Journal of Applied Research in Intellectual Disabilities 2008, **21**, 183–193

Specialist Versus Generic Models of Psychiatry Training and Service Provision for People with Intellectual Disabilities

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Accepted for publication *26 June 2007*

Background Models of service provision and professional training differ between countries. This study aims to investigate a specialist intellectual disabilities model and a generic mental health model, specifically comparing psychiatrists' knowledge and competencies, and service quality and accessibility in meeting the mental health needs of people with intellectual disabilities.

Method Data were collected from consultant and trainee psychiatrists within a specialist intellectual disabilities model (UK) and a generic mental health model (Australia).

Results The sample sizes were 294 (UK) and 205 (Australia). Statistically significant differences were found, with UK participants having positive views about the specialist intellectual disabilities service model they worked within, demonstrating flexible and accessible working practices and service provision, responsive to the range of mental health needs of the population with intellectual disabilities, and providing a wide range of treatments and supports. The UK participants were knowledgeable, well trained and confident in their work. They wanted to work with people with intellectual disabilities. In all of these areas, the converse was found from the Australian generic mental health service model.

Conclusions The specialist intellectual disabilities model of service provision and training has advantages over the generic mental health model.

Keywords: intellectual disabilities, international comparisons, mental health needs, psychiatric training, service provision

Introduction

People with intellectual disabilities have a higher level of additional mental ill-health than does the general population (Beange *et al.* 1995; Cooper *et al.* 2007). This is because of biological, psychological, social and developmental predisposing factors, all of which are in excess of those experienced by the general population. It is recognized that much mental ill-health within the population with intellectual disabilities is an unmet health need (Lennox *et al.* 2000; Cooper *et al.* 2004; Gustavson *et al.* 2005; Van Schrojenstein Lantman-de Valk 2005). Many factors contribute to this, including the effectiveness of, and ease of appropriate access to, mental health services for this group, and co-ordination/communication of the work of the mental health service with other services, carers and families (N.H.S. Health Scotland 2004).

National and state policy, together with historical developments and cultural differences have resulted in models of mental health services for people with intellectual disabilities that differ between countries (Australian Health Ministers 1998; Scottish Executive 2000; Department of Health 2001; State Government of Victoria Department of Human Services 2002; Welsh Assembly 2002; N.H.S. Health Scotland 2004). The UK and Australia provide examples of different models, in both cases working in partnership with general practice.

 10.1111/j.1468-3148.2007.00394.x

Within the UK, mental health services for people with intellectual disabilities are chiefly provided through publically funded (N.H.S.) specialist intellectual disabilities services based within the community. These typically comprise teams of health and social work professionals from a range of disciplines, who have chosen to work just with, or predominantly with, people with intellectual disabilities. In contrast, the Australian model is provision through private fee-for-service or publicly funded generic mental health services for the whole general population. The private fee-for-service model consists of psychiatrists who do not often work within multidisciplinary teams, whereas the public generic mental health services provide multidisciplinary care. Both private fee-for-service and public services work predominantly with the general population who do not have intellectual disabilities. Social care is delivered via state disability services which focus on accommodation and occupational services for people with intellectual disabilities.

Regarding psychiatrists specifically, within the UK, registered medical practitioners train and are examined in all aspects of psychiatry over a 3-year period, which must include 6 months clinical training in developmental psychiatry (which must include both intellectual disabilities psychiatry, and child psychiatry, although the majority of the period may be spent in one or other of these two specialities). They then select a branch of psychiatry in which to specialize for a further 3 years training. Following satisfactory completion, they are eligible for the position of consultant psychiatrist. One branch of psychiatry in which trainees can choose to specialize is intellectual disabilities psychiatry (Royal College of Psychiatrists 1998). In Australia, registered medical practitioners train and are examined in general psychiatry over a 3-year period, followed by 2 years of advanced training. This latter does not include intellectual disabilities psychiatry, as it is not a recognized speciality in Australia and the few accredited training positions have precarious funding arrangements. Following satisfactory completion of advanced training they are eligible for Fellowship of the Royal Australian and New Zealand College of Psychiatrists (Royal Australian and New Zealand College of Psychiatrists 2003). The UK provision aims for one specialist intellectual disabilities psychiatrist per 100 000 general population. Within the state of Victoria, Australia there are three to four public sector psychiatrists specializing in work with adults with intellectual disabilities for 4 000 000 general population.

It is important to be clear about terminology, and hence it should be noted that the specialist intellectual disabilities psychiatrists in the UK work within the specialist intellectual disabilities services (not generic mental health services). Hence the term 'specialist intellectual disabilities services', which is used throughout this paper for the current UK model, actually provides specialist mental health services and facilities specifically for people with intellectual disabilities, as well as other health and social care services for people with intellectual disabilities.

