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DOI:

[10.1080/19315864.2022.2029647](https://doi.org/10.1080/19315864.2022.2029647)

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*Document Version*

Publisher's PDF, also known as Version of record

*Citation for published version (Harvard):*

Ee, J, Stenfert Kroese, B & Rose, J 2022, 'Specialist Mental Health Services for People with Intellectual Disabilities in Singapore -: What Do Stakeholders Think of Them and How Do They Relate to Service Accomplishments?', *Journal of Mental Health Research in Intellectual Disabilities*, vol. 15, no. 2, pp. 130-150. <https://doi.org/10.1080/19315864.2022.2029647>

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To cite this article: Jonathan Ee, Biza Stenfert Kroese & John Rose (2022) Specialist Mental Health Services for People with Intellectual Disabilities in Singapore - What Do Stakeholders Think of Them and How Do They Relate to Service Accomplishments?, Journal of Mental Health Research in Intellectual Disabilities, 15:2, 130-150, DOI: [10.1080/19315864.2022.2029647](https://doi.org/10.1080/19315864.2022.2029647)

To link to this article: <https://doi.org/10.1080/19315864.2022.2029647>



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# Specialist Mental Health Services for People with Intellectual Disabilities in Singapore - What Do Stakeholders Think of Them and How Do They Relate to Service Accomplishments?

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## ABSTRACT

**Introduction:** This research investigated the views of different stakeholders regarding the specialist mental health service for people with intellectual disabilities (ID) in Singapore.

**Method:** Interviews were conducted with mental health professionals, family carers and service users with ID. Framework analysis was adopted to identify common dominant themes among the different participant groups.

**Results:** Analysis revealed four themes 1) Giving choice and autonomy; 2) Training to become competent; 3) Respect and 4) Part of the community

**Conclusions:** People with ID living in Singapore have limited opportunities to express their choices and autonomy especially when it comes to treatment planning. Family carers have a significant influence on the level of community presence of their relatives with ID. Participants identified employment for people with ID as a way to improve public perceptions. There was no mention of people with ID developing social relationships. Recommendations are discussed in the context of current service provision.

## KEYWORDS

Intellectual disabilities; qualitative research; mental health services; views; service users; staff; family carers

## Introduction

During the last 50 years there has been a drive toward improving the quality of services provided to people with intellectual disabilities (ID) in western countries. New concepts such as person-centered approaches have been introduced to promote individualized goals and outcomes of people with ID. The early normalization principle developed by Nirje (1969) advocate for people with disabilities to have easier access to general services and facilities so that they can live their lives in a similar manner to their non-disabled peers. The self-determination theory (Ryan & Deci, 2000) highlights autonomy, the need for belonging and connectedness with others as necessary for human functioning. This theory has been applied in the disability-related clinical field (Frielink et al., 2018) to recognize that people with ID have the potential and motivation to

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maximize their independence in different life domains, such as having a job and developing relationships with people in the community. Updates to the normalization principle have been suggested to explore how services can work toward enhancing the roles that people with ID play and how they can participate and contribute within their local community (Wolfensberger, 2000). O'Brien (1992) developed a framework that consists of five service accomplishments to evaluate services for people with disabilities. These service accomplishments as described in Figure 1 and include 1) assisting people to make choices, 2) increasing their competency, 3) respecting them and treating them with dignity, 4) facilitating their integration, sharing places and activities with others and lastly, 5) assisting them in developing meaningful relationships.

O'Brien's five service accomplishments influence what domains of quality of life were considered as indicators for general well-being and functioning in people with ID (Schalock et al., 2002, 2005). Policy documents were developed to provide guidelines for services for people with ID based on the key principles of rights, independence, choice and inclusion as described in the UK White Paper document entitled *Valuing People* (Department of Health, 2001). This influential paper clearly states that people with ID should be allowed equal rights and to have access to education, express their opinions, vote, have romantic

