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Ee, Jonathan; Lim, Jan Mei; Stenfert Kroese, Biza; Rose, John

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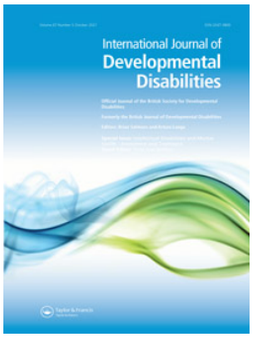

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Services for people with intellectual disabilities and mental health problems in Singapore: perspectives from mainstream mental health professionals

Jonathan Ee[1], Jan Mei Lim[2], Biza Stenfert Kroese[1] and John Rose[1]

[1]Centre for Applied Psychology, The University of Birmingham, Edgbaston, Birmingham, UK; [2]Department of Psychology, Institute of Mental Health, Singapore, Singapore

Background: Generic mental health staff often have contact with people with intellectual disabilities when they access mainstream mental health services. To date, there has not been any research conducted in non-western countries to explore their views. This paper investigates the views and experiences of mainstream mental health professionals regarding the mental health services for people with intellectual disabilities in Singapore.
Methods: Eight staff members from generic mental health services were interviewed. Thematic analysis was used to identify main themes.
Findings: The main themes are related to their work experiences, perceptions of people with intellectual disabilities, ideal staff characteristics and service recommendations.
Conclusions: Participants identified a lack of experience and knowledge when working with this population. They highlighted the challenges they face promoting choice and autonomy for people with intellectual disabilities. The discussion includes recommendations for improving staff knowledge through training opportunities, consideration of non-pharmacological approaches and early collaboration with caregivers during the treatment process.

Keywords: intellectual disabilities; qualitative research; mental health professionals; staff attitudes; mental health services

Introduction

Although there is a higher prevalence of mental health problems recorded for people with intellectual disabilities (Cooper *et al.* 2007, Hatton *et al.* 2017), only a relative small number receive mental health services (Emerson *et al.* 2011, Shimoyama *et al.* 2018). Whittle *et al.* (2018) comments on the poor quality of mental health services, due to a lack of knowledge and experience among mental health professionals (MHPs).

Chaplin (2009) noted that adults with intellectual disabilities continue to access generic mental health services despite the establishment of specialised intellectual disability services (Nawab and Findlay 2008). Mainstream services have been deemed unsatisfactory by different stakeholders. For example, the carers of people with intellectual disabilities perceived that their relatives were discriminated against and poorly treated by MHPs when they receive generic mental health services (Donner *et al.* 2010, Longo and Scior 2004, Scior and Longo 2005). Similarly, the accounts of service users indicate that MHPs in mainstream mental health services are often ill-equipped to deal with their specific needs (Crane *et al.* 2019, Donner *et al.* 2010, Lunsky and Gracey 2009). Although Chaplin (2011) was unable to find significant differences in the health outcomes between those admitted to specialised and generic mental health services, qualitative data highlighted the negative experiences of people with intellectual disabilities when they receive generic mental health services.

Recent literature has explored the roles of mental health nurses in assessment and care of people with intellectual disabilities that includes working with family members on health-related issues of people with intellectual disabilities, implementing behavioural interventions and working with other MHPs in a multidisciplinary team (Taua *et al.* 2012). Taua and Farrow (2009) recognised that mental health nurses encounter difficulties working with people with intellectual disabilities due to their complex mental health

Correspondence to: Jonathan Ee, Centre for Applied Psychology, The University of Birmingham, Edgbaston, Birmingham, B15 2TT, UK. Email: jpe669@alumni.bham.ac.uk

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presentation. Other research literature has revealed that for nurses there is a lack of organisational support to address distress and burnout when working with people with intellectual disabilities who display challenging behaviours and/or mental health problems (Campbell 2011, Capri and Buckle 2015).

