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What Can the Experiences of People With an Intellectual Disability Tell Us About the Desirable Attributes of a Mental Health Professional?

Janelle Weise[a], Karen R Fisher[b], Erin Whittle[a], and Julian N Trollor[a]

[a]Department of Developmental Disability Neuropsychiatry, School of Psychiatry, UNSW Sydney, Sydney, Australia; [b]Social Policy Research Centre, Faculty of Arts and Social Sciences, UNSW Sydney, Sydney, Australia

ABSTRACT

Introduction: Mental health professionals have reported that they have limited knowledge, skills, and confidence in the area of intellectual disability mental health. This article aims to learn from the experiences of people with intellectual disability about the attributes that may assist mainstream mental health professionals to provide them with a quality mental health service. *Methods*: Six people with intellectual disability participated in an interview or focus group. Thematic analysis was undertaken applying the Intellectual Disability Mental Health Core Competencies Framework. *Results*: The findings supported previous research for the need for mental health professionals to be adaptable, able to communicate, and work with a person's support network. The study reinforced the need for professionals to undertake professional development in the area but also suggested that people with intellectual disability be included as educators and as peer workers. New attributes were identified, including the need for mental health professionals to be able to build rapport and trust through demonstrating their experience and respect for working with people with intellectual disability, and their ability to understand trauma and how it may influence mental health needs. *Conclusions*: The attributes identified in the study could be used to inform an intellectual disability mental health workforce development framework.

People with an intellectual disability represent approximately 1–2% of the population (Maulik, Mascarenhas, Mathers, Dua, & Saxena, 2011; Wen, 1997) and compared to the general population experience very poor health status characterized by multiple morbidities (Cooper et al., 2015), premature mortality (Florio & Trollor, 2015; NSW Ombudsman, 2013), and elevated rates of physical and mental health problems (Beange, McElduff, & Baker, 1995; Cooper, Smiley, Morrison, Williamson, & Allan, 2007). Compared to the general population,

people with an intellectual disability and co-occurring mental ill health (illness) are higher users across the health-care sector including, for example, primary care, ambulatory care, and emergency hospital care (Howlett, Florio, Xu, & Trollor, 2015; Lunsky et al., 2012; Weise, Pollack, Britt, & Trollor, 2016). However, in spite of high levels of service use, people with an intellectual disability continue to have high rates of undetected and undermanaged health conditions compared to the general population (Beange et al., 1995). In many countries, mental health services for people with an intellectual disability are predominately delivered within mainstream services, also referred to as generalist services, such as public hospitals and community mental health centers. Given this, it is important that the mainstream mental health workforce is appropriately equipped to detect and manage mental ill health in people with an intellectual disability.

Research indicates that mental health professionals have limited confidence, knowledge, and skills to meet the needs of people with an intellectual disability (Lennox & Chaplin, 1995, 1996; Man, Kangas, Trollor, & Sweller, 2016; Torr et al., 2008; Weise & Trollor, 2017). For example, a recent study of mental health professionals in Australia reported that they had received insufficient education and training (Weise & Trollor, 2017). In addition, when providing a service to people with an intellectual disability compared to people without, the study found that mental health professionals were less confident in key areas of clinical practice, including the capacity to: (i) recognize when a patient may have a mental disorder; (ii) communicate effectively; and (iii) understand potential adverse effects of psychotropic medication. These findings complement discipline-specific research which reveals insufficient education and training in intellectual disability mental health for psychiatrists and psychologists, especially in the areas of assessment, diagnosis, and treatment (Lennox & Chaplin, 1995, 1996; Man et al., 2016; Torr et al., 2008). Further, psychiatrists lack confidence to provide quality care for people with an intellectual disability, particularly relating to adopting a developmental approach and managing adults with comorbid mental health and epilepsy or dementia (Torr et al., 2008). The available research suggests that the current capacity of the mental health workforce is one of the barriers to participation in quality mental health care by people with an intellectual disability and co-occurring mental ill health (Whittle, Fisher, Reppermund, Lenroot, & Trollor, 2017).

