A systematic review of training for mainstream mental health professionals working with people with intellectual disabilities and mental health needs

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Abstract

Purpose – *Policy in the UK and many other countries states that mainstream mental health services should be accessible to people with intellectual disabilities (ID). The purpose of this paper is to systematically review training and development needs assessments and delivered training and development for professionals working in mainstream mental health services who may work with people with IQ.*

Design/methodology/approach – *A systematic search of four databases (Web of Science; PsychInfo; PubMed; CINAHL) over the period of 2011–2023 was used. Papers were included if they described training or development delivered to, or specific training or development needs analyses of, mainstream qualified staff to support working with adults who have an ID.*

Findings – *Two papers were found that described training and development initiatives and six that described training and development needs analysis, five of these papers originated from Australia and were part of the development of a comprehensive workforce competency framework.*

Research limitations/implications – *Training and development approaches for mainstream mental health services to facilitate the support of people with IQ should be systematically developed and trialled.*

Originality/value – *To the best of the authors' knowledge, this is the first study to review training and training needs analysis in this area since 2012. The review finds only a small number of papers in what is an important area for service development.*

Keywords *Intellectual disabilities, Training, Systematic review, Mental health professionals, Quality ratings, Training needs analysis*

Paper type *Literature review*

Introduction

Ensuring that people with intellectual disabilities (ID) use mainstream health services is a policy target in many countries (e.g. McConkey *et al.*, 2020). In the UK, policy documents state that people with ID should, where possible, use mainstream mental health services. The National Service Framework for Mental Health (Department of Health and Social Care, 1999) emphasised equality of access and associated service quality for people with disabilities and endorsed the development of "[…]*key skills and competencies required throughout mental health services to ensure services are non-discriminatory, and sensitive to the needs of all service users and carers regardless of age, gender, race, culture, religion, disability, or sexual orientation*". This was reiterated in the Learning Disabilities Mental Health Outcomes Charter (NHS, 2013), which stated: "*It is imperative that people with learning disabilities who have mental health needs have the same access to generic mental health services as the general population using reasonable adjustments where needed.*" There is some guidance for specific services such as NHS Talking

Therapies for Anxiety and Depression (NHSTTAD), which is universal model of primary care psychological therapy in England (previously known as IAPT services). The service is required to make adaptations for people with "protected characteristics", which includes ID (National Collaborating Centre for Mental Health, 2023). Guidance is available describing how services can be made more accessible to people with ID in both specific service models such as NHS Talking Therapies (e.g. Dagnan *et al.*, 2015a, 2015b) and general mental health services (NDTfI, 2022).

A range of factors will influence whether services are able to work with people with ID. Whittle *et al.* (2018) report a scoping review of barriers and enablers for people with ID in their use of mental health services. The paper uses Gulliford *et al.*'s (2002) framework for understanding service access, which has four dimensions; availability, (the primary presence of services); utilisation, (the organisational process and structural barriers to accessing services when available); relevance and effectiveness, (the quality of service); and equity, (the access to the service for different groups with the same needs). Whittle *et al.* (2018) conclude that whilst literature identifies barriers for people with ID in accessing mainstream mental health services, the research in this area has not been systematic. There is a need for more research to understand how people with ID can best access such services.

The knowledge, attitudes and confidence of carers and professionals are identified as factors that support the access of people with ID to mainstream services (Whittle *et al.*, 2018). There have been several systematic reviews of the knowledge and attitudes of staff working within mainstream mental-health settings, supporting people with ID and mental health conditions (e.g. Whittle *et al.*, 2018; Ee *et al.*, 2022). There have been reviews of training for healthcare staff who may support people with ID (Adirim *et al.*, 2021; Hemm *et al.*, 2015), reviews of the attitudes of professionals working in areas other than mental health who were working with people with ID(e.g. Pelleboer-Gunnink *et al.*, 2017) and meta-ethnography of the experience of professionals providing services for people with ID (Ee *et al.*, 2022). These studies provide a context for the need for service development and professional training but do not explicitly describe training and development needs analyses or training and development curricula.