Qualitative research addressing the experiences of psychologists and psychiatrists working in generic mental health services has revealed a self-confessed lack of skill and experience which contributes to low self confidence in their ability to provide mental health services and care to people with intellectual disabilities (Lunsky *et al.* 2008, McNally and McMurray 2015, Rose *et al.* 2007). Quantitative research has similarly found that nurses and therapists reported low self confidence in working with people with intellectual disabilities (McConkey and Truesdale 2000), psychiatrists had difficulties identifying mental health problems (Mason and Scior 2004) and a lack of available training for family physicians and doctors undergoing psychiatric residency programs (Sajith *et al.* 2019, Wilkinson *et al.* 2012)

Currently, there is no empirical evidence specific to the perspectives and experiences of mainstream MHPs in Singapore towards people with intellectual disabilities and their understanding of the factors that contribute towards good recovery outcomes for this client group. Singapore has its own unique culture (Kee 2004), hence it remains unknown whether the mainstream MHPs in Singapore have similar experiences and views found in western societies. Kwok and Chui (2008) found that Asian countries offer varying standards of generic psychiatric care to people with intellectual disabilities, often using treatment approaches such as restraints, psychotropic medication and behavioural interventions. Wei *et al.* (2012) reported that there are limited resources in Singapore to address the mental health and behavioural problems of people with intellectual disabilities. Mainstream MHPs in Singapore may lack the necessary expertise and knowledge to address this client group's complex presentations, which is likely to result in misdiagnosis of mental health conditions in people with intellectual disabilities and inappropriate treatment that includes unnecessary hospitalisation and overuse of medication. Mainstream MHPs remain the first point of contact for people with intellectual disabilities before referral to the specialist mental health intellectual disability services in Singapore, thus it is important to understand their working experiences, knowledge and skills, as well as their perception of people with intellectual disabilities.

The first aim of the current paper is, therefore, to explore the views of mainstream MHPs working in generic mental health services regarding their experiences of working with people with intellectual disabilities in Singapore. The second aim is to identify the issues faced by mainstream MHPs in their work with people with intellectual disabilities as well as their views regarding mental health service models for this population.

Method

The use of qualitative research enables generation of knowledge about human experiences (Sandelowski 2004) and allows an initial exploration of the issues that affect the MHPs in Singapore. A qualitative methodology applied in health-related research can produce a personal and cultural account of human experiences and how participants construct meaning from their experiences, and provides the groundwork for future quantitative studies. For this purpose, the current study has adopted a qualitative approach to explore the experiences and perspectives of mainstream MHPs in Singapore towards people with intellectual disabilities and mental health problems.

Procedure

The study received ethical approval from University of Birmingham (UK) (Reference No: ERN_17-1730) and the National Healthcare Group Domain Specific Review Board (Reference No: 2018/00956) in Singapore. The participants were informed that their participation in the study would not affect their work performance. The names of the participants in the written transcripts were deidentified and identifying details removed before analysis. The transcripts were stored in a password protected laptop which could only be accessed by the named authors.

Inclusion criteria were: (a) mainstream MHPs working the hospital for a minimum of the past six months in the generic mental health service, (b) have direct contact with people with intellectual disability in their work and (c) have not worked in the specialist mental health service prior to recruitment.

Following ethical approval, potential participants were identified by the first author (JE) and invitation letters that contained brief information about the aims of the study were distributed to them. Potential participants who were interested in the study contacted the first author to arrange a face-to-face interview. Before the start of the interview, participants were provided with an information sheet and a consent form. Participants were asked to provide basic demographic information before the interview. Ten participants expressed an interest to participate in the study, however only eight consented as the other two potential participants were not available due to work demands. The first author did not have any prior relationship with the participants and carried out the interviews. Each individual interview was conducted in English and lasted up to 50 min after written consent was obtained. The interviews were audio-recorded and took place in a private room in the hospital. The recordings were deleted after the interviews were transcribed. Participants were

Table 1. Interview schedule.