A concerted effort is required to enhance the capacity of the mental health workforce in intellectual disability mental health. In the Australian context, the need for enhanced workforce capacity is articulated in the National Disability Strategy (Council of Australian Governments, 2011) and is one of the key elements of reform identified at a National Roundtable on the Mental Health of People with Intellectual Disability (NSW Council for Intellectual Disability, 2013). To enhance workforce capacity, a strategic,

coordinated, and multilevel approach is needed that targets individuals, organizations, systems, and the broader environmental context (Hughes, 2003; LaFond, Brown, & Macintyre, 2002; Skinner, Roche, O'Connor, Pollard, & Todd, 2005). At an individual level, a critical precursor to enhancing workforce capacity is to articulate the attributes that are required of mental health professionals to meet the rights of people with an intellectual disability to access quality mental health care. Existing research suggests that workforce attributes may be important because they can provide a framework on which to base workforce development activities (Barry, Allegrante, Lamarre, Auld, & Taub, 2009; Brownie, Bahnisch, & Thomas, 2011; Hughes, 2004; Nelson & Graves, 2011).

Two previous studies undertaken by the authors' research group report on the attributes that may facilitate mainstream mental health professionals to meet the needs of people with an intellectual disability (Weise, Fisher, & Trollor, 2017a, 2017b). The first study suggested that intellectual disability mental health clinical experts thought that attributes are important across all areas of clinical practice. More specifically, the clinical experts indicated the need for additional attributes in the areas of communication, assessment, and intervention (Weise et al., 2017a). The findings highlighted, among other things, the importance for mental health professionals to be able to use assistive communication technologies, and to acknowledge and articulate how their personal beliefs and emotional reactions toward people with a disability might influence their clinical practice. The second study reported on the workforce attributes that family members and support persons of people with an intellectual disability thought were important (Weise et al., 2017b). A range of attributes were identified, including the ability of mental health professionals to be able to differentiate between behavior and mental health, acknowledge professional limitations, and seek appropriate guidance and support.

A review of the literature was unable to identify previous research that specifically describes the attributes that people with an intellectual disability think are important for mainstream mental health professionals. However, one study explored the perspective of people with an intellectual disability on psychiatric service improvement (Parkes, Samuels, Hassiotis, Lynggaard, & Hall, 2007). This study found that people with an intellectual disability could provide detailed feedback on the care that they had received. Further, when this feedback was used to improve mental health service for people with an intellectual disability, it appeared to have a positive impact on their experience in some areas of their care. The inclusion of people with an intellectual disability in all mental health initiatives has also been specifically identified as one of the elements to mental health reform (NSW Council for Intellectual Disability, 2013). This article aims to learn from the experiences of people with an intellectual disability about the attributes that may assist mainstream mental health professionals to provide them with a quality mental health service.

Method

Study design

The study is part of a larger partnership project which aims to identify and address the key gaps in mental health policy and practice that prevent people with an intellectual disability from accessing quality mental health support. The partnership project involves partners who are representatives from academics, health and disability sectors, support services, and consumer/advocacy groups.

This study used data from one stream of the project, which is the qualitative analysis of barriers and enablers to access to mental health care for people with an intellectual disability from professional, consumer, and support persons' perspectives. Within this stream, professionals, consumers, and support persons were invited to participate in either a focus group or an interview and they were provided with an opportunity to have a support person present if this was their preference. A broad thematic guide to the topic was developed and used in both the focus group and interviews to initiate and guide the discussion with the participants (See Table 1). These themes included, for example, the identification of mental health issues, accessing appropriate mental health care and treatment, and participants' experience of mental health care. However, the interviews were designed with an in-depth narrative approach in mind, and the interviewer focused on allowing participants to tell their own stories. As a result, not all topic areas were necessarily covered.

The focus group ran for 120 minutes and the interviews ran between 40 and 120 minutes.

A researcher with a background in qualitative public health research and sociology conducted the interviews and focus groups.

For this article, the researchers extracted the interview (three participants) and focus group (three participants) transcript data of people with an intellectual disability. If the person had a support person assisting them to participate, their data was also included as they helped the person to express their views.

The study received ethics approval from UNSW Human Sydney Ethics Committee (reference number HC15201).