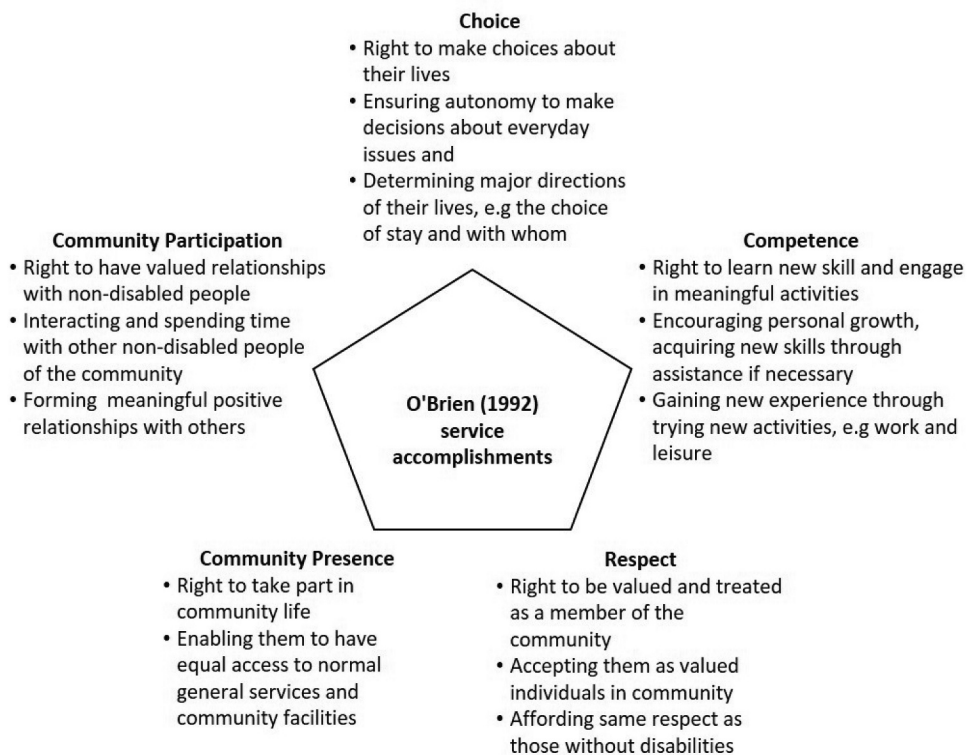


Figure 1. O'Brien (1992) five service accomplishments.

relationships, marry and have a family. Services should aim to maximize independence of people with ID and help them exercise their rights. Opportunities should be provided for people with ID to express their choices over where they want to live or work and services should actively encourage public acceptance of people with ID in the community by promoting equal access to community facilities and having public campaigns to raise awareness and improve attitudes. A more recent summary report entitled *Valuing People Now* from the Department of Health (2010) indicated improvements in the UK as a result of the 2001 paper in accessibility of general healthcare services, early health screening, staff with the knowledge of ID supporting mainstream staff, and supporting people with ID to live and work in their own communities. These improvements were said to have increased the value of the roles of people with ID in society and improved public perceptions (Wolfensberger, 2011).

In 2011, Singapore established specialist mental health service to cater the mental health needs of people with ID. The specialist mental health ID service is one of a kind amongst services that cater for the mental health needs of people with ID in Southeast Asia and is based in a tertiary psychiatric hospital in Singapore. This service provides both inpatient and outpatient services to adults with ID and/or comorbid neurodevelopmental disorders including autism. Every individual is assessed by a multidisciplinary team consisting of a psychiatrist, case manager, psychologist and occupational therapist. Other services including those of medical social worker, nurse and speech therapist are available if required. A recent cross-sectional audit found that adults with ID comprised the largest percentage of referrals (Moon et al., 2020). These specialist mental health services are complimented by social agencies that provide services for adults with ID such as long-term residential placements, vocational training and daycare (Wei et al., 2012).

People with ID have a higher vulnerability toward developing mental health problems and poorer access to services (Bhaumik et al., 2008; Hatton, 2016), thus it is therefore important to explore the views of relevant stakeholders to consider how the mental health problems of this population can be addressed. A number of western studies have included the views of service users to explore ways to improve the mental health services (Lloyd et al., 2013; Lunskey & Gracey, 2009; Stenfert Kroese et al., 2013). Others have focused on the perspectives of family carers and professional staff to evaluate the quality of services for people with ID and identify desirable attributes of mental health professionals working in specialist services (Lunskey et al., 2008; Weise et al., 2017; Weiss & Lunskey, 2009).

There have been no studies conducted in Singapore to understand the societal issues that affect the provision of services for people with ID. Ee et al. (2021c) identified that people with ID face challenges to find employment and participate in the community as they can experience negative public reactions. Additionally, they found that mainstream professional staff report

negative emotional reactions when working with people with ID, associated with a lack of expertise and confidence (Ee et al., 2021b). As the specialist mental health service is a new service, there is as yet little information available on how this service strives to meet the needs of people with ID and improve their quality of life in the community.