Semi-structured interview questions
1. What is it like working with people with intellectual disability?
2. What makes someone suitable to work with this people with intellectual disability?
3. How do you think mainstream healthcare workers/professional staff react when working with individuals with intellectual disability?
4. When you are working with people with intellectual disability, who do you mostly work with/talk to?
5. Do you think there is a difference in how people with intellectual disability are being cared for by professional staffs and family members?
6. Are there any differences in how you manage the mental health problems of people with and without intellectual disability?
7. What do you think about involving individuals with intellectual disability having a say about how they wish to manage their health?
8. What do you think about giving individuals with intellectual disability a say in their own care management?
9. What do the people and family members find helpful when engaging with your services?
10. What could help you do to improve your clinical practice?
11. How can healthcare professionals improve the quality of life of individuals with intellectual disability?

provided with a shopping voucher for taking part in the study.

The interview questions (see Table 1) address the issues and challenges that the participants face working with people with intellectual disabilities, their views about the mental health services for this population and public reaction towards people with intellectual disabilities and mental health problems in the community. They were asked to share experiences of encountering people with intellectual disabilities in their work and their emotional reactions. Lastly, they were asked to provide recommendations to improve the mental health services and address the mental health needs of this population. The development of the questions were informed by previous literature in this area of research and they were designed to be open-ended and broad ranging in order to capture the wide-ranging experiences of participants.

Participant characteristics

Participants are referred to as Mainstream Mental Health Professionals (MMHPs) in the research study. Four men and four women MMHPs aged 29 to 50 years (median age 36) were recruited. All of them had worked in the mainstream mental health services and had no work experience in the specialist mental health intellectual disability service. Years of work experience ranged from 4 to 20 (median 9.5 years). All the participants had encountered people with intellectual disabilities in their line of work and had provided basic treatment before referring them to other services., Five of the participants (MMHP 1, 2, 3, 6 and 7) had less than one year, two participants (MMHP 4 and 8) had one year and one (MMHP 5) had four years of experience of working with people with intellectual disabilities. This last participant had not provided interventions to people with intellectual disabilities, only screening and assessment to ascertain their level of cognitive impairment. MMHP 1, 2, 3 and 8 had prior exposure working with people with intellectual disabilities as part of their psychiatric residency training. Four participants were medical staff that consisted of two psychiatrists (MMHP 1 and 8), two medical officers (MMHP 2 and 3), three were clinical psychologists (MMHP 4, 5 and 7) and one (MMHP 6) was a medical social worker. Detailed information about the individual participants' background are not provided to protect privacy and confidentiality.

Data analysis

All interviews were transcribed verbatim, verified with the corresponding participants and analysed following the Braun and Clarke (2006) method for thematic analysis. An inductive, bottom-up approach was used to extract themes from the transcripts. The first author familiarised himself with the data and noted down initial comments, ideas and observations. The detailed set of comments and notes guided the development of the emergent themes which were categorised and labelled into main themes and corresponding sub-themes. This process was repeated throughout the different transcripts. Subsequently, the themes across the transcripts were reviewed, re-categorised and condensed into a final list of main themes with corresponding sub-themes.

One approach to ensure credibility of the findings is the use of appropriate sample size which can determine data saturation. Braun and Clarke (2013) propose a sample size of 6 to 10 for a small scaled qualitative research project. Boddy (2016) recommend that the inductive approach and interpretivist paradigm allows for the sample size to remain small. Additionally, Ando *et al.* (2014) suggest to focus on the depth and quality of the interviews to ensure that the topics in the interview schedule are addressed by the participants. Data collection was discontinued after eight participants were recruited as no new codes or information occurred in the data. Thematic saturation was achieved when the themes were adequately represented in the data using the participants' quotes.

Each stage of the data analysis was audited by the second and third authors (BSK and JR) experienced in qualitative research methodology. Two transcripts were given to them to check for consistency in coding and ensure that the issues were adequately covered. The first author produced a summary of each interview with the

Table 2. List of themes.