Participant recruitment and profile

The research team initially generated a list of key stakeholders such as disability support agencies, disability advocacy groups, and mental health teams who were in contact with the target population. The research team

Table 1. Interview and focus group thematic question schedule.

Theme	
Theme 1	Identification of mental health issues in people with an intellectual disability
Theme 2	Issues around accessing appropriate mental health care for people with intellectual disability
Theme 3	Receiving mental health treatment
Theme 4	Positive experiences with mental health services
Theme 5	Areas for improvement for mental health services

asked these stakeholders to discuss the research and pass on the details of the research to people that they thought may be eligible and interested in participating. Potential participants or their support person initiated contact with the research team and the researchers only contacted a potential participant directly at the participant's request.

The eligibility criteria for the target population of the study were people who had a lived experience of intellectual disability, were 18 years or over, and were not currently experiencing psychosis, mania, major depression, or severe anxiety disorder. The study was open to people who used verbal and alternative forms of communication.

Six adults participated in the study and a profile of each of these participants is in Table 2. An alias was assigned to each person and the details in these profiles have been modified to ensure participant anonymity.

Data analysis

Audio files were transcribed verbatim and de-identified versions of the transcripts were imported into a project file in QRS NVivo 10. To ensure immersion, the researchers reread each transcript multiple times. Thematic analysis (Braun & Clarke, 2006) was undertaken to identify themes relating to workforce attributes. The identified themes were subsequently categorized and analyzed within the Intellectual Disability Mental Health Core Competencies analytical framework (the Framework). The Framework was developed as part of the Intellectual Disability Mental Health Core Competencies Project and consists of four domains: (i) approaches to clinical practice, (ii) working with people with an intellectual disability, (iii) clinical competencies and (iv) quality improvement and professional development (see Table 3 for a definition of each domain). The researchers selected this framework because there is no clear consensus on how to define workforce attributes (Brownie et al., 2011); nor is there agreement on the best means of analyzing and structuring the qualitative results relating to workforce competencies. The Framework was also selected because it provides a broad definition of workforce competence that relates directly to providing a service to people with an intellectual disability and has been used in previous research that explores the attributes expected of mental health professionals when working with people with an intellectual disability (Reference removed for peer review). This approach also allowed for the results to be compared with the findings of previous research in this area.

Reflexivity

The research team applied Mays & Pope's (2000) practical understanding of reflexivity, which involves being sensitive to the ways in which the subjectivities of the researchers affect the data collection and analytical process. The

Table 2. Participant profiles.

Participant alias	Participant details
Patricia (I)	Patricia is woman in her 20s who lives in a regional town, within two hours of a major city. She has a history of trauma and violence and experiences mental health issues, including anxiety and hearing voices. She previously lived in a number of institutional settings, and has been a long-term inpatient in a regional mental health ward. She now lives independently and has close contact with services and her mother, who is her primary carer and support person.
Michael (FG)	Michael is a young man who has Down syndrome. He lives near a major city. He has experienced some depression, and now attends university and is completing a degree. His mother is his primary carer and support person, and he lives at home with her. He has developed a comprehensive group of support people.
Sebastian (I)	Sebastian is a young man who lives in a regional town with his mother, who is his primary carer and support person. He has recently turned 18, and is finishing his final year of high school. He has some physical disabilities, which necessitate using a wheelchair and has resulted in a need for constant and ongoing medical care. He has experienced severe and ongoing anxiety and depression since primary school, and is transitioning out of school-related services due to his age. He has experienced a lack of available services and extremely long waiting times for those services that are available in his area.
Rosie (I)	Rosie is aged in her early 40s. She lives independently and maintains a close relationship with her mother, who is her primary support person. She received a mental health diagnosis early in her 20s, which took some time to identify, and has maintained good health since then, until a recent episode. She has spent some time in mental health inpatient wards, and has had some contact with emergency services as a result of mental health issues. She participates in many activities that help her maintain her mental health.
Jane (FG)	Jane is a young woman. She lives close to a major city. Her family remains involved in her life and she is engaged in local disability services.
Vincent (FG)	Vincent is in his 40s. He lives independently and works as a disability advocate for other people with disability.