There is some evidence that UK policy is shifting in the direction of 'mainstreaming' services for people with intellectual disabilities, with some views that the current model is one of segregation; and hence may hinder progress in community participation. This would move in the direction of the Australian model for provision of mental health services. There has been previous debate regarding the advantages of specialist versus generic service provision for people with intellectual disabilities and additional mental health need (Bouras & Holt 2004). One view is that specialist services may result in stigma and labelling. Others consider that generic service provision for adults with mental health needs additional to their intellectual disability has not been successful, with reasons including divisions between mental health services and disability services in Australia, inappropriate settings, negative attitudes and inadequate training of mental health professionals (Bennett 2000; O'Neal *et al.* 2005).

The aim of this paper is to investigate the resultant outcomes of a specialist intellectual disabilities service model (UK model) and a generic mental health service model (Australian model). Specifically, the present authors aimed for testing whether there are differences with regards to psychiatrists' knowledge and competencies, and service quality and accessibility in meeting the mental health needs of people with intellectual disabilities.

Method

Study design

The study was approved by Monash University Standing Committee on Ethics in Research Involving Humans, and by the Registrar of the Royal College of Psychiatrists, UK. In the UK, the questionnaire, with an explanatory covering letter and a stamped addressed return envelope was sent to psychiatrists of all grades on the mailing list of the Faculty of Psychiatry of Learning Disabilities of the Royal College of Psychiatrists. A second questionnaire was sent to non-responders. In Australia,

the questionnaire, with similar explanatory covering letter and stamped addressed envelope, was sent to psychiatrists and trainees in receipt of the Victorian Branch of the Royal Australian and New Zealand College of Psychiatrists newsletter. This was followed by a second mail out of the questionnaire.

Materials

The six page questionnaire was an updated version of that originally used by Lennox & Chaplin (1996). The questionnaire includes sections on (i) the characteristics of the respondent; (ii) details of the work of the respondent with people with intellectual disabilities; (iii) the views of the respondent regarding the role of psychiatrists for people with intellectual disabilities; (iv) the views of the respondent on a range of issues, using a 1–6 point Likert scale, where 1 indicates very much agreeing and 6 indicates very much disagreeing. The areas in section (iv) included views on psychiatric facilities for people with intellectual disabilities; access to multidisciplinary supports; appropriateness of treatments; knowledge; and having training/experience relevant for working with people with intellectual disabilities.

Analyses

The data collected from the questionnaires were entered onto SPSS version 11.5 (SPSS Inc., Chicago, IL, USA) for analysis. Frequency data were derived. To test the hypothesis that there was no difference between UK and Australian respondents in the proportion of respondents who work with people with intellectual disabilities with specified additional health needs, the chi-square statistic was calculated. To test the hypothesis that there were no differences between the views of UK and the Australian respondents (regarding psychiatric facilities; access to multidisciplinary supports; appropriateness of treatments; knowledge; and relevant training/experience for work with people with intellectual disabilities), the Mann–Whitney *U* statistic was calculated.

Results

Response rate

In the UK, 511 questionnaires were distributed. In 25 cases, the psychiatrist had retired or moved. Completed questionnaires were received from 329 psychiatrists; a 68% response rate. In Australia, 904 questionnaires were distributed, and 235 completed questionnaires were returned; a 26% response rate. A small proportion of respondents were excluded as they did not work with people with intellectual disabilities. Hence, the final sample size was 294 in the UK and 205 in Australia.

Characteristics of respondents

The male : female ratio was 57% : 43% for the UK respondents and 60% : 40% for the Australian respondents. The UK respondents had qualified from medical school an average of 21.1 years previously (range = 3–51 years). The Australian respondents had qualified from medical school an average of 19.8 years previously (range = 3–46 years). Of the UK respondents, 75% were consultant psychiatrists, 7% were non-consultant career grade psychiatrists and 19% were trainee psychiatrists. Of the Australian respondents, 71% were consultant psychiatrists, 28% were trainee registrars and 1% were medical officers. Hence, there was a similar proportion of consultant psychiatrist respondents in both groups, but a higher proportion of trainee psychiatrists in the Australian group. Consequently, further investigations compared the two groups overall (to be indicative of the views of the overall workforce), and then separately compared responses from the consultant psychiatrists, and from the trainee psychiatrists.