Main themes	Sub themes	Participants contributing to the themes
1. Interactions	i. Challenging work	1, 2, 3, 4, 5, 7, 8
	ii. Emotional reactions	1, 2, 3, 4, 7
2. Lack of empowerment	i. Level of autonomy	1, 2, 3, 4, 5, 8
	ii. Reaction from the public	1, 2, 3, 5, 6, 8
3. Ideal characteristics of mental health professionals		1, 2, 3, 4, 6, 7, 8
4. Service recommendations	i. Having more resources and time	1, 2, 3, 6, 7, 8
	ii. Training support staff	2, 3, 4, 5, 7
	iii. Empowering family carers	2, 3, 4, 5, 6, 7, 8

emergent themes to discuss possible interpretations with the other two authors to ensure good level of agreement. The final list of main themes was also discussed together and the quotes from the participants were used to ensure that the findings are grounded in the data.

The first author is a qualified clinical psychologist with previous work experience with people with intellectual disabilities and has worked in a similar setting as the participants, which helped him to understand the issues and challenges they faced working with this population. As well as receiving regular supervision and discussion with the other authors, he kept a journal to note down thoughts and feelings in order to minimise the possibility of biases.

Results

Four main themes emerged from the analysis with corresponding sub-themes described in Table 2.

Theme 1: Interactions

This theme describes how participants view the mental health problems of people with intellectual disabilities and their emotional reactions when encountering them in the services.

Sub theme 1: Challenging work

The majority of the MMHPs described the challenges in understanding and communicating with people with intellectual disabilities because of their cognitive deficits,

> *"They have more conduct disorders … but they have difficulties in communicating, they have a very low frustration tolerance … " – MMHP 2*

They noted a higher prevalence of mental health problems in people with intellectual disabilities than the general population, however it was more difficult to identify triggers that contribute to or maintain their symptoms,

> *"We guess what is going on and have multiple hypotheses of what is causing this behaviour and how we can come out with alternative behaviour. A lot of times it's really trial and error." – MMHP 7*

Some MMHPs (i.e social workers and psychologists) found it difficult to engage these clients in talking therapies and had observed poor adherence towards treatment,

> *"Most of them find it difficult to grasp concepts of psychotherapy, so when you talk about suitability for therapy, most of them would struggle because they may not be able to understand some of the concepts when you try to explain to them."– MMHP 5*

Sub theme 2: Emotional reactions

One MMHP acknowledged feeling intimidated when working with people with intellectual disabilities and recounted his negative experiences,

> *"They tried to … I mean three times they failed. One tried to kick me, the other tried to poke my eyes … another one managed to scratch me." –* MMHP 2

Other MMHPs acknowledged that their colleagues also had negative reactions of fear and uncertainty when people with intellectual disabilities displayed aggressive behaviours,

> *"Wary, careful, cautious, like they may think their behaviours are unpredictable and sometimes, it's … even for with experienced ones may find themselves unable to deal … unpredictable triggers." – MMHP 4*

MMHPs shared third-person account of how their colleagues' lack of experience and knowledge contributed to the negative feelings and unwillingness to care for this population,

> *"I think they feel overwhelmed and may assume that it could just be a behavioural problem or this is just how they are, think that they cannot manage – "I don't want to take care of them" whereas people with intellectual disabilities could be experiencing mental health issues."– MMHP 3*

At times, MMHPs acknowledged feeling burnt out and the work being "*emotionally draining"* because of inadequate and prolonged hospitalisation,

> *"… when you are frustrated because the treatment didn't work out, and it (the behaviours) happen repeatedly, then whatever resources that you have right from the start would just deplete and you become exhausted." - MMHP 4*

Theme 2: Lack of empowerment

This theme primarily focuses on how MMHPs perceive people with intellectual disabilities and mental health problems and the level of stigma they face in public.