Note: The names used are an alias and the profiles of the participants have been modified for anonymity. The amount of detail about each participant varies based on the information that they provided the researcher.
I: The person participated in an interview
FG: The person participated in a focus group

Table 3. Intellectual disability mental health analytical framework—domain definitions.

Domain	Definition
Approaches to clinical practice	Attributes that describe the overall approaches, and the desirable values, attitudes, and beliefs that a mental health professionals should hold
Working with people with an intellectual disability	Attributes that are relevant across all interactions a mental health professionals has with a person with an intellectual disability and co-occurring mental ill health
Clinical competencies	Attributes that are required to undertake specific clinical tasks (for example assessments and interventions)
Quality improvement and professional development	Attributes that mental health professionals require to ensure quality improvement, and to uphold their professional development in the area of intellectual disability mental health

practical application of this involved one member of the research team who undertook the primary analysis of the data. In addition, to encourage reflexivity, a second member of the research team independently analyzed a sample of the transcripts. Two other members of the research team also

reviewed and critiqued the codes attributed to each of the domains within the framework. When there was disagreement between group members, the group held a discussion to determine the reasons for differences in opinion and to develop a strategy for continuing with the analysis.

Results

The analysis of the participants' accounts of their experiences implies a range of attributes that could support mental health professionals to deliver a quality service to people with an intellectual disability and co-occurring mental ill health. The findings from the analysis are discussed below.

Domain 1: Approaches to clinical practice

The first domain in the analytical framework is approaches to clinical practice. This domain, as described in table three, explores the overall approaches, desirable values, attitudes and beliefs that a mental health professional should exhibit when working with a person with an intellectual disability. The analysis identified the need for mental health professional to be adaptable in their clinical practice.

Adaptable

Within the adaptable theme, the participants spoke about positive experiences where a mental health professional had been able to modify their clinical practice to respond to the person's needs. Examples were situations where mental health professionals had changed where they met, had allowed their family to attend the consultation with them, or did not ask too many questions at one time. Conversely, Vincent, when asked about accessing mental health care, said that the appointments were sometimes too short and that it would be better if *"the person [the mental health professional] had a bit more time to listen."* Sebastian also supported this when he described an experience of working with a mental health professional and said that *"the worst thing is, I had half an hour with the counsellor. And I mean, that's not enough."*

These findings indicate that not adapting clinical practice, for example not allowing additional time, could be a barrier to people with an intellectual disability receiving the service that they need. It also highlights the importance of working in a person-centered manner to be able to identify the needs of the person and how to best modify practice to meet these needs.

Domain 2: Working with people with an intellectual disability

The second domain in the framework explores the attributes that mental health professionals require when working with people with an intellectual disability. The analysis of the participants' experiences identified four major themes including: (i) rapport and trust building; (ii) communication; (iii) working with the person's family, friends, and support persons; and (iv) understanding how the person experiences their intellectual disability and mental health.

Rapport and trust building

Within the rapport and trust-building theme, some of the participants said that it was hard to speak about mental health issues, especially if they did not trust the mental health professional. Jane, when discussing what would have made it easier to talk to a mental health professional about how she was feeling, said that *"when you've got a disability, you don't know if you can trust a person who has not got a disability."* Michael also supported this when he agreed with another participant that people needed to trust a mental health professional before they could discuss their mental health. Some of the mental health professionals with whom the participants had come in contact were reported to have tried to develop trust by talking about things that were significant to the person with a disability. For example, Rosie spoke about an experience when a mental health professional had talked with her about not only her current mental health symptoms but also things that were important to her, such as a show she has been doing or cricket. It appeared that the mental health professional taking time to talk about these things was a key component for her to build rapport with the professional and feel comfortable to talk about more personal issues.

These findings suggest that an important attribute of a mental health professional could be spending time getting to know the person and building a trusting relationship before shifting to direct requests to solicit personal information. It may also indicate that mental health professionals need to be able to demonstrate their experience of working with people with an intellectual disability, as this could assist in facilitating trust. The finding that participants more readily trust others with a disability compared to those without a disability may also indicate that a peer workforce in intellectual disability mental health could assist mental health professionals to develop and demonstrate their understanding and skills.