The current qualitative study adopts O'Brien's five service accomplishment framework to ask the following research questions:

- (1) What are the views of different stakeholders (i.e mental health professionals, family carers and service users) toward the specialist mental health services for people with ID in Singapore?
- (2) How does this specialist mental health service measure up to the different domains of O'Brien's service accomplishments?

## Method

### Participants

Participants were eligible to participate if they met the following inclusion criteria:

- (a) Mental health professionals working in the Singapore psychiatric hospital for a minimum of six months or;
- (b) Unpaid primary family carers of adult (18+) persons with ID receiving mental health services in the hospital or;
- (c) Adults (18+) service users (people with ID and comorbid neurodevelopmental disorders) who had received specialist mental health ID services for a minimum of three months. The adult service users had to demonstrate capacity to consent and participate in the interviews.
- (d) Demonstrate capacity to consent and participate

The recruitment was carried out in the tertiary mental health hospital in Singapore which offers specialist mental health ID services. A total of 36 participants (19 men and 17 women) aged 21 to 72 years (median age 36.5) were recruited. Participants included mental health professionals (N = 16), family carers (N = 9) and service users (N = 11). Participant demographics are offered in [Table 1](#), but not to an extent that would comprise participant anonymity.

The mental health professionals (Participants 1 to 16) comprised of mainstream (n = 8) and specialist (n = 8) health professionals including: psychiatrists (3), medical officers (2), nurses (2), psychologists (5), social workers (2), speech therapist (1) and occupational therapist (1). Years of work experience with people with ID ranged from less than 1 to 6 years. Qualifications of the mental health professionals ranged from undergraduate to postgraduate degree in medicine, nursing or allied health specialization.

**Table 1.** Participant demographics.

Participant	Gender	Age range	Role	Years of work experience with people with ID	Relationship of relative with ID to carer
1	Female	30–40	Mainstream staff	<1	NA
2	Male	20–30	Mainstream staff	<1	NA
3	Male	30–40	Mainstream staff	<1	NA
4	Female	30–40	Mainstream staff	>1	NA
5	Male	30–40	Mainstream staff	<5	NA
6	Female	40–50	Mainstream staff	<1	NA
7	Female	30–40	Mainstream staff	<1	NA
8	Male	30–40	Mainstream staff	>1	NA
9	Female	30–40	Specialist staff	>1	NA
10	Male	30–40	Specialist staff	>5	NA
11	Female	20–30	Specialist staff	<5	NA
12	Male	30–40	Specialist staff	>1	NA
13	Female	20–30	Specialist staff	<5	NA
14	Male	30–40	Specialist staff	>5	NA
15	Male	30–40	Specialist staff	>1	NA
16	Female	20–30	Specialist staff	>1	NA
17	Female	60–70	Family Carer	NA	Daughter
18	Male	60–70	Family Carer	NA	Daughter
19	Male	70–80	Family Carer	NA	Son
20	Female	40–50	Family Carer	NA	Son
21	Female	60–70	Family Carer	NA	Son
22	Female	50–60	Family Carer	NA	Son
23	Female	70–80	Family Carer	NA	Granddaughter
24	Female	60–70	Family Carer	NA	Son
25	Female	50–60	Family Carer	NA	Son
26	Male	20–25	Service User	NA	NA
27	Male	20–25	Service User	NA	NA
28	Male	45–50	Service User	NA	NA
29	Male	60–65	Service User	NA	NA
30	Male	55–60	Service User	NA	NA
31	Male	70–75	Service User	NA	NA
32	Female	25–30	Service User	NA	NA
33	Male	20–25	Service User	NA	NA
34	Female	20–25	Service User	NA	NA
35	Male	20–25	Service User	NA	NA
36	Male	25–30	Service User	NA	NA

Eight family carers (Participants 17 to 25) identified themselves as parents while one identified herself as a grandparent. The service users (Participants 26 to 36) were adults (18+) with ID (9 men and 2 women) who accessed specialist mental health services in the hospital. All the participants had mild to moderate ID (IQ between 55 to 70) with co-morbid neurodevelopmental disorders and psychiatric diagnoses. Three service users received supported employment training, the other eight were unemployed.