Sub-theme 1: Level of autonomy

MMHPs expressed a willingness to allow people with intellectual disabilities to make decisions and respect their choices,

"Everyone should have a say and have control in how they want to manage their health and their treatment. So this should apply for patients with intellectual disabilities." – MMHP 8

Unfortunately, their wishes regarding their treatment or care plans are not always taken into consideration which has a detrimental impact on their health outcomes,

"… sometimes their flourishing (recovery) has been stunted and their freedom (community integration) has been limited because they are institutionalized for long period of stay." – MMHP 3

MMHPs (i.e doctors) acknowledged the struggles in respecting and carrying out the wishes of the person with intellectual disabilities which may differ from their family members,

"In Singapore setting, we tend to listen to the family members more. Ultimately the decision to discharge or admit the patient is based on the history from family members. Majority of the time, we listen to the family members and the family has the final say on whether to admit or discharge." – MMHP 2

One MMHP noted that it is impossible to advocate for the needs of the person with intellectual disabilities because ultimately, they "are not the one paying the bills" (MMHP 5*)* and discussed the challenges in helping the person with intellectual disabilities to fulfil their wishes and desires,

"We need to recognise that if the patient is not able to take care of himself, how is he going to take care another person? … it doesn't work that way, so unless the hospital is willing to take care which is definitely not in our ability to do so, we have to respect the family or the support staff from the nursing home who is actually the one taking care of the patient. So in this case, yeah … likely the goals and the likes or the wishes of the patient would be overruled." – MMHP 5

Sub-theme 2: Reaction from the public

In this sub-theme MMHPs explained that the public may not understand the manifestation of the behaviours in people with intellectual disabilities,

"They (the public) find it very hard to understand them which can sometimes put people off if they don't understand." – MMHP 6

MMHPs noted that the behaviours in people with intellectual disabilities are often noticeable by the public especially when their behaviours are outside the norm,

"It's different when a person with intellectual disabilities is behaving slightly differently from the rest, for example talking loudly or suddenly shouting. In those cases, I suppose the public might react negatively and avoid them."– MMHP 8

These negative perceptions are sometimes reinforced by their family members or carers where they *"would just attribute it to, almost like blaming the condition (intellectual disability diagnosis) of the person" (MMHP 8)*. MMHPs acknowledged that people with intellectual disabilities and mental health problems are being stigmatised and discriminated against especially in terms of employment opportunities in the community,

"Getting jobs can be quite difficult … some employers are not so accepting, can be quite difficult" - MMHP 1

Theme 3: Ideal characteristics of mental health professionals

MMHPs were asked to identify desirable characteristics required for working with people with intellectual disabilities and mental health problems,

"I think patience is a core personality trait that is needed. For example, being patience to ask questions to family members or looking through the case note for those that do not have family members to find out more about the person which require spending more time." – MMHP 2

Other MMHPs defined patience as being able to accept that recovery is a slow process with repeated setbacks including frequent hospital re-admissions. They shared that having this quality helps them to moderate their expectations to avoid feeling frustrated or discouraged,

"Patience towards understanding that the progress may be more gradual. For example, a person who displays some problem behaviours will often come back for readmission. The person cannot be so discouraged by that, so patience and commitment for the long haul." – MMHP 3

Having prior knowledge and understanding of the field of intellectual disability and being creative in adapting clinical techniques and strategies are important,

"You really need to find more creative means of engaging them, you don't want to rely on talk therapy … You have to do more activity based, you have to do more." – MMHP 5

MMHPs (i.e doctors) identified the importance of collegiality. They valued the professional input and involvement from other professionals to understand the person with intellectual disabilities better,

"You have to be part of the team because a lot of the work as a doctor is probably minor when compared to the work that allied health professionals have to do. You would have to be able to work with more people than just with the patient and talking to them." – MMHP 3

Many MMHPs stressed the need to remind themselves that *"there's a person behind that label"* and taking into account their strengths, limitations and support network in the community,

"Asking questions about what the person likes and enjoys doing those times when this person doesn't manifest any behavioural issues. How is he or she like as a person?" – MMHP 6

Theme 4: Service recommendations

In this theme, MMHPs provided suggestions and ideas on how to improve the mental health services for people with intellectual disabilities.