Communication

The second theme within this domain is communication. Within this theme the participants spoke about experiences where a poor communication style had affected them, and the service they had received. For example, when a

mental health professional did not directly speak to them, the participants said that it made them feel *"small"* (Sebastian) and as if they were *"not even there"* (Jane). Conversely, Patricia said that when she was hearing voices, she was able to talk directly to her mental health professional. When asked if she liked being able to talk to them she said *"I do."*

The participants also spoke about their communication preferences, such as using sign language, non-face-to-face forms of communication such as *"talking to someone [mental health professional] via phone,"* (Sebastian), or using *"straightforward"* (Jane) methods of communication, and not being given too much verbal information at one time. Michael's experience supports this further, as he agreed when asked if he found it difficult when a mental health professional gives him too much information. He said that it *"would be better"* if someone could go back over the information provided, particularly after a *"huge meeting"* where lots of things had been discussed.

These findings suggest that mental health professionals need to be able to (i) determine the person's preferred communication style, (ii) talk directly with the person with an intellectual disability if that is their preference, and (iii) use accessible communication that considers the mode and pace of the communication, and which is responsive to the person's preferences.

Working with the person's family, friends, and support persons

The analysis of the participants' experiences highlighted the need for mental health professionals to not only work with them but also with their family, friends, and support persons. Some of the participants said that when they were unwell, they told their family and friends. For example, Rosie, when asked who she spoke to when she experienced a decline in her mental health, said that *"I talked to mum."* Michael also said that he talks to his *"mother about the trouble that I go through."* Others had paid carers they referred to; for example, Patricia said that *"if I'm not feeling well, I tell [support service worker] straight away."* Sebastian also highlighted the importance of including a support person because he would tend to tell the mental health professional *"yeah, I'm good today,"* but that this response was a *"'mask'"* and did not reflect how he was really feeling. Sebastian also spoke about how he forgets when he has had a bad day and *"just moves on to the next day,"* and so may not accurately recall the events leading up to meeting with a mental health professional. His experience of recalling information and accurately reporting on how he is feeling suggests the need to include a support person who knows him well and can support him to accurately report on his mental health.

These findings highlight that family members, friends, and paid support persons are likely to have important information about the person's mental health. Where appropriate, including a person's support network in the

person's mental health care could help the mental health professional gain a more comprehensive picture of the person's mental health status over time.

Understanding how the person experiences their intellectual disability and mental health

The last theme is about understanding how the person experiences their intellectual disability and mental health. Within this theme, some of the participants described how their disability and mental health interacted and influenced their well-being. For example, Sebastian, when reflecting on his earlier years, said that *"I kind of find now that, well since when I was like younger, I was always taking my anger out on other people from just frustration of my mobility and just everything…now kind of taking that out on myself."* While Jane, when talking about her experience of engaging with mental health professionals, said, *"and when you've got a disability,… you deal with that so much in yourself, when you've got to explain it to somebody, a lot of people don't understand."* Michael and his support person also spoke of an experience in which he had been denied access to mental health care because the mental health professional had said that he is *"not my normal client, my normal client is an intellectual person"* and that he *"was too difficult to work with because they (the mental health professional) can't understand the way he thinks."*

These experiences suggest that an important attribute may be for mental health professionals to be able to gain insight into how the person experiences their disability and mental ill health, and how it impacts on their participation in a mental health service. This capacity could be important because each person's needs and experiences are unique.

Domain 3: Clinical competencies

The third domain in the framework is clinical competence, which considers the attributes that mental health professionals require to undertake clinical tasks. The analysis of the participants' experiences identified three main themes: (i) the ability to develop and communicate a mental health care plan from illness to wellness, (ii) the need to support the person to develop relationships and engage in meaningful activity, and (iii) the need for mental health professionals to have an understanding of trauma and how it may influence mental ill health. These three themes are described in more detail below.