### Ethical Considerations

The study was approved by a University ethics committee in the UK and the National Healthcare Group Domain Specific Review Board in Singapore. Safeguards regarding data storage were implemented and participants have been de-identified in this paper.



Additional considerations were made for the adult service users to determine that they understood the study and had the capacity to consent. Service users were provided with a simplified consent form that uses basic language, 18 font size and images. The first author read aloud the information sheet and the adult service users were then asked to answer some questions about the study and their rights as a participant which they had to answer correctly before signing the consent form (Arscott et al., 1999).

## Interview Guide

All participants were asked their views of the specialist mental health services, the public reaction toward people with ID in the community and recommendations to improve the provision of services for people with ID. Mental health professionals were asked about their experiences interacting or working with people with ID and to describe the issues they faced. Family carers were asked about their experiences of taking care of their relatives with ID and what prompted them to seek mental health services. Participants who were service users engaged in activities with the first author using *'Tools for Talking'* resources (Unwin et al. (2016), a resource pack comprised of exploratory activities that facilitate participants to discuss a variety of issues. Activities chosen from *'Tools for Talking'* allowed service users to talk about important relationships, their mental health problems and to identify ideal attributes of professional staff. These activities helped service users to express themselves by the use of verbal prompts and concrete language, identifying images to represent their feelings and thoughts, and allowing time for them to respond.

## Procedure

Following ethical approval, invitation letters containing brief information about the aims of the study were distributed to the potential participants in the hospital. They were told that participation in the study was voluntary and their treatment of care or work performance would not be affected regardless of their participation. Potential participants who were interested in the study contacted the first author to arrange a face-to-face interview. Participants were provided an information sheet and a consent form before the start of the interview.

Two mental health professionals and one family carer initially requested to join but dropped out as they could not make time available to attend. Participants were also asked to complete a brief questionnaire detailing their age, gender, employment and educational qualifications. The first author did not have any prior relationship with the participants and carried out the interviews which took place at a place most convenient



to the participants. Each individual interview was conducted in English and lasted up to 50 minutes. The interviews were audio-recorded and took place in a private room in the hospital. Participants were provided with a shopping voucher for taking part in the study.

## Data Analysis

These data were used in previous studies conducted by (Ee et al., 2021a, 2021b, 2021c) that used other types of qualitative analysis to address the different research questions. The data were analyzed using Framework Analysis (Ritchie & Spencer, 1994; Ritchie et al., 2003). The main feature of this analysis is a matrix output developed from a theoretical framework where the data sets can be summarized and reduced in a systematic manner to form a coherent understanding of any topic under investigation. The current qualitative study adopts a deductive approach to manage the data across the different groups of participants by organizing and categorizing the themes according to O'Brien's five key service accomplishments as described in Figure 1, using this as a framework to evaluate the specialist mental health services for people with ID in Singapore.

Familiarization of the data was carried out through multiple readings of the transcripts, subsequently the coding of the transcripts began by annotating key points, comments and ideas which are used to develop emerging themes. The emerging themes together with the key topics and ideas were arranged in a matrix table derived from O'Brien's Five Accomplishments. This involved grouping the responses that matched a particular theme in the framework. Emerging themes were categorized to form main themes with sub-themes within each section of the matrix table and verbatim quotes were used to illustrate each theme.

Care was taken to ensure that the themes were grounded in the original data. The first author carried out the analysis which was independently verified by the other authors. As well as receiving regular supervision and discussion with the other authors, the first author kept a journal to note down thoughts and feelings in order to minimize the possibility of biases and remain sensitive to the cultural context.

## Results

Analysis of the interviews revealed four key themes with relevant sub-themes that are mapped on the O'Brien service accomplishments. Table 2 shows the list of key themes and sub-themes of participants from the five studies.

**Table 2.** Results of key themes and sub-themes.

O' Brien Service Accomplishments	Key themes	Sub themes
Choice	1. Giving them a voice	i. Is it possible? ii. The challenges
Competence	2. Taking care of themselves	i. Work-related skills and employability ii. Self-care
Respect	3. Public perception	i. Reaction from the public – 'dangerous!' ii. Cannot contribute to society
Community Presence Community Participation	4. Part of the community	i. Having a presence ii. Having meaningful relationships

## Key Theme 1: Giving Choice and Autonomy

In this theme the participants discussed whether choice and autonomy should be offered to people with ID, the challenges in achieving this and environmental factors that impact choice and autonomy.