The work of respondents with people with intellectual disabilities

Table 1 shows the number of people with intellectual disabilities that the two groups of respondents (the UK group and the Australian group) provided assessment or treatment for over the 6-month period preceding completion of the questionnaire. The UK respondents

Table 1 Percentage of respondents providing assessment or management for each presented category of number of patients with intellectual disabilities (for the 6-month period preceding the survey)

Number of patients	*UK respondents (n = 294) %*	*Australian respondents (n = 205) %*
0	1	6
1–5	15	72
6–15	7	18
16–50	18	3
51–100	17	1
101–200	23	0
>200	20	0

provided assessment or treatment for a larger number of people with intellectual disabilities than did the Australian respondents, presumably because most of the work of Australian respondents was with people of average ability. A similar difference was found for the comparison of UK and Australian consultant psychiatrists, and for the comparison of UK and Australian trainee psychiatrists.

The UK respondents worked with people in a wider range of settings compared with the Australian respondents. They were more likely to attend the person with intellectual disabilities' own home, day centre, school, social work setting and forensic/prison settings than were the Australian respondents. Respondents were asked to indicate the setting in which they were *most* likely to work with adults with intellectual disabilities. For UK respondents this was outpatient clinics in the NHS, which 59% said was the most common setting, followed by the patient's own home; for Australian respondents, the most likely setting was general adult/acute admission units in the public sector, which 35% said was the most common setting, followed by outpatient clinics in the public sector. These differences were also found in the separate analyses for consultant psychiatrists, and for trainee psychiatrists. Australian consultant psychiatrists were more likely than Australian trainee psychiatrists to work with people with intellectual disabilities in outpatient clinics in the private sector.

Table 2 shows the percentage of respondents in each of the two groups who worked with people with intellectual disabilities who had specified categories of

Table 2 The percentage of respondents who work with people with intellectual disabilities with specified categories of additional needs

Category of need	*UK respondents (n = 294) %*	*Australian respondents (n = 205) %*	χ^2	*P-value*
Problem behaviours	93	83	11.83	0.001
Depression	92	67	47.02	<0.001
Schizophrenia (delusional disorder/schizoaffective disorder)	92	83	9.04	0.003
Personality problems	91	49	108.99	<0.001
Autistic spectrum disorders	89	39	138.17	<0.001
Epilepsy	85	31	149.61	<0.001
Mixed affective disorders	84	23	179.16	<0.001
Mania	83	34	120.70	<0.001
Mental health act or forensic work	83	20	194.55	<0.001
Obsessive compulsive disorder	78	19	166.99	<0.001
Generalized anxiety disorders	77	18	161.73	<0.001
Social problems	77	50	38.10	<0.001
Dementia	75	31	93.14	<0.001
Panic disorders	71	13	163.97	<0.001
Agoraphobia/other phobias	69	6	188.94	<0.001
Alcohol/substance use	66	30	62.73	<0.001
Sleep disorders	62	7	151.44	<0.001
Attention deficit hyperactivity disorder	60	10	123.71	<0.001
Service management or service planning	58	6	141.18	<0.001
Eating disorders	50	9	92.54	<0.001
General medical problems	47	22	32.77	<0.001
Research	45	1	114.27	<0.001
Delirium	44	26	15.22	<0.001
Incapacity work	41	0	–	
Health promotion	26	1	56.92	<0.001
Health screening	22	1	45.01	<0.001

additional need. Differences can be seen between the two groups of respondents with, in all cases, UK respondents being more likely to work with people with intellectual disabilities with the specified additional type of health need compared with Australian respondents. For many types of additional need where the majority of UK respondents indicated that they worked with the person, the majority of Australian respondents indicated that they did not. This was also the case for the separate analyses of the consultant psychiatrists only, and the trainee psychiatrists only. The three most common additional needs of the people with intellectual disabilities with whom the psychiatrists worked were problem behaviours, then autistic spectrum disorders, then depression for the UK respondents and problem behaviours, then psychosis, then depression for the Australian respondents.

Views on the role of psychiatrists for people with intellectual disabilities

The majority of respondents thought there should be a specialty of intellectual disabilities psychiatry: this included 97% of the UK respondents and 89% of the Australian respondents. The UK respondents were asked: 'what do you think is the most appropriate future role of intellectual disabilities psychiatry?' Options were presented for the respondent to choose from. Of the UK respondents, only one person (<1%) ticked 'the role should be chiefly facilitating access to generic services' no-one ticked 'the role should be service planning and training others, rather than direct clinical care', no-one thought ''the role should change from 'catchment patch' to a model of tertiary care'', just under 100% thought ''the current 'catchment patch' model should be retained, with some additional supra-specialization, and some facilitation of access to generic services'', i.e. chiefly direct clinical care, and no-one ticked 'other, please specify'. No-one ticked more than one option. The Australian respondents were asked ''if there was a specialty of intellectual disabilities psychiatry, what would the role of such a service be?'' Hundred per cent ticked the option 'the role should be the provision of direct psychiatric care for adults with intellectual disabilities'; 4% additionally ticked 'the role should be chiefly facilitating access to existing services', and 12% also ticked 'the role should be one of service planning and training others, rather than direct clinical care', even though this appears contradictory. No-one ticked 'other, please specify'. The question necessarily differed on the UK and Australian versions, because of the different existing services and use of terminology.

