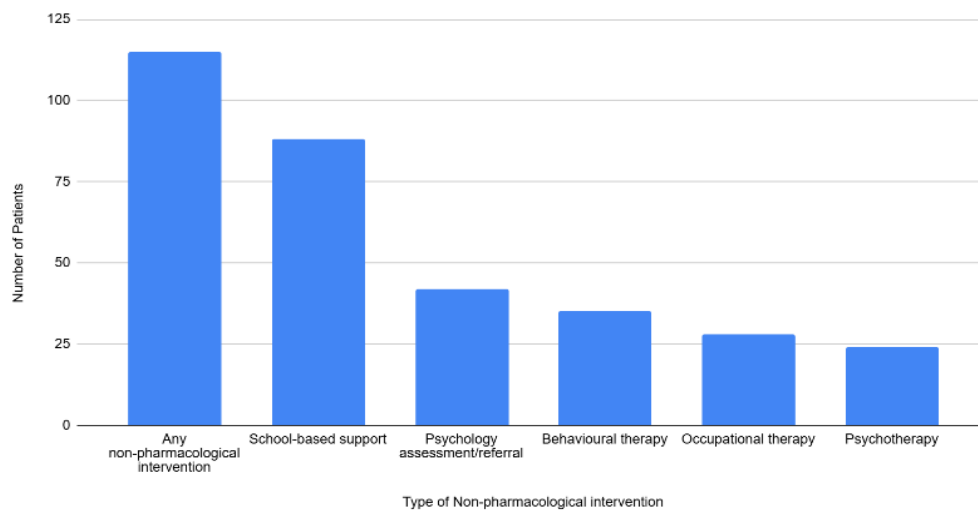
Key Strengths Identified

1. Clear Clinical Justification: Every prescription had a documented clinical indication, ensuring transparency and accountability in prescribing.
2. Multidisciplinary Approach: The vast majority of cases showed MDT involvement, in spite of having such a small team, suggesting good practice.
3. Regular Review Processes: Medication reviews were consistently documented, aligning with STAMP recommendations (NHS England, 2019; Swanepoel and Lovell, 2023).
4. Carer Involvement: Families were actively involved in decision-making, promoting shared and informed care planning.



5. Depre
proportion of
reduction or t

Number of Patients vs. Type of Non-pharmacological intervention



Areas Requiring Further Development

1. Formal behavioural therapy was documented in only 30% of cases, despite guidance recommending behavioural approaches as first-line management where no defined psychiatric disorder is present. This may be as general CAMHS practitioners are not always trained to carry out behavioural work in our cohort of patients (NICE, 2015).
2. Greater emphasis is needed on structured behavioural strategies before initiating or continuing medication.
3. Polypharmacy as highlighted by 67 patients out of 120 patients total (55.83%), being on two or more psychotropic medications.
4. This audit did not look at doses of psychotropic medication used, something which is worth noting in future projects to ensure appropriate prescribing in paediatric cohorts.

The audit relied on patient documentation, so missing or incomplete records may have affected the findings. There was insufficient detail about the school-based interventions offered, and records did not consistently show whether support was provided by the national health service or the private sector.

Our Action Plan

To improve further, we plan to:

1. Introduce a structured side-effect and benefit checklist for all medication reviews.
2. Monitor the progress of patients currently on reduction plans through quarterly follow-up.
3. Develop easy-read medication leaflets for families and children.
4. Re-audit in 6–12 months after change is implemented to monitor for progress.

Conclusion

This audit describes a highly complex paediatric neurodevelopmental population. While psychotropic medication use was high, prescribing was largely supported by clear documentation, multidisciplinary involvement, and regular review.

This audit hopes to highlight the need for behaviour support practitioners within the intellectual disability team. This would further support the implementation of behavioural strategies and would support reducing psychotropic prescribing and a shift away from medicalised models of care and towards holistic care centred around the family and the child.