### *Sub-theme 1: Is It Possible?*

The majority of mental health professionals agreed it is important to respect the wishes of the person with ID and they should be involved in their own treatment regarding the mental health care they receive. However, they considered that only people with mild and moderate ID and/or mental health problems are able to communicate their interests and values whilst people with more severe problems are unlikely to have the capacity to make choices:

“For clients who are very low functioning, if they don't know how to make a choice then it won't be relevant. If they don't understand and you allow them to do what they want, sometimes it may bring harm to them.” – Participant 16

Mental health professionals noted that inpatients with ID who requested to be discharged home were often denied this choice. They mostly went with the choices made by family members regarding the health-related issues of people with ID and those made by people with ID were often ignored:

“... it can be very difficult, for example, maybe family members want to admit the patient which the patient refused. That can be really difficult for us. I think the doctors in the emergency department admit them under family's pressure.” – Participant 1

One of the service users was upset and angry that the mental health professionals had admitted her to hospital against her will and disturbingly described how she was treated harshly:

“They keep quiet, they never talk to me. They (slightly agitated) tie up me from behind until my leg, tie me, pull me like that ... – Participant 32

### **Sub-theme 2: The Challenges**

Mental health professionals encountered practical challenges to involve people with ID in their discharge plans because their family would make the final decisions. They noted that the family was often not in agreement with the wishes of their relative with ID:

“People don’t agree with what they want . . . so most of the time, the needs of the caregiver vs the needs of the person clashes regarding what’s best for the person.” – Participant 4

Similarly, mental health professionals admitted not considering the views of people with ID and made decisions on their behalf without consulting them:

“We’re not really empowering but we’re making the choices for them . . . right now it’s more like a patronizing type of work where we make decisions for them . . .” – Participant 3

One family carer highlighted disparity between the mainstream and specialist services:

“The mainstream ward is different from the specialist ward even though it is within the same hospital. The specialist ward is much better, provides exercises and activities which the other wards doesn’t have and the staff monitors his medication.” – Participant 25

Service users expressed hopes that the choices that they made during the inpatient treatment would be respected by staff:

“Just respect my life, my family, my friends, people that I talk to. In general, just respect me.” – Participant 36

### **Key Theme 2: Taking Care of Themselves**

Participants talked about supporting people with ID to become more independent and discussed ways to prepare people with ID for employment or train them in basic self-care skills.

#### **Sub-theme 1: Work-related Skills and Employability**

People with mild ID and mental health problems were considered suitable candidates for work training to improve their chances of being employed in the community. Mental health professionals, family carers and service users viewed this would increase the self-esteem and confidence of people with ID and improve the public image of them as productive members of society:

“Then maybe if given a chance and he can go for an employment, it will do something good for him and make him an adult.” – Participant 22

There was a desire among both mental health professionals and family carers that the public would view people with ID more positively when they are working and contributing to society:

“My hope for her is that one day she will be much more normal. She can go out to work for companies.” – Participant 23

### ***Sub-theme 2: Self-care***

The three groups of participants noted that mental health professionals focused on providing training to people with ID on social and self-regulation skills to cope with difficult situations:

“... patients get angry less often, the patient is able to regulate himself. He knows to ask for help rather than just punching someone.” – Participant 11

There were concerns among the family carers about their relatives' lack of competence in social interaction skills and self-care. As such, they hoped that their relatives could learn to take care of themselves independently to alleviate their high care burden of assisting them with their day-to-day activities:

“Be independent, go toilet shower himself, eat himself, now all these things now we are helping. I just hope he can do it by himself. That is the only thing I need.” – Participant 25

Service users receiving outpatient services described learning coping skills and hoped to recover from their mental health problems:

“... attending social skills course, coping strategies, having to do worksheets to help me understand and how to handle stress.” – Participant 36

## **Key Theme 3: Public Perception**

This key theme describes the dignity and respect (or lack thereof) with which services for people with ID were provided.

### ***Sub-theme 1: Reaction from the Public – ‘Dangerous!’***

Mental health professionals reported a general lack of public respect toward people with ID:

“The public may perceive patients with ID as kind of dangerous, unpredictable ... because of the stigma, it will have barriers for the person with ID to integrate back into the society.” – Participant 12

Family carers noted similar negative reactions from the public and the discrimination they witnessed when accompanying their relatives out in public. They speculated that the public blamed them when their relative with ID became aggressive and noted that they did not receive assistance from the public:

“Some of the public don’t understand the children. They thought that they are ill bred, throw tantrum and have bad upbringing – thinking ‘Is that the way you teach your kid?’ – Participant 23

Service users did not recount any negative reactions but stressed how important it is to “*behave normally*” (Participant 36) in public. They desired for mental health professionals to treat them “*as an individual*” (Participant 32), with respect and kindness.