Two reviews have considered training for staff working with people with ID, and included training for supporting those with mental health conditions (Rose *et al.*, 2012; Werner and Stawski, 2012). Werner and Stawski reviewed literature up to 2011 regarding the knowledge, attitudes and training of professional staff working with people with ID and mental health needs, they found 27 papers of which 13 related to training for staff working with ID and mental health needs. Most papers described training content and training needs of staff who worked in specialist services for people with ID and only four related to professionals who worked in mainstream mental health services (the majority of which were psychiatrists in training). Similarly, Rose *et al.* (2012) reviewed up to 2009 and found 29 studies which predominantly describe training to staff working in specialist services for people with ID.

The aim of this review is to identify papers that give clear statements of empirically derived training and development needs for professional staff working in mainstream mental health services and/or describe specific curricula for training such staff to work with people with ID, experiencing mental health conditions. This review is important in the context of a continued interest in ensuring people with ID access mainstream mental health services (e.g. McConkey *et al.*, 2020; National Collaborating Centre for Mental Health, 2023).

Method

This paper will review relevant literature related to training/development delivered to and/or the training/development needs of mainstream mental health professionals who might work with adults with ID and mental health conditions. The review was ineligible for registration with Prospero as it does not relate to direct clinical outcomes.

Studies were included in the review if they:

- described the content of training on working with people with ID delivered to qualified staff, working in mainstream mental health settings or;
- a specific training or development needs analyses on working with people with ID for qualified staff, working in mainstream mental health settings; and
- were in English.

Studies were excluded if:

- The training/development or training/development needs analysis related to groups that were not typically, solely associated with ID (for example, autism).

The search covered the period 2011–2023 to update the work of Rose *et al.* (2012) and Werner and Stawski (2012). Following an initial scoping of the literature, a set of terms were chosen which allowed a broad range of papers to be captured in the initial search. Thus, initial searches were carried out using the keywords ((“intellectual disab*” OR “learning disab*”) AND (“mental health” OR “mental ill-health” OR psychiatr*) AND (training OR develop* OR knowledge OR “training need”)), the search yielded 1,316 studies (521 Web of Science, 327 Psychinfo, 246 PubMed and 222 CINAHL). Duplicates were removed and following a screening of titles, 88 studies remained. The abstracts of these studies were then read, leaving 32 papers to be read in full and eight papers that were included in the final review. The citation list from each of the final identified papers was considered and a forward citation search was carried out for each paper identified. At each stage 40% of excluded studies were checked to ensure agreement on the application of inclusion and exclusion criteria; there were no disagreements on studies that should not have been excluded at any stage. Figure 1 presents this review process.

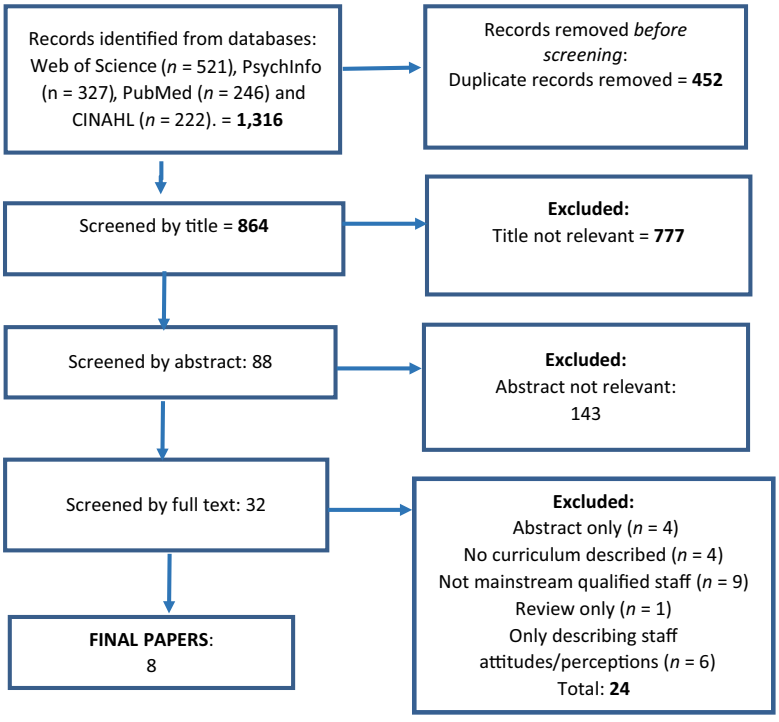
A quality assessment of the papers included was carried out. The needs analysis papers were predominantly cross-sectional designs and the training papers were single single-group studies, with and without follow-up. A single quality framework was constructed for both types of paper based on the Downes *et al.* (2016) appraisal tool for the quality of cross-sectional studies. The papers were initially rated by EH and then rated by DD. Initial agreement was calculated as a percentage for all ratings; there were eight disagreements in 96 ratings (91.6% agreement). Disagreements were discussed and a consensus was agreed.