Sub-theme 1: Having more resources and time

MMHPs shared that one of the ways to improve services is to allocate more resources to improve their competency. The psychiatrists recalled brief work experiences with people with intellectual disabilities during their residency training, stating that training and exposure had been limited and additional skills in *"basic communication skills, and also some tips on how to manage the behavioural issues… " (MMHP 1)* would be beneficial for mainstream professionals working in a community setting.

There was a desire to learn non-pharmacological therapeutic approaches but MMHPs cited lack of time and available manpower to do so*, "… it's very difficult to be trained because sometimes we don't have time because we encounter a shortage of staff (MMHP 2)."* Thus, having more time for opportunities to keep abreast of appropriate and evidence-based treatments was deemed important,

> *"Reading up on research to know the standard evidence-based care that has been practiced overseas in terms of caring for adults with intellectual disabilities." – MMHP 7.*

Other MMHPs discussed the administrative bureaucracy in a hospital setting such as insufficient consultation time to address the complexity of mental health problems in people with intellectual disabilities and suggested alternative ways to review their progress,

> *"They need to be seen in their community and environment, it is no point bringing them to clinic and ask them how things are. It may not work that way, for that to happen then (working in the community setting) would need more dedicated time…" – MMHP 6*

Sub-theme 2: Training support staff

Providing training to support staff caring for people with intellectual disabilities and mental health problems in residential homes was highlighted by the participants,

> *"They (support staff) feel overwhelmed because of aggressive behaviour in people with intellectual disabilities, they bring them to the hospital because they cannot manage, which could lead to negative perceptions of them" - MMHP 3*

MMHPs acknowledged the work done by colleagues providing consultancy and training to support staff in residential homes to facilitate a smoother transition of care after people with intellectual disabilities are discharged from hospitals,

> *"Our allied health team, like social workers and psychologists, will conduct home visits to their adult disability homes to see how they behave over there. To teach the staff in the adult disability homes on the strategies to handle them." – MMHP 2*

Sub-theme 3: Empowering family carers

Family members may experience feelings of grief and have differing views regarding the causes of the mental health problems, hence it is important need to engage them during the treatment process,

> *"Family members need to have adequate education (knowledge) on how to take care of them, currently they do not know the resources available and they do not know what to do with them due to lack of knowledge." – MMHP 2*

MMHPs acknowledged the important role of family when the person with intellectual disabilities is admitted to the hospital for treatment and recommend engaging them during the early phase of the treatment process to reduce the likelihood of the person being admitted to a residential institution,

> *"If you don't engage the family members early, they don't know how to handle and then there's no way for them (people with intellectual disabilities) to go home, they can only go to adult disability homes." – MMHP 2*

On a positive note, MMHPs reported that the involvement and empowerment of family during the treatment process improves family relations and strengthens the relationship between the person and their family,

> *"The positive treatment outcome is that you see the bond between the patient (person with intellectual disabilities) and their father, it's feels like that is also what matters, there's no way that he would probably get it (without the intervention). You can see that his father's happy and seemed joyful with some things that he can do with his child…" – MMHP 4*

Discussion

The study has collated narratives of the experiences of MMHPs working with people with intellectual disabilities and mental health problems as well as their views and recommendations on improving the services for this population. The high prevalence rate of mental health problems among people with intellectual disabilities in Singapore is something that MMHPs acknowledge in this study and confirms existing findings that this population faces a higher vulnerability towards developing mental health problems (Cooper *et al.* 2007, Moon *et al.* 2020). MMHPs noted difficulties understanding and identifying the mental health problems in people with intellectual disabilities as compared to the general population due to barriers of communication which are well-documented in previous research (Bekkema *et al.* 2014, Pelleboer-Gunnink *et al.* 2017, Sowney and Barr 2007, Storms *et al.* 2017). MMHPs' reported emotional reactions, feeling less positive and holding negative attitudes in response to violent episodes involving people with intellectual disabilities, are reported by previous researchers (Araten-Bergman and Werner 2017, Campbell 2011). MHPs in Singapore face the same challenges as their level of training and work exposure is insufficient for them to be equipped with adequate skills to work with this population and find it difficult to adapt their therapeutic techniques and resources to cater to their needs.