References

1. Matson, J.L. and Neal, D. (2009) 'Psychotropic medication use for challenging behaviors in persons with intellectual disabilities: an overview', *Research in Developmental Disabilities*, 30(3), pp. 572–586. doi: 10.1016/j.ridd.2008.08.007.
2. NHS England (2019) STOMP and STAMP: patient leaflet. Available at: NHS England STOMP and STAMP patient leaflet (Accessed: 8 September 2026).
3. National Institute for Health and Care Excellence (NICE) (2015) Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges. NICE guideline NG11. Available at: NICE guideline NG11 (Accessed: 8 September 2026).
4. Royal College of Psychiatrists (2021) Stopping the over-medication of people with intellectual disability, autism or both (STOMP) and supporting treatment and appropriate medication in paediatrics (STAMP). Position statement PS05/21. Available at: Royal College of Psychiatrists position statement PS05/21 (Accessed: 8 September 2026).
5. Swanepoel, A. and Lovell, M. (2023) 'Stopping inappropriate medication of children with intellectual disability, autism or both: the STOMP–STAMP initiative', *BJPsych Advances*, 29(5), pp. 358–366. doi: 10.1192/bja.2023.14.

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**Professor Joan Bicknell Medical
Student Essay Prize 2025**

Balancing Risk and Autonomy: Reflections from a Forensic Intellectual Disability Tribunal



Chandan Singh Sekhon

***“No one shall be deprived of his liberty save...
in accordance with a procedure prescribed by
law” - European Convention on Human
Rights, Article 5***

The first words Ms A whispered after her tribunal were, “I just want to go home.” I met Ms A during a psychiatry placement on a forensic intellectual disability ward. She was a 28-year-old woman with a mild intellectual disability and schizoaffective disorder, detained under section 3 of the Mental Health Act after an incident that injured a neighbour. My conversations with her and attendance at her tribunal prompted me to reflect on how forensic services balance safety, liberty and respect for autonomy.

Risk Management:

Ms. A's case highlights how challenging behaviours intersect with care. Under UK law, individuals with ID can be detained if they exhibit dangerous and harmful behaviours even without a diagnosis for a separate mental illness (Hollins, Lodge and Lomax, 2019). In practice, it is

the responsibility of healthcare professionals to interpret such behaviours carefully, as there is the risk of diagnostic overshadowing if attributing behaviours solely to ID (Hollins, Lodge and Lomax, 2019).

Although section 3 of the Mental Health Act authorises detention for renewable six- and twelve-month periods, in practice, patients with ID in forensic settings often remain in hospital for years (Alexander et al., 2015), oftentimes without a clear care and treatment plan in place (Care Quality Commission, 2022), ultimately delaying discharge (Ince et al., 2022). Despite comparable clinical and forensic histories between ID and non-ID patients, ID patients report higher levels of behavioural incidents and risk assessment scores compared to their non-ID counterparts (Chester et al., 2018). This can lead to greater rates of seclusion and long-term enforced isolation, which may not be therapeutic for ID patients (Chieze et al., 2019), and can instead be harmful, potentially risking patients' mental and physical health (Quinn et al., 2022).

Individuals with ID may not be in a position to advocate for better care and high-quality service provision, and there may be difficulty in delivering adequately high-quality care in some environments due to, for example, staff numbers, local follow-up services, and physical space in wards. This issue, combined with the fact that patients with ID can be ‘stuck in the system’, means that this demographic is often highly vulnerable in this setting (Sampson et al., 2016).

Ethical and Legal Considerations:

Ms. A was detained under section 3 of the Mental Health Act 1983, giving her the right to periodic review. Patients are entitled to a first-tier Mental Health Tribunal to contest their detention (GOV.UK). A tribunal is “a formal meeting where a group of people discuss the decision to continue to care for and treat you in hospital” (Royal College of Psychiatrists, 2023). The tribunal aims to consider the hospital's view and the interests of the patient, aiming to “listen



to both sides of the argument” (Royal College of Psychiatrists, 2023).

Ms. A very kindly consented for me to attend the tribunal and observe the process. During the hearing, the ward nurse presented evidence of Ms. A's continuing symptoms, with other staff members supporting the nurse in highlighting Ms. A's improvement and ongoing personal wishes. An 'easy read' summary of the process was provided for Ms. A. Conversations with the consultant psychiatrist after the tribunal helped me understand the fact that although Ms. A may have had capacity for some decisions (such as her personal preferences), she likely lacked capacity to fully understand the legal nuances of the tribunal. Under the Mental Capacity Act, if someone lacks capacity to make a decision, any action must be in their “best interests” and as least restrictive as possible (Mencap, n.d.). The difficulty of balancing the patient's wishes and the clinical opinion of the team responsible for her care struck me, because she may not have had capacity, but she did have very real emotions.