Results

Quality appraisal

The rating for quality of papers included is shown in Table 1. The two training studies involve 419 participants in two countries (UK and Australia) and the six training needs assessment papers involve 1,115 participants in three countries, with four papers reporting work in Australia (as the sites involved in these papers overlap it is not easy to identify whether the same participants were present in more than one study). All studies are clear about their aims and describe the included respondents. Measures were judged to be appropriate to the studies and some measurement properties of the measures used were reported. Studies generally discussed their limitations and all described implications for practice and service development. However, although studies could place their samples within the context of the wider professional groups they represented, studies rarely compared responders and non-responders and all studies had a lower than 75% response rate to training evaluation or training needs measures. No studies had a maximum score for quality, although the two studies describing training and implementation (Eagleson *et al.*, 2022; Dagnan *et al.*, 2018) were amongst the four highest-scoring studies.

Figure 1 PRISMA (Page *et al.*, 2021) flow diagram for identification of studies



Source: Authors' own work

Table 1 Quality ratings for papers in the review

	Quality ratings (see key below)												
	1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*	Total
Dagnan *et al.* (2018)	1	1	1	1	1	1	1	1	0	1	0	1	*10*
Eagleson *et al.* (2022)	1	1	1	0	1	1	1	1	0	1	1	1	*10*
Sajith *et al.* (2019)	1	0	1	0	0	1	1	1	0	1	1	1	*8*
Werner *et al.* (2013)	1	1	1	1	0	1	1	1	0	1	1	1	*10*
Man *et al.* (2017)	1	1	1	1	0	1	0	1	0	1	1	1	*9*
Trollor *et al.* (2017)	1	0	1	0	0	1	1	0	0	0	1	1	*6*
Weise *et al.* (2017)	1	1	1	1	0	1	1	1	0	0	1	1	*9*
Weise and Trollor (2018)	1	1	1	1	0	1	1	0	0	0	1	1	*8*
Column total	*8*	*6*	*8*	*5*	*2*	*8*	*7*	*6*	*0*	*5*	*7*	*8*	

Notes: 1. Were the aims/objectives of the study clear? 2. Was the sample size justified? 3. Was the sample clearly defined? 4. Was the target population shown to be representative of the wider population of the profession involved? 5. Were measures undertaken to address and categorise non-responders? 6. Were the outcome or needs assessment variables measured appropriate to the aims of the study? 7. Were the properties of the outcome or needs assessment used reported in the paper? 8. Were the methods (including statistical methods) sufficiently described to enable them to be replicated? 9. Response bias (is response rate at least 75% of people who were surveyed)? 10. Were key potential confounding variables considered? 11. Were the limitations of the study discussed? 12. Does the paper identify implications for practice?
Source: Authors' own work

Study details

Table 2 shows the two papers that described training and competence development and implementation, whilst Table 3 shows details of the six papers that describe training and development needs analyses.