Lack of opportunities

In the second theme, MMHPs expressed disappointment that those with mild levels of cognitive impairment were not allowed opportunities to express their opinions, instead having to accommodate the needs and wishes of other stakeholders, such as family carers and support staff. Medical staff often acceded to family members' wishes and needs at the expense of the person's autonomy and freedom. These findings highlight the predominant collectivist culture in Singapore where people identify themselves as part of a larger social identity group, as well as ascribing to the virtues of filial piety and strong beliefs of family hierarchy which prescribe that family members are to be respected and consulted when making important life decisions (Liu 2005).

Who is the client?

Another explanation is that MMHP participants of the current study encountered difficulties in determining who is the client. In Singapore, family members often pay on behalf of their relative with intellectual disabilities for the healthcare services that they receive (Lai 2015, Singapore Ministry of Health, n.d) and as a result, MMHPs may feel obliged to prioritise the family's wishes. This creates challenges for MMHPs to advocate for people with intellectual disability to express their choices and consider their wishes, as family members may reject them in favour of their own needs. MMHPs may not see the need to go against the cultural norms and needs of the family carers to allow the voices and views of people with intellectual disabilities to be heard and instead defer the decision-making to their family.

Negative attitudes

MMHPs in the current study perceive that the public holds negative attitudes towards them. This stigmatisation of disability is common in other cultures and it has been found in the UK, Hong Kong and Libya that there is a preference for social exclusion and 'sheltered' services (Benomir *et al.* 2016, Coles and Scior 2012, Sankhla and Theodore 2015, Scior *et al.* 2010, Sheridan and Scior 2013). A lack of understanding of people with intellectual disabilities, especially with regards to their behaviours when they are out in public may reinforce the negative stereotypes of dangerousness that may affect their employment and living opportunities (Werner 2015). Although research indicates that negative attitudes and strong views about social segregation of people with intellectual disabilities in East Asian culture are common (Hampton and Xiao 2013, Scior *et al.* 2010), there is a lack of peer-reviewed research specific to Singapore, which warrants further research in this area.

Negative attitudes and perceptions of people with intellectual disabilities may impact on the experiences of carers and contribute towards this population staying longer than necessary in hospital (Hensel *et al.* 2014). MMHPs reported difficulties in discharge planning where residential support staff felt unable to deal with their clients' challenging behaviours. Involvement of MHPs such as psychologists in a community setting can provide consultation, training and support for residential staff to give them the necessary skills and confidence to carry out basic interventions (Stenfert Kroese and Smith 2018). Training staff in positive behavioural support (Allen 2009) has been shown to have good outcomes (Dodd *et al.* 2013, Rose *et al.* 2014). Education is an important contributor to increase staff's awareness and understanding of challenging behaviours and can also change negative misconceptions of sexuality issues relevant to people with intellectual disabilities (Costello *et al.* 2007, Woodward and Halls 2009).

Desirable staff qualities

MMHPs in this study identified desirable qualities for staff including patience, willingness to work in a team, clinical skills and awareness to see beyond the psychiatric diagnoses of people with intellectual disabilities. Patience was considered to help allay burnout and soften feelings of disappointment or frustration about the poor outcomes in people with intellectual disabilities. Moreover, it was viewed as a way for MMHPs to be more thorough and comprehensive in their assessment of people with intellectual disabilities although building therapeutic rapport was not mentioned by the participants of this study unlike findings from Capri and Buckle (2015) which indicate the importance of healthcare professionals building meaningful relationship with their clients with intellectual disabilities to improve quality of care. The MMHP participants did recognise the need to move beyond concentrating on mental health problems and viewing their clients in a holistic manner, taking into account their strengths, including their relationships and interactions with their family and community. Skills relevant to partnership, collaboration and good communication were identified in previous western studies (Weise *et al.* 2017) as well as warmth, openness and gentleness to promote empowerment and foster genuine relationship with people with intellectual disabilities (Stenfert Kroese *et al.* 2013).