This experience reinforced for me that legal hearings, while necessary, can be an alienating experience. It was a difficult experience, ultimately, as I thought Ms. A felt powerless under the law. However, I felt more determined to advocate for the patient's voice more strongly in my own practice. Reflecting on the tribunal heightened my awareness of rights. Whilst the current Mental Health Act contains an exceptional clause for people with intellectual disability, this is controversial. Some critics argue that it is discriminatory that patients with ID can be detained “purely on grounds of behaviour” that wouldn't justify others' detention (Hollins, Lodge and Lomax, 2019). However, the 2024-25 Mental Health Bill proposes removing learning disability and autism as stand-alone grounds for compulsory treatment under section 2, reserving detention only for cases with co-existent psychiatric disorder, although the proposals do not fully abolish the exception in criminal justice settings (Paveley and Lavis, 2024).

Conclusion:

My time with Ms. A helped me understand how to address the individual's needs and help make the person feel valued. Simultaneously, understanding legal frameworks (such as the Mental Health Act and Mental Capacity Act) was paramount to understanding and respecting Ms. A's rights. Personally, this experience taught me to be reflective of my own practice to recognise the patient perspective, and to monitor my own emotions when making legal decisions to act in the patient's best interests.

References

1. Alexander, R., Devapriam, J., Michael, D., McCarthy, J., Chester, V., Rai, R. et al. (2015) 'Why can't they be in the community?' A policy and practice analysis of transforming care for offenders with intellectual disability. *Advances in Mental Health and Intellectual Disabilities*, 9(3), pp. 139–148. doi: 10.1108/AMHID-02-2015-0011.
2. Care Quality Commission (2022) Out of sight – who cares? Restraint, segregation and seclusion review. Available at: <https://www.cqc.org.uk/publications/the-med-work/rssreview> (Accessed: 1 October 2025).
3. Chester, V., Völlm, B., Tromans, S., Kapugama, C. and Alexander, R.T. (2018) 'Long-stay patients with and without intellectual disability in forensic psychiatric settings: comparison of characteristics and needs', *BJPsych Open*, 4(4), pp. 226–234. doi: 10.1192/bjo.2018.24.
4. Chieze, M., Hurst, S., Kaiser, S. and Sentissi, O. (2019) 'Effects of seclusion and restraint in adult psychiatry: a systematic review', *Frontiers in Psychiatry*, 10. doi: 10.3389/fpsy.2019.00491.
5. GOV.UK (n.d.) Apply to the Mental Health Tribunal. Available at: <https://www.gov.uk/mental-health-tribunal> (Accessed: 1 October 2025).



6. Hollins, S., Lodge, K.M. and Lomax, P. (2019) 'The case for removing intellectual disability and autism from the Mental Health Act', *British Journal of Psychiatry*, 215(5), pp. 633–635. doi: 10.1192/bjp.2019.26.
7. Ince, R., Glasby, J., Miller, R. and Glasby, A. (2022) 'Why are we stuck in hospital? Understanding delayed hospital discharges for people with learning disabilities and/or autistic people in long-stay hospitals in the UK', *Health and Social Care in the Community*, 30(6), pp. e3477–e3492. doi: 10.1111/hsc.13964.
8. Mencap (n.d.) The Mental Capacity Act. Available at: <https://www.mencap.org.uk/advice-and-support/mental-capacity-act> (Accessed: 1 October 2025).
9. Paveley, E. and Lavis, P. (2024) Mental Health Bill 2024: what you need to know. NHS Confederation. Available at: <https://www.nhsconfed.org/publications/mental-health-bill-2024> (Accessed: 1 October 2025).
10. Quinn, S., Rhynas, S., Gowland, S., Cameron, L., Braid, N. and O'Connor, S. (2022) 'Risk for intellectual disability populations in inpatient forensic settings in the United Kingdom: a literature review'. doi: 10.1111/jar.13030.
11. Royal College of Psychiatrists (2023) Mental Health Tribunals. Available at: <https://www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing/mental-health-tribunals> (Accessed: 1 October 2025).
12. Sampson, S., Edworthy, R., Völlm, B. and Bulten, E. (2016) 'Long-term forensic mental health services: an exploratory comparison of 18 European countries', *International Journal of Forensic Mental Health*. Available at: <https://journals.sagepub.com/doi/10.1080/14999013.2016.1221484> (Accessed: 1 October 2025).