Training and development implementation papers

Two papers describe training and development interventions for staff working in mainstream mental health services. The two studies describe quite different target populations and consequent levels of specificity of curriculum. Dagnan *et al.* (2018) describe training for NHSTTAD staff. The curriculum delivered was modularised with staff getting the introductory and more detailed modules. The introductory modules were the epidemiology, nature and causes of ID, an introduction to assessment, an introduction to adaptation of therapy and an overview of local support services for people with ID. The more detailed modules were advanced assessment, stigma and therapy alliance, specific adaptations and case conceptualisation. The primary outcome measure was confidence in therapy with people with ID (Dagnan *et al.*, 2015a, 2015b) and general therapy efficacy (Dagnan *et al.*, 2015a, 2015b). Both measures showed a statistically significant increase immediately post-training which was maintained at three-month follow-up.

The second intervention paper describes the introduction of a competency framework on working with people with ID for staff working in mainstream mental health services (Eagleson *et al.*, 2022). The intervention took place at a statewide level in Australia and was available to all mental health staff in the area. The framework development is described in Troller *et al.* (2017) and consists of 11 competencies, split into communication and values, clinical competencies and quality and professional development activities. The framework offers general background and greater detail within each element (NSW Ministry of Health, 2017). The intervention in this study involved making the framework materials available to participants and the outcome was primarily the degree of engagement with the framework.

Training and development needs analysis

Six papers specifically report data on training and development needs. Two of these papers describe the development of the competence framework evaluated by Eagleson *et al.* (2022). Weise *et al.* (2017) and Troller *et al.* (2017) describe the development of the competency framework and an associated tool kit using a "multi-phase, multi-method design" using both qualitative and quantitative data. The process began with a scoping survey, followed by a modified Delphi study and was finalised with a multiple stakeholder consultation and demonstrated a comprehensive consultation process in developing a competency framework.

Two further papers are from the same research group and describe the training needs of an Australian public mental health workforce and Australian psychologists. Weise and Trollor (2018) describe an online survey of practitioners in 17 of the 18 health districts in New South Wales; the invitation to participate was sent to 6,012 members of the public mental health workforce of which 566 (9.4%) responded. The key training finding from this study was a list of preferred training delivery approaches, with the top three being face-to-face training seminars, face-to-face workshops and online self-paced training packages. A similar approach was taken by Man *et al.* (2017) who compared confidence, experience and training needs for 109 registered and provisionally registered Australian psychologists, of which 85% identified a need for further training in the mental health needs of people with ID. There were some differences in the training needs identified depending on years qualified, however the key areas for training identified were assessment and treatment of mental health conditions and training in specialised assessment tools, with online and workshop formats as the preferred delivery method.

Table 2 Papers reporting curricula and outcomes

Authors and article title	*Training/delivery approach*	*Curriculum content*	*Participants*	*Measures used*	*Evaluation results*
Dagnan *et al.* (2018). *Training therapists to work with people with intellectual disability in improving access to psychological therapies (IAPT) services*	1- and 2-day modularised face-to-face training course of eight sessions, each of 75 min each	1. Introduction to intellectual disability, epidemiology, nature and causes 2. Stigma and its impact on therapy relationships 3. Introduction to the assessment of people with intellectual disabilities 4. Advanced assessment of people with intellectual disabilities 5. Overview of adaption of therapeutic techniques 6. Specific examples of adaption 7. Therapeutic approaches and formulations 8. Overview of local services and discussion of communication and support systems	Primary care psychological therapists in an English NHS Taking Therapies service. Psychological wellbeing practitioners ($n = 32$); high intensity practitioners ($n = 36$)	Participants completed measures pre-, post- and 3 months after training 1. The Therapy Confidence Scale – Intellectual Disabilities (TCS-ID; Dagnan et al., 2015a, 2015b). 2. A five-item General Therapy Self-Efficacy Scale (Dagnan et al., 2015a, 2015b). 3. Six members of each group interviewed three months after training with a focus on their use of knowledge and skills gained in the training	Both groups reported significant positive changes in confidence and general therapy efficacy immediately post-training, maintained at 3 months post-training All participants interviewed identified changes to their practice that they attributed to the training sessions. The four key themes identified were: increased awareness and sensitivity; adaption and simplification of communication; adaption and simplification of materials and adaption and simplification of interventions
Eagleson *et al.* (2022) *Evaluation of an intellectual disability mental health core competency framework*	The core competency framework was made available online	Part 1: Working with people with an intellectual disability 1. Responsible, safe and ethical practice 2. Recovery focus 3. Meeting diverse needs 4. Communication 5. Partnership, collaboration and integration Part 2: Clinical competencies 6. Common clinical competencies 7. Intake 8. Assessment 9. Mental health interventions and care planning 10. Transfer of care Part 3: Quality improvement/professional development 11. Research, quality improvement, professional development	Of 1,072 mental health professionals who downloaded the manual; 351 (32.7%) completed a pre-download questionnaire, 111 (31.6%) completed a 3-month follow-up and 78 (22.2%) a 12-month follow-up	A study-specific survey questionnaire with pre-, 3 and 12-month follow-up. Survey question areas 1. Engagement with the core competency framework and how it was used 2. Feedback on the utility of the core competency framework 3. Attitudes, skills, knowledge and confidence working with people with intellectual disabilities and mental ill-health	At 3-month follow-up 105 (94.6%) of the 111 respondents had engaged wholly or partially with the competency framework Two items showed significant change over the course of the study 1. Confidence in providing the same level of service to people with intellectual disabilities as those without 2. "I have considered how my own beliefs, emotions and attitudes towards people with intellectual disability affect my professional practices"