Limitations

The current research does have a number of limitations. It was conducted on a small number of participants in a specific area, thus the findings may not generalise to other MHPs working in other fields. Every effort was made to include different professional groups, however the mainstream mental health nurses were not available

for the research due to their work demands. Future research could explore alternative ways to include the experiences of mental health nurses and support staff working in generic mental health services in the hospital or community setting. The sample in the research study consisted of mainstream MHPs and it may be beneficial if staff from specialist mental health intellectual disability services could be involved in future research.

Implications

Improve staff training and resources

The findings of this study contribute to the existing literature to highlight on-going regular training is necessary for mainstream MHPs to keep abreast of evidence-based practices in mental health issues of people with intellectual disabilities. The findings may help the policy makers in Singapore to develop appropriate training programmes for MHPs providing care for individuals with intellectual disabilities and mental health problems. Having more training resources may address the gaps in knowledge and ameliorate negative misconceptions in MHPs would increase confidence to provide mental health services for people with intellectual disabilities. Also, training in non-pharmacological interventions such as cognitive behaviour therapy (Jahoda *et al.* 2017), relaxation techniques and behavioural management (Hassiotis *et al.* 2009) needs to be prioritised.

Organisational factors such as lack of time and available manpower were also identified as barriers to improving mainstream service provision. Mainstream MHPs should be encouraged by their managers to attend these courses by allocating protected time for them as part of their professional development. Supervision by experienced and specialist clinical staff can guide MMHPs and help them attain interpersonal skills to build rapport with this population.

Community mental health services

MMHPs participants appear to be concerned that the hospital environment is an unsuitable location to review the progress of people with intellectual disabilities and they prefer dedicated time to review them in their own community. The development of community services to provide specialist intellectual disability services was perceived as a better alternative for people with intellectual disabilities which has explored in the research literature (Hemmings *et al.* 2014, Hemmings *et al.* 2009). Mental health services could be redesigned with involvement from mainstream and specialist staff working together to address the mental health and/or behavioural problems of people with intellectual disabilities in a community setting. This possibility might allow the mainstream staff to gain expertise and confidence under the supervision of the experienced specialist staff. Furthermore, the service users and their family carers can access the services promptly and seek early treatment which may reduce the need to be hospitalised and incur higher costs.

Increasing family involvement

MMHPs in the study spoke about the importance of involving the family when adults with intellectual disabilities are hospitalised for treatment. Often family members feel confused and blame themselves for not being able to take care of or manage their relative's behaviour (Ali *et al.* 2012). Family members may sometimes choose to deal with the challenging behaviours or mental health symptoms on their own instead of seeking early treatment. By then, the mental health and/or behavioural problems have become too overwhelming for family members to cope and result long period of hospitalisation stay. Family members may feel disempowered and not be keen for their family members with intellectual disabilities to be discharged and return home for fear of being unable to manage their relative's behaviours. More support and resources need to be targeted at the family to ensure that relatives are equipped with relevant skills and techniques to address their own mental well-being and are encouraged to liaise with community services to ensure a smooth transition from hospital. Early engagement with the family can alleviate their psychological distress and address any problematic issues that they experience when caring for their family member, thus preventing a crisis to develop (Dawson *et al.* 2016). In addition, MHPs can provide signposts to community resources for them so that follow-up intervention and support can continue to address their difficulties.

Addressing public stigma

The findings of the study indicate that there is a possibility of negative public perception and reaction towards people with intellectual disabilities in the community. Although the findings are based on a small sample of MHPs it is important to consider the possibility that there is a need to address the public stigma towards people with intellectual disabilities and take steps to improve attitudes through educational campaigns to increase public awareness. A desirable service development is for MHPs to have access to supports and resources to promote the autonomy and independence of people with intellectual disabilities in the community.

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ORCID

Jonathan Ee http://orcid.org/0000-0002-8965-8639
John Rose http://orcid.org/0000-0003-2672-9767

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