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**Professor Joan Bicknell Medical
Student Essay Prize 2025**

Beyond the Medical Model: Learning Disability and the Art of Person-Centred Care



Dr Annelore Figari

As I approach the end of medical school, I've started reflecting on the experiences that shaped my understanding of what it means to practise medicine. Among them, my learning disability placement stands out. It challenged assumptions I hadn't realised I held and reshaped how I think about patient care.

Before starting the placement, my knowledge of learning disability was largely theoretical. My thinking centred on genetics, developmental delay, and diagnostic criteria. I expected consultations focused on complex medical problems and behavioural management.

In hindsight, this perspective reflected the traditional medical model of disability, which views disability primarily as an individual condition requiring treatment (Oliver, 1990). What I hadn't fully appreciated was how communication, social context, and attitudes influence the experiences of people with learning disabilities (Campinha-Bacote, 2018).

First Encounters

One of my earliest meaningful interactions was with a man in his thirties with Down syndrome attending an annual health check. He arrived with his support worker carrying a carefully organised health passport. As the consultant introduced me, he greeted us warmly and asked about my studies.

What stood out immediately was how the consultant conducted the consultation. She spoke directly to him, used clear language, allowed extra time for responses, and regularly checked understanding.

When discussing recent weight gain, the conversation extended beyond simple dietary advice. She asked about his daily routine, his work at a local café, and his goal of learning to swim. Health was discussed within the wider context of independence and personal aspirations.

This encounter challenged my assumption that people with learning disabilities are passive recipients of care. He expressed clear preferences and actively participated in decisions about his health. His support worker added information when needed but never spoke for him, reflecting the person-centred participation promoted in learning-disability policy (Martin, 2001).

Learning Beyond the Clinic

The placement also extended into community settings. I accompanied community nurses on home visits, attended day centre activities, and observed supported employment programmes. These experiences revealed lives far richer and more complex than the clinical labels suggested.

At a day centre, I met a woman who had recently moved into supported living. She described situations where healthcare professionals spoke to her mother rather than to her during consultations, despite her clear ability to understand and make decisions about her care. Her frustration was clear. She felt



invisible during conversations about her own health.

Listening to her made me reflect on my own behaviour during previous clinical encounters. Had I directed questions toward carers rather than patients? Had I assumed limited capacity without properly assessing it? These reflections were uncomfortable but important.

Diagnostic Overshadowing

Another important lesson involved diagnostic overshadowing, the tendency to attribute new symptoms to an existing learning disability rather than investigating other causes (Mason and Scior, 2004).

During the placement, a woman with moderate learning disability developed increasing confusion and memory problems. Initially, these changes were dismissed as part of her baseline condition. However, persistent advocacy from her support worker led to further investigation and a diagnosis of early-onset dementia.

This experience reinforced the importance of clinical vigilance. A learning disability should never prevent clinicians from considering alternative diagnoses or investigating new symptoms thoroughly, particularly given documented avoidable inequalities in healthcare and mortality (Mencap, 2012; LeDeR, 2021). It also highlighted the valuable role of carers and support workers, who often recognise subtle changes long before professionals do.

Capacity and Communication

The placement also provided valuable experience observing capacity assessments under the Mental Capacity Act. One case involved a man with Down syndrome who required surgery. At first, he appeared to agree with everything suggested. However, careful questioning revealed that he had not understood what anaesthesia involved and felt anxious about the procedure.

Through simplified explanations, visual aids, and time for discussion, he was able to reach a

genuine understanding and make an informed decision.

This experience taught me that apparent agreement does not necessarily mean true consent. Ensuring understanding requires patience, flexibility, and thoughtful communication.

A Shift in Perspective

Perhaps the most important shift during the placement came from encountering the social model of disability, which locates disability in social and environmental barriers rather than solely within the individual (Oliver, 1990). Through conversations with people with learning disabilities and self-advocacy groups, I began to see how social barriers often create greater limitations than the disability itself.

One woman summarised this powerfully when she said, "I'm not disabled by my learning disability. I'm disabled by people's attitudes and the way services are organised."