Source: Authors' own work

Table 3 Papers reporting training and development needs analysis

Paper title and authors	*Type of service, participants (numbers and any characteristics reported)*	*Method used to determine training needs*	*Training content identified*
Sajith *et al.* (2019) *Perceptions of psychiatry residents and nonresidents on training needs and care related to patients with intellectual disability and mental health problems: a study from Singapore*	Tertiary psychiatric service in Singapore, 48 (63.16%) out of possible 76 psychiatrists responded, 26 (54.2%) men; 38 (79.2%) more than one year of experience in psychiatry and 16 (33.3%) more than four years of experience	Part of a survey on clinical experience and training in intellectual disabilities and mental health problems. Training needs questions were six possible areas to be placed in order of individual priority	Six training areas identified in order of priority 1. Management of behaviour problems 2. Diagnosis and management of mental disorders in ID 3. Pharmacological therapy 4. Non-pharmacological therapy 5. Diagnosis of ID 6. Autism spectrum disorder
Werner *et al.* (2013) *Psychiatrists' knowledge, training and attitudes regarding the care of individuals with intellectual disability*	Two hundred and fifty-eight (38%) of 679 Israeli psychiatrists completed questionnaires. Mean age, 47.9 years, mean years since qualification 21.6 (SD = 11.1), 80.7% were general psychiatrists; 29.4% reporting more than 5% time commitment to people with intellectual disabilities	A study-specific survey on knowledge, and attitudes to working with people with intellectual disabilities and mental health conditions. Participants ranked eight possible areas of training content in order of priority	The following areas for training in relation to intellectual disability were identified, in order of priority 1. Medical treatment for children/adults 2. Diagnosis of psychiatric illness among children/adults 3. Different treatment options 4. Diagnosis of intellectual disability 5. Differential diagnosis between different factors related to intellectual disability 6. Communication problems among children/adults 7. Behavioural phenotypes connected to specific syndromes 8. Dealing with personal attitudes towards people with intellectual disability 9. Psychotherapy
Man *et al.* (2017) *Clinical competencies and training needs of psychologists working with adults with intellectual disability and comorbid mental ill health*	One hundred and nine psychologists in Australia who were training and qualified and working in specific and generic setting mental health settings	A survey specific to the study, with 25 statements on training and mental health care of people with intellectual disability	Ninety psychologists (86%) indicated they would like further training in mental health and intellectual disability. Key training areas and preferred formats were 1. Assessment and treatment of mental health conditions in adults with intellectual disabilities 2. Training in specialised assessment tools 3. Online, workshop and conference formatting preferable

(*continued*)