### **Sub-theme 2: Cannot Contribute to Society**

In addition to the common negative public perception that people with ID are ‘dangerous,’ mental health professionals noted that people with ID had few employment opportunities because they were seen as unproductive and unsuitable for work:

“... people with ID who cannot contribute to society as much in that aspect, and would be valued lower. We value what utility they can bring, what can they contribute to society.” – Participant 3

Mental health professionals felt that employers were not willing to make the necessary accommodations to include people with ID and people with ID lack opportunities to work with other non-disabled people in the community. There was a sense of resignation among family carers where they acknowledged that society focused on their limitations and was not ready to accept them:

“Because to work for a company, I don’t see that happening. If you’re not efficient enough, they (employer) wouldn’t want you.” – Participant 23

### **Key Theme 4: Part of The Community**

In this theme participants describe the lack of inclusion and participation for people with ID in the community and the lack of opportunities for people with ID to interact with other members in the community and form social relationships.

***Sub Theme 1: Having a Presence***

Mental health professionals talked of the need for more effort to facilitate people with ID to access general services and facilities. They also noted that the family has a strong influence regarding their relatives' involvement and participation in the community:

“ . . . they (family) would not bring them out because of this limitation they (people with ID) have . . . sometimes they don't have the opportunities to join in many activities in the community.” – Participant 13

Mental health professionals and family carers noted that the general public did not regularly come into contact with people with ID in the community and were often unsure how to interact with them which may impact on their accessibility to mainstream services and facilities:

“ . . . some (staff) can be very not welcoming . . . like when they make noise in the bus . . . so sometimes they will be told off to alight in the next bus stop . . . ” – Participant 13

Some family carers talked about their hesitation to bring their relatives with ID out in the community:

“Cannot bring him out in the public or to crowded areas or to use public transport because he will be frustrated and shout which we feel very embarrassed . . . ” – Participant 24

Service users reported enjoying the time spent with their relatives and friends in the community, accessing mainstream facilities and celebrating important personal events whereas others service users receiving inpatient mental health services shared feelings of sadness about being excluded from their families.

***Sub Theme 2: Having Meaningful Relationships***

There were concerns among mental health professionals that people with ID lacked opportunities to form meaningful relationships with others which may negatively impact their mental well-being:

“One of the biggest sources of barriers or conflicts is between the patient with ID versus parents, (disability) home because when it comes to relationships, usually they want to have a relationship but the support staff and family are not keen . . . ” – Participant 13

Although mental health professionals acknowledged that the aim of the service is for people with ID to have meaningful employment and social relationships in the community, they considered it difficult to achieve:

“ . . . it's generally a good idea and intention to integrate people with ID back in society. But if you ask for more details, I think the general answer is just wishful thinking.” – Participant 5

Some family carers did not express much concern about integrating their relatives with ID in the community and preferred their relatives to stay at home as a result of past negative experiences:

“I don’t have the confidence because we never know what may happen; because of all the bad incidents in the past years, I’m a bit anxious.” – Participant 21

On the other hand, service users noted that having friendships with others ameliorated their emotional difficulties: “*Every time I write to my friend that I’m sad, then he will talk to me*” (Participant 34) and helped to fill a void when their relatives left them in the hospital: “*like take care for him and spend time with him when he is lonely*” (Participant 30). Service users mainly spoke of the positive experiences of the friendships that they made when staying in the hospital and attending courses: “*... support from people I know over there*” (Participant 34) and “*... friends that I have made when attending the course*” (Participant 33).

## Discussion

These findings indicate that the specialist mental health service in Singapore has recently made progress in achieving some of the five service accomplishments as described in the four key themes that are mapped on the O’Brien service accomplishments

The first positive achievement is that the specialist mental health service strives to increase the competency of people with ID which is in line with O’Brien’s (1992) service accomplishment ‘Competence.’ This is done through providing skills training to increase independence in self-care and helping service users find work in the community. Family carers and service users in this study were satisfied with the services because of the strong emphasis on skills acquisition by which mental health professionals taught emotion regulation and social skills. The Singapore policy of inclusive practice described in the government document titled *Enabling Masterplan* has a strong emphasis on achieving this accomplishment and recommends that people with ID be integrated as part of the workforce (Singapore Ministry of Community Development, 2016). Scheef et al. (2019) found that employers in Singapore preferred people with ID to have soft skills such as communication and being dependable as compared to job-specific technical skills.