Her words reframed how I think about healthcare. Good care is not only about treating medical conditions but also about recognising barriers within healthcare systems and advocating for more inclusive practice.

Conclusion

My experience in learning disability services has profoundly shaped my approach to medicine. It strengthened my communication skills, deepened my understanding of capacity and consent, and challenged assumptions I had not previously recognised.

Most importantly, it reinforced that good medical care is not fundamentally different for people with learning disabilities. It requires time, respect, clear communication, and genuine partnership—principles consistent with person-centred and culturally responsive practice (Campinha-Bacote, 2018; Martin, 2001).

Learning to provide excellent care for this population ultimately makes us better doctors for all patients.



References

1. Campinha-Bacote, J. (2018) 'Cultural competemility: A paradigm shift in the cultural competence versus cultural humility debate – Part I', *OJIN: The Online Journal of Issues in Nursing*, 24(1). Available at: <https://doi.org/10.3912/OJIN.Vol24No01PPT20>.
2. Hatton, C., Emerson, E., Rivers, M., Mason, H., Mason, L., Swarbrick, R., Kiernan, C., Reeves, D. and Alborz, A. (1999) 'Factors associated with staff stress and work satisfaction in services for people with intellectual disability', *Journal of Intellectual Disability Research*, 43(4), pp. 253–267. Available at: <https://doi.org/10.1046/j.1365-2788.1999.00208.x>.
3. LeDeR (2021) *Learning Disabilities Mortality Review (LeDeR) Programme annual report 2020*. Bristol: Norah Fry Centre for Disability Studies, University of Bristol.
4. Martin, G. (2001) "Valuing people"—a new strategy for learning disability for the 21st century: How may it impinge on primary care?', *British Journal of General Practice*, 51(471), pp. 788–790.
5. Mason, J. and Scior, K. (2004) 'Diagnostic overshadowing amongst clinicians working with people with intellectual disabilities in the UK', *Journal of Applied Research in Intellectual Disabilities*, 17(2), pp. 85–90. Available at: <https://doi.org/10.1111/j.1360-2322.2004.00184.x>.
6. Mencap (2012) *Death by indifference: 74 deaths and counting*. London: Mencap.
7. Oliver, M. (1990) *The politics of disablement*. London: Macmillan Education. Available at: <https://doi.org/10.1007/978-1-349-20895-1>.

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PRIZES AND BURSARIES

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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.

Explore the range of prizes and bursaries offered by the RCPsych Intellectual Disability Faculty:

[Intellectual disability faculty prizes and bursaries](#)

UPCOMING FACULTY CONFERENCE

Join us in **Cardiff** at the Voco hotel **on 1 to 2 October** for the 2026 Royal College of Psychiatrists Annual Faculty of Psychiatry of Intellectual Disability Conference, an outstanding opportunity to hear from leading experts, share best practice and explore the future of intellectual disability psychiatry.

Highlights include keynote presentations from **Professor Andre Strydom, Professor Angela Hassiotis, Professor Sanjay Sisodiya, and Professor Umesh Chauhan**, alongside the prestigious Joze Jancar Lecture being delivered by **Dr Jane McCarthy** and a range of expert panel discussions.

This will be an in-person event at **the [Voco Hotel](#), Havannah St, Cardiff CF10 5SD.**

Please book and view this year's preliminary programme and speaker biographies on the [event webpage](#).

RESIDENT DOCTORS WELCOME EVENT

Join us for the welcome event for resident doctors in Intellectual Disability (ID) psychiatry on **12 October 2026** on **MS Teams** from **09:30 am to 1:00 pm**. This event is primarily aimed at new higher trainees and run-through trainees in ID psychiatry, but resident doctors of any training grade are welcome.

To attend please complete the [attached form](#) by **8 October 2026 4pm** and you will be sent a Teams link nearer the time.

EDITORIAL COMMITTEE

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Rory Sheehan
Mervyn Yong
Afia Ali
Unsa Athar
Sharna Bennett
Laura Korb (Faculty Executive Representative)

SUBMITTING ARTICLES/JOINING THE EDITORIAL COMMITTEE

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.

The Editorial Team also welcome expressions of interest to join us on the team. This can be team members of any level. Please do send a paragraph about yourself, why you would be keen to join the editorial team and what previous relevant experience you have.

For submissions or expressions of interest, please email to newsletter.psychid@gmail.com.