Table 3

Paper title and authors	*Type of service, participants (numbers and any characteristics reported)*	*Method used to determine training needs*	*Training content identified*
Troller *et al.* (2017) *Development and dissemination of a core competency framework*	Six people with an intellectual disability, 28 family members and support persons and 36 experts participated in the development of the framework. No further details of the groups are available	A five-phase process for development and evaluation was described 1. Scoping the need for an intellectual disability mental health core competency framework (described in detail in Weise and Trollor, 2018) 2. Consultation with key stakeholders 3. Development of the intellectual disability mental health core competency framework 4. Implementation of the intellectual disability mental health core competency framework 5. Evaluation of the intellectual disability mental health core competency framework (described in Eagleson et al, 2022)	The framework identified has the following three core dimensions Part 1: Working with people with an intellectual disability Part 2: Clinical competencies Part 3: Quality improvement/ professional development The core elements of these are described in detail in Eagleson *et al.* (2022)
Weise *et al.* (2017) *Establishing core mental health workforce attributes for the effective mental health care of people with an intellectual disability and co-occurring mental ill health*	Thirty-six intellectual disability mental health experts from across Australia participated in a modified online Delphi	A study-specific survey with quantitative and qualitative components was used in a Delphi process. Participants were asked to rate their level of agreement that the proposed attributes were core elements of clinical practice for mental health professionals working with people with intellectual disability in mainstream services Consensus was defined as 70% or more of participants agreeing or strongly agreeing that an attribute was core to clinical practice	The study further develops the framework identified in Eagleson *et al.* (2022). The Delphi process identifies 110 competencies required by a mental health workforce when working with people with intellectual disabilities As an example, for 'core clinical competencies' there are seven detailed elements, the first two are: 1. Demonstrates the ability to assess the capacity of a person with an intellectual disability to understand information and make decisions about their mental health care 2. Takes the time to prepare for working with a person with an intellectual disability by finding out about their strengths and the support that they may require, to ensure their active engagement and participation in the service

(*continued*)

Table 3

Paper title and authors	*Type of service, participants (numbers and any characteristics reported)*	*Method used to determine training needs*	*Training content identified*
Weise and Trollor (2018). *Preparedness and training needs of an Australian public mental health workforce in intellectual* Disability mental health	Staff of a general mental health service in New South Wales of which 566 took part. Professional backgrounds included nursing, occupational therapy, psychiatry, psychology and social work	A study-specific survey with questions on attitudes to people with intellectual disabilities, previous contact and professional training One questionnaire gave seven options for preferred modes of training delivery which were ranked in order of preference by each participant	Preferred training delivery (ranked) 1. Face-to-face training seminars 2. Face-to-face workshops 3. Online self-paced training packages 4. Face-to-face tutorials 5. Online tutorial 6. Online seminar 7. Tele-link training sessions

Source: Authors' own work

Two further papers describe training needs of mainstream psychiatrists when working with people with ID. Sajith *et al.* (2019) report an analysis of data from 48 (63.16%) of 76 training psychiatrists in Singapore with between 1 and 5 years of qualified practice. Participants responded to a questionnaire that suggested six training areas that respondents placed into order of priority. The top three were the management of behaviour problems, the diagnosis and management of mental disorders in IQ and pharmacological therapy. Werner *et al.* (2013) report the responses of 258 psychiatrists in Israel who returned completed surveys gathering data on demographics of participants, knowledge and attitudes. Assessment of training needs was derived from eight pre-suggested topics, which participants were asked to place into order of priority. The most selected training topics were medical treatment for children/adults with ID, diagnosis of psychiatric illness among children/adults with ID and different treatment options for people with ID.