Developing and communicating a mental health care plan—from illness to wellness

The experiences of the participants suggested that an important attribute of a mental health professional may be the ability to develop and communicate a comprehensive mental health care plan for people with an intellectual disability. Some of the participants spoke about the experience of being

discharged from hospital without follow-up care. For example, Patricia and her support person described a cycle in which she would make a suicide attempt, then be taken to the hospital and the mental health care plan developed would be to be *"given some other drug"* (Patricia's support person), and then discharged back home where she would make another suicide attempt. This cycle of attempted suicide and readmission suggest that the care plan was not effective in facilitating Patricia's recovery and maintaining wellness when living in the community. Jane also supported this when she agreed with another participant that there was no follow up once a person had been discharged from a mental health service. She said that *"they (referring to mental health professionals) forget"* about people once discharged. These experiences may highlight the negative impact that the lack of a comprehensive mental health care plan and follow-up care can have on a person's recovery. Similarly, Rosie talked about how she felt that she was unable to access the help that she needed *"because I think my doctor says, thinks I'm well."* She did not receive support or planning to remain well, or information about how to react to early changes of deterioration in her mental health.

These experiences could indicate that an important attribute of a mental health professional is the ability to develop and communicate a plan to the person and their support network about their discharge and ongoing treatment. Also important, perhaps, is ability to educate the person about recovery and what it means to be well and not experience the symptoms of mental illness. In addition, Rosie's experience perhaps highlights the need for mental health professionals to be able to refer people to appropriate community supports that can assist ongoing recovery and well-being.

Support the person to develop relationships and engage in meaningful activity

The need for mental health professionals to support the person with an intellectual disability to develop relationships and engage in meaningful activity was indicated by the participants' experiences of staying and feeling well. The participants spoke about a range of ways that they stay well, such as going out with friends (e.g., Patricia spoke about *"going to barbeques"* with her neighbor), listening to music, and acting. For example, Sebastian, when reflecting on his experience of mental ill health, said that *"you've got to find an outlet and once you have an outlet, whether it's music or art or anything that you enjoy doing, or school even, then do that outlet."* Michael also spoke about how he had been supported to form a *"circle of friends"* whom he felt comfortable talking too and who would check in on him and ask questions when they thought his mental health was declining. Upon reflection, Michael said that the formation of this support network had *"saved his life."*

The participants' experiences demonstrate a recognition of the need for non-medication related strategies to promote wellness. These include supporting a person to develop relationships and to engage in meaningful activities as core components of a mental health recovery care plan. The findings also suggest that mental health professionals need to have knowledge and the ability to link a person with formal or informal support to facilitate engagement in meaningful activities, and support them to develop relationships. This could be particularly important for people with an intellectual disability, as they are more likely to be socially isolated than their peers.

Understanding trauma and mental ill health

Although not extensively discussed, some of the participants described traumatic events in their lives that had a negative impact on them, for example being physically abused or being excluded from school tasks because of their disability. For example, Patricia's support person described how she had received a phone call from Patricia telling her that she had been inappropriately *"touched"* by a person that she had formed a friendship with. The support person also described other incidents where Patricia had been physically assaulted while walking in the community or being sprayed with mace by the local police. Sebastian also said that the teachers and students at his school had *"bullied"* him. He said that a teacher had told him that *"you can't do this music test, because what's the point, when you'll never, ever be able to play guitar."* For Sebastian, the experience of being bullied was linked to the decline in his mental health and in particular when he *"started self-harming and having suicidal thoughts."* The impact of these experiences could suggest the need of mental health professionals to be able to recognize the likelihood of life-course trauma and adapt and apply current trauma-informed practice when working with people with an intellectual disability.

Domain 4: Quality improvement and professional development

The final domain in the analytical framework is quality improvement and professional development. This domain explores the attributes that may support mental health professionals to undertake personal and service improvement activities. The analysis of the participants' experiences identified minimal content relating to quality improvement and professional development. However, the analysis identified the benefit of mental health professionals participating in professional development activities, and specifically those delivered by people with an intellectual disability.