Another positive achievement of the specialist mental health service is that it seeks to carry out O’Brien (1992) service accomplishment ‘Community Presence.’ Mental health professionals focused on working with the family to facilitate discharge of patients back into the community under the care of their family. All the participant groups identified that employability in people with ID increases their presence and participation in the community which improves their well-being and provides more opportunities for social interactions. Singapore is a developed South-East Asian country known for its



competitive economy with high social and economic inequalities (Yahya, 2014). A unique socio-characteristic of Singapore culture is the concept of meritocracy which is engrained in Singaporeans' values and beliefs systems, where socioeconomic mobility can be achieved based on merit, ability and working hard to attain success regardless of one's background or ethnicity. The principle of meritocracy has led Singaporeans to define success as having a good education and being employed (Foo et al., 2006). Hence, people with ID are viewed more positively when they can find work and obtain a stable income as they are then seen to be more independent and productive within the Singapore society (Kurochi, 2019). This contrasts with other non-western culture (for example, Bangladeshi and ethnic Chinese culture) in which women with ID are more valued for their biological role to bear children and may be at times forced into arranged marriages where the family hopes to increase their relative's social identify and thus become more integrated into the society (Hepper, 1999; Pan & Ye, 2011).

The societal stigma described by the mental health professionals and family carers in the current study has an impact on service provision. Although the mental health professionals provided support and resources to help integrate people with ID in their own communities, this was hampered by public stigma and discrimination. It remains a challenge for people with ID to access general services and for family carers to feel comfortable bringing their relatives out in public, especially for those with more severe complex presentations and requiring high levels of care.

There is as yet no research on the public attitudes toward people with ID and the impact of stigma in Singapore, however findings carried out in non-western countries with a similar culture as Singapore indicate that people with ID are portrayed negatively and caregivers experience high levels of stress dealing with public stigma that affect their overall mental and general health (Chen et al., 2012; Chiu et al., 2015). Participants focused on improving the competency of people with ID to enter the workforce as a way to improve the public perception and respect of people with ID, thus striving to meet O'Brien (1992) accomplishment 'Dignity and Respect.' However, it is challenging for the specialist mental health service to make a positive impact on public perception and attitudes toward this client population as highlighted in the current study. The impact of public stigma and difficulty to care for people with ID may make family carers hesitate to take their relatives back following their hospitalization, leaving no other option than transferring them to an institution, further depriving them of the opportunity to integrate and have a presence in the community which may perpetuate negative attitudes and stigma within the community. The Singapore government is looking to mitigate this through organizing events for the public and people with ID to interact with each other through mutually shared activities (Singapore Ministry of Community Development, 2016).

Cannella et al. (2005) carried out a review of studies conducted in western countries which found that people with ID had limited decision-making opportunities regarding their own health-related issues which were similarly to the findings in this study. The lack of opportunities to provide choice and autonomy for people with ID could be likely explained mental health professionals assuming that the family should make the decisions on their relative's behalf and underestimate competency of people with ID to understand their own health conditions (Ferguson et al., 2010). Service users in this study spoke of a lack of empowerment during their hospital stay and their choices regarding treatment and discharge being ignored. This is likely to encourage passivity and may affect their relationships with mental health professionals (Fish & Hatton, 2017).

O'Brien's service accomplishment 'Community Participation' was not often mentioned and emphasized by the participants in the current study. However, different participant groups had differing views when it concerned relationships or social interactions. Family carers in the study did not prioritize this and sometimes chose to avoid dealing with the issue, possibly due to their perceptions that people with ID are not competent or ready to have relationships with others. Mental health professionals highlighted difficulties in accomplishing this principle when working with this client population because of lack of support from family and support staff. Hence they appeared uncertain about how to advocate for the rights of people with ID when their family discouraged them from pursuing intimate relationships. This is consistent with literature that found that although professional staff are open to discussing sexuality and intimate relationships, the family is reluctant for their adult relative with ID to have intimate relationships although more accepting of them forming non-intimate friendships (Evans et al., 2009).