Discussion

This paper has presented a systematic review of completed training and development and training needs of mainstream mental health staff on working with people with ID. The review period was from 2011 to extend the findings of two systematic reviews published in 2012 (Rose *et al.*, 2012; Werner and Stawski, 2012) which had included a small number of examples of training for mainstream staff. During this period there have been several systematic reviews of associated areas such as a meta-synthesis of qualitative studies of the experience of mainstream staff supporting people with ID (Ee *et al.*, 2022) and a systematic review of the training needs of general health staff in working with people with ID (Hemm *et al.*, 2015). However, there are only two studies describing training and development interventions for mainstream staff and only six papers reporting training and development needs assessments (of which four are from the team involved in one of the reported interventions). Only one of these papers reports data from the UK. The small number of papers meeting the review criteria deserves comment. It is as important that systematic reviews highlight an absence of research as it is that they review substantial bodies of research. There is a disparity between what is known about training and development initiatives for mainstream physical health staff (e.g. Doherty *et al.*, 2020) compared to the results reported here for mainstream staff working in mental health. This review highlights this disparity and the need for further research in this area.

The quality of papers included was generally acceptable, however no studies achieved a high response rate to needs analysis surveys or training follow-up and few studies were able to demonstrate that responders to surveys and evaluations were representative of the possible participant group and so there should be caution in generalising findings from these studies to other populations. Because of the different service areas targeted, there is little commonality in the curricula of the training and development approaches described and the training needs content. However, the papers suggest that it may be helpful to have training and development for both comprehensive general competencies (Eagleson *et al.*, 2022) and very specific skills and adaptations for service pathways (Dagnan *et al.*, 2018). However, both intervention papers describe approaches based on a thorough understanding of the services involved and their processes which is reflected in the training and development approaches described. The measures used in the studies generally have some described properties specific to the study; although Dagnan *et al.* (2018) use a measure described in detail by Dagnan *et al.* (2015a, 2015b) which has subsequently been used in several studies (e.g. Hronis *et al.*, 2018; Hinde and Mason, 2020) which emphasises that many of the core skills of mental health professionals are applicable to people with IQ but that confidence in their use may be lacking.

The training needs and training delivery described in this review treat people with ID as a distinct group. However, people with ID are a heterogeneous group with a significant difference in presentation between people with severe ID and those with milder disabilities. It is generally not clear whether the intended service populations are all people with ID or

only those with milder ID. In the UK, the prevalence of ID is expected to be around 2% of the population (Public Health England, 2016) however, only 0.5% of the adult population is identified in health systems (Public Health England, 2022), thus, in the UK, potentially 75% of people with, typically, milder ID are not immediately known to services and may be using mainstream mental health services without their ID being formally recognised. It is also true that training for mainstream mental health staff with respect to people with ID will include skills that are potentially useful for a much wider group of people, as adaptation required for someone with an IQ score below 70 may also help people with low IQ scores that do not formally indicate ID (for example people who have IQ scores between 70 and 80; or 9% of the population). In general, people with ID have difficulties with information processing, and with emotional and other self-regulation activities (e.g. Levén *et al.*, 2008; Dučić *et al.*, 2018). However, people with lower IQ scores that are outside of the ID range will also present with difficulty in these areas (Friedman *et al.*, 2006). Thus, the training and development areas reviewed here may be of wider importance to mainstream services which makes the small amount of reported research in the areas of particular concern.

Clearly, training is not the sole intervention required to ensure that services are accessible to people with ID (Walton *et al.*, 2022). The development and commissioning of pathways and the building of relationships between specialist and general mental health services are all factors that will need to be in place for mental health services to develop confidence in working with people with ID. Models and recommendations for how such services should be structured exist (e.g. Royal College of Psychiatrists, 2020) and their implementation should be explored, researched and reported. What little evidence there is currently does not identify differences in outcomes for people with ID in mainstream and specialist service structures (Walton *et al.*, 2022). Access to mental health services for people with ID has been further explored by Whittle *et al.* (2018). In a qualitative study, they found themes of service availability, relevance, effectiveness and access and equity and access as central to creating disparities in access. Dykens (2016) identifies actions that may rectify such disparities in research and clinical care for people with ID and mental health conditions, a key element of which is to "reform and improve training in specific mental health professions, and train non-specialists to deliver care". Local training and associated supports will specifically raise confidence and capability of services and may serve to develop relationships between services. It is important that initiatives of these types are reported to support the development of generalizable, empirically informed approaches and to explore the impact of such training on the approaches of staff and the outcomes and experience of people with ID in mainstream mental health services.

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