Participate in professional development activities delivered by people with an intellectual disability

Within the professional-development theme, some of the participants said that mental health professionals *"don't know the area [intellectual disability*

mental health]"' (Jane). Rosie also said that "*no one [mental health professionals] noticed*" when she was unwell. Patricia and her support person also spoke of an experience when mental health professionals "*would not believe*" (Patricia's support person) that she was experiencing mental ill health and kept saying that it was "*behavioral issues*" (Patricia's support person). The participants felt that if mental health professionals were confident in this area, "*it would have been easier*" (Michael) to participate in mental health services. For example, when Jane spoke about a friend with an intellectual disability and mental illness and how they were unable to afford the medication that they had been prescribed, she said that they had a choice to "*take medication or starve.*" When asked if she thought that mental health professionals should receive education on the impact of prescribing expensive medication, she said "*that's a good idea.*" These findings suggest that some mental health professionals need to undertake professional development in the area of intellectual disability mental health to gain the necessary experience, confidence, knowledge, and skills.

Interestingly, when talking about how to better equip the workforce, Michael spoke about a recent experience of using his experience to present at a university and a congress which had supported others to gain knowledge and skills. He said that "*I'm revealing to everyone about myself, so they have a better understanding.*" When asked about who should be providing training to mental health professionals, Jane also said "*I believe myself.*" She said that if "*you're more hands on with person with disability, more, you have more answers.*" These experiences and opinions of the participants indicate the benefits of having people with a lived experience involved in the education and training of mental health professionals.

Discussion

The study has explored the experiences of people with an intellectual disability in relation to accessing and participating in Australian mainstream mental health services. The participants' experiences suggest a range of professional attributes that may better equip mental health professionals to meet the needs of people with an intellectual disability and co-occurring mental ill health. This enhanced capacity within the mental health workforce may in turn facilitate access to quality care for people with an intellectual disability. The study has also highlighted the benefits of consulting with people with an intellectual disability, as they provided unique insights into the core attributes of mental professionals that had not previously been identified by clinical experts (Weise et al., 2017a), and with family and support persons of people with an intellectual disability and co-occurring mental ill health (Weise et al., 2017b). The findings need to be viewed with

caution because of the small sample size. However, the findings can be used to draw preliminary implications for workforce attributes.

A comparison of the workforce attributes identified in this study to those previously identified by clinical experts (Weise et al., 2017a) and by family members and support persons (Weise et al., 2017b) highlights both similarities and differences (summarized in the Appendix). Of particular interest are the attributes uniquely identified by people with an intellectual disability, which included the need for mental health professionals to be able to build rapport and a trusting relationship, to apply a trauma-informed approach, and to participate in professional development activities delivered by people with an intellectual disability.

Within the rapport and trust-building theme, the findings suggest that it could be easier for a person with an intellectual disability to trust and talk to another person with a disability about their mental ill health. This suggests the potential importance of peer workers within the mental health workforce. This is an interesting finding because existing literature on the best type of workforce for people with an intellectual disability has predominately focused on comparing the benefits and downfalls of a specialist compared to a mainstream workforce (Giuntoli, Newton, & Fisher, 2015). The introduction of a peer mental health workforce would be in alignment with the work in Australia of the National Mental Health Commission, the Fourth National Mental Health Plan (Australian Government Department of Health and Ageing, 2009), and the National Mental Health Recovery Framework (Department of Health and Ageing, 2013). However, currently there is inconclusive evidence about the effects of peer support for people with mental ill health and further research is required in this area (Lloyd-Evans et al., 2014).

The ability to use a trauma-informed approach is also particularly important because of the emerging association between traumatic life events and mental health problems (Tsakanikos, Bouras, Costello, & Holt, 2007). Further work is required to see how current trauma-informed guidelines and practices could be adapted for mental health professionals to apply to this population. In addition, unlike previous research in this area, the participants in the study were the first to articulate experiences that implied the importance of including people with an intellectual disability as providers of professional development. Further research may be required to explore how to best include people with an intellectual disability as educators.