On the other hand, service users in the study shared the significance of having relationships and social interactions with others as a way to ameliorate feelings of loneliness when they lost contact with their family members following inpatient treatment. Participants with ID of qualitative studies conducted in other countries did not talk about their social interactions and friendships during inpatient treatment. Yet, there is an acknowledgment that having friends is important to a person's well-being and research has found that having a social network of friends improves quality of life outcomes for people with ID (Friedman & Rizzolo, 2017; Van Asselt-goverts et al., 2015). However this is largely neglected by service providers and people with ID are found to have poor friendships, lack support in activities with their friends in institutionalized setting and few have non-disabled friends in the community (Emerson & McVilly, 2004).

The lack of mention of these relationship issues is not uncommon and it has been noted by other authors that people with ID are often restricted from exploring sexual intimacy and forming relationships with others (Alexander &

Taylor Gomez, 2017; Evans et al., 2009). The desire to have relationships with others is universally found among people with ID and many aspire to get married and have a family (Healy et al., 2009). At the same time, people with ID often lack knowledge of their rights and of information regarding sexual health issues as a result of strong negative attitudes from their family (Healy et al. (2009). The impact of culture on attitudes toward sexuality in people with ID and their sexual rights has also been researched (Ditchman et al., 2017; Sankhla & Theodore, 2015), revealing that South Asians endorsed more negative attitudes compared to Westerners. In Singapore, it is considered taboo to discuss sexuality and intimacy issues openly which may likely contribute to the challenges for mental health professionals to advocate the sexual rights of people with ID (Paulo et al., 2020). It may be a possible explanation that family carers prioritize on ensuring that their family members with ID gain employment as a way to improve their level of independence and be accepted in the society.

### *Limitations*

There are some limitations that needs to be considered. As this study is small scaled and exploratory, the views of the participants may not be representative of staff from different healthcare settings or all people with ID or their carers in Singapore. The narratives of the family carers and service users might have been influenced by social desirability and the sample consists of only a small percentage of people who accessed the specialist mental health service in Singapore. Future research could include the views of staff in community services and mainstream staff from other healthcare settings. This study does not explore in depth the quality of treatments that the specialist mental health service provides for people with ID, for example, exploring the outcomes of people with ID after receiving psychological therapy, which may be worth considering for future research.

### *Implications*

The findings of this study highlight the cultural differences that mental health professionals in Singapore need to consider when working with people with ID. More efforts could be made to address the choice and autonomy of people with ID. The results suggest a role for improved training of mental health professionals to involve people with ID in decision making. Mental health professionals could learn to adapt communication techniques to encourage people with ID to express their views and make decisions about how they wish to lead their lives. At the same time, mental health professionals could also work with family carers to avoid miscommunication and ensure collaboration to help their relative with ID to be more involved in their treatment and discharge plans. People with ID should be provided with

resources to allow for supported decision making and be provided with opportunities to make choices about their daily routine of activities during their treatment process.

The family plays a significant role in the treatment and recovery outcomes of their relatives with ID, especially when it comes to integrating them in the community. Hence, mental health professionals working in the specialist services may need to collaborate with family carers and understand their concerns about their relatives pursuing relationships and wanting opportunities to participate in the community. At the same time, mental health professionals need to work with the family members and the person with ID to develop coping strategies to deal with public stigma as well as working with community partners to encourage people with ID to have a more significant presence in the community.

The specialist mental health service aims to integrate people with ID in the community through employment. Participants of this study mainly discussed the impact of employment on the self-identity and self-worth of people with ID. Government and social agencies could work toward providing more employment opportunities as well as reducing societal stigma through public campaigns that raise awareness and through the development of new policies to promote inclusion in the community. There are other ways to improve the self-identity of people with ID, namely through having social interactions or relationships with others or with members of the public. Mental health professionals in the specialist service could collaborate with the family to develop short-term goals for their relative with ID to develop social networks and friendships where they can participate in leisure activities. Research has shown that social skills training programs have helped people with ID to form meaningful relationships that can increase their social network (Ward et al., 2013). This is something that the specialist mental health ID service may consider to improve the social and relationship aspects of lives of people with ID.

## Acknowledgments

The authors thank all the participants who shared their experiences and to the hospital for allowing the study to be carried out.

## Disclosure Statement

There are no known conflicts of interest.

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