Three of the attributes identified in this study were consistent with those identified by intellectual disability mental health experts, and the family and support networks of people with an intellectual disability. These included the need for mental health professionals to be adaptable and flexible in their clinical practice (Weise et al., 2017a, 2017b), to have enhanced communication skills, and to be able to work with the person's family, friends, and support network. The need for enhanced communication skills may be

particularly important when working with people with an intellectual disability because they can experience communication impairments which can affect their ability to effectively communicate their health care needs (Ziviani, Lennox, Allison, Lyons, & Mar, 2004). People with an intellectual disability and their support networks have also previously identified communication as a barrier to access mental health services (Donner, Mutter, & Scior, 2010; Lunsky & Gracey, 2009). Workforce development activities aimed at enhancing communication capacity may be particularly pertinent because a recent survey found that just over half of mainstream mental health professionals were less confident communicating with people with an intellectual disability compared to people without an intellectual disability (Weise & Trollor, 2017).

The ability to work with the person's family, friends, and support staff could also be important because some of the participants in this study said that they spoke to their support network, including family members and paid carers, when they are feeling unwell. As such, family members and support persons may have important insights into the mental well-being of the person. However, this should only occur when this is the preference of the person with an intellectual disability. The inclusion of carers aligns with expectations outlined in the Australian Fourth National Mental Health Plan (Australian Government Department of Health and Ageing, 2009) and the National Mental Health Recovery Framework (Department of Health and Ageing, 2013). Yet the broader mental health literature reports that family members and support persons are often not appropriately included within mental health services and that issues pertaining to privacy and confidentiality are frequently cited reasons as a barrier to participation (Cleary, Freeman, & Walter, 2006). Careful consideration needs to be given to developing clear processes that support people with an intellectual disability to make an informed decision about their support network being involved in their mental health care. Furthermore, when consent is provided, mental health professionals need to be equipped to facilitate the meaningful inclusion and participation of the person's support network. In alignment with person-centered care, this would involve working with the individuals involved to determine what they can contribute and how they want to be included within the person's care.

The analysis of the participants' experiences has also highlighted the importance of non-medication interventions for promoting and maintaining mental health wellness. However, research has shown that some mental health professionals perceive that psychological interventions are ineffective in a person with cognitive impairment (Vereenooghe & Langdon, 2013). Significant effort may be required to support the workforce to gain skills and change attitudes toward psychological interventions for people with an

intellectual disability. Mental health professionals may also benefit from knowledge and the ability to link a person with individualized support which facilitates engagement in meaningful activities and relationships that aim to meet the person's wants and needs. This type of intervention may be important, as participants identified community participation and meaningful relationships as key elements to staying and feeling well.

Limitations

A limitation of the study is the small sample size, as this may limit the transferability of the results to other workforces. Another limitation was that all of the participants used verbal communication. This is because the researchers were unable to recruit people who used alterative and augmentative forms of communication. As such, the sample is not representative of all people with an intellectual disability, especially those with higher support needs. The recruitment strategy used also did not allow the researchers to determine if the characteristics of those who participated were different to those who were approached but decided not to participate. The presence of the support people, while intended to facilitate participation, may also have deterred some participants from speaking as openly as they might have.

Conclusion

This study highlights the importance of including people with an intellectual disability within workforce-related research. The experiences of this group identified a diverse range of attributes that could assist mental health professionals to deliver quality mental health care. The attributes identified in the study, in conjunction with those identified by clinical experts and family and support persons, could be used to provide a framework on which to base the objectives of future intellectual disability mental health workforce development activities.

Conflicts of Interest

None to report.

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Appendix: Comparison of the attributes identified from the experiences of people with an intellectual disability, clinical experts, and family and support persons

Domain	Attributes identified from the experience of people with an intellectual disability	Attributes identified in previous research	
		Clinical experts[a]	Family members and support persons[b]
Approaches to clinical practice	Adaptable	✓	✓
Working with people with an intellectual disability	Rapport and trust building	X	X
	Communication	✓	✓
	Working with the person's family, friends, and support persons	✓	✓
	Understanding how the person experiences their intellectual disability and mental health	✓	X
Clinical competence	Developing and communicating a mental health care plan—from illness to wellness	✓	X
	Supporting the person to develop relationships and engage in meaningful activity	✓	X
	Understanding trauma and mental ill health	X	X
Quality improvement and professional development	Participate in professional development activities delivered by people with an intellectual disability	X	X

[a]Weise et al. (2017a).
[b]Weise et al. (2017b).