Views of respondents

Respondents scored a series of statements on a Likert scale, where 1 = I agree very much, through to 6 = I disagree very much. Tables 3–7 present the mean scores for the two groups of respondents, and the probability of significant difference between the groups; the probability of significant difference in scores is also presented for the separate comparisons for the Australian versus UK consultant psychiatrists, and for the Australian versus UK trainee psychiatrists.

- Table 3 represents the statements and results regarding facilities.
- Table 4 represents the statements and results regarding multidisciplinary work.
- Table 5 represents the statements and results regarding treatments/interventions.
- Table 6 represents the statements and results regarding knowledge based items.
- Table 7 represents the statements and results regarding training/experience of respondents.

These tables reveal considerable differences between the UK and Australian respondents, almost all of which were statistically significantly different. There were only six out of the 35 statements where there was not a significant difference between the two groups. For many of the statements, both groups of respondents had mean scores in the same direction of the dichotomy of agree/disagree, but the difference related to the extent to which the view was held (i.e. very much, moderately or a little). However, there were some statements where there was a difference in direction of view (agree versus disagree) between the two groups. In general, the most prominent differences between the two groups were found regarding the statements on multidisciplinary working (Table 5), and training/experience (Table 7).

Both groups of respondents believed that intellectual disabilities psychiatry should be offered as an option for all trainee psychiatrists. The UK respondents disagreed very much with the statement 'I would prefer not to work with adults with intellectual disabilities', whereas the Australian respondents mean score was mid-way between agreeing a little/disagreeing a little for this statement. The UK respondents disagreed moderately/very much that UK psychiatrists trained only in general adult psychiatry could adequately assess and manage adults with significant intellectual disabilities who have mental health needs. This view appears in

Table 3 The views of respondents regarding psychiatric facilities for people with intellectual disabilities

Statement	*Mean score of UK respondents (n = 294)*	*Mean score of Australian respondents (n = 205)*	*P-value (all)*	*P-value (consultants)*	*P-value (trainees)*
Inpatient facilities in mainstream psychiatric services are adequately suited to adults with mild intellectual disabilities and mental health needs	3.96	3.85	0.328	0.482	0.235
Inpatient facilities in mainstream psychiatric services are adequately suited to adults with severe intellectual disabilities and mental health needs	5.85	5.52	<0.001	0.002	<0.001
Inpatient psychiatric care should be provided in units dedicated to adults with intellectual disabilities	1.97	2.81	<0.001	<0.001	<0.001
Adults with significant intellectual disabilities are vulnerable to exploitation by other patients using mainstream in patient psychiatric services	1.69	2.01	<0.001	0.009	0.004
Adults with intellectual disabilities and mental health needs receive a relatively poor standard of psychiatric care	3.55	2.25	<0.001	<0.001	<0.001
Adults with intellectual disabilities commonly stay too long as inpatients when they are admitted for assessment and treatment	1.99	2.97	<0.001	<0.001	0.005
Specialist psychiatric services for adults with intellectual disabilities with mental health needs provide a lower standard of care than do mainstream psychiatric services	5.22	4.95	<0.001	0.005	<0.001
The care of adults with significant intellectual disabilities, who are over the age of 65, and have mental health needs, should be the responsibility of the old age psychiatrist	4.36	3.20	<0.001	<0.001	<0.001
The assessment of adults with significant intellectual disabilities, who are under 65 and have possible dementia, should be the responsibility of the intellectual disabilities psychiatrist	2.35	3.43	<0.001	<0.001	0.002

Scale: 1 = I agree very much, through to 6 = I disagree very much.

keeping with the Australian respondents views about their own training and experience. The separate analyses of the two groups of consultant psychiatrists only, and of the trainee psychiatrists only, did not generate any results appreciably different from those of the two groups of all respondents.

Discussion

Key findings and their interpretation

Flexibility and accessibility of service models

The specialist intellectual disabilities model within the UK resulted in work taking place in a wider range of settings, suggesting greater flexibility compared with the Australian generic mental health service model, in which practice was more restricted in setting. The Australian psychiatrists who worked in private (rather than publically funded) services often worked in isolation, and had the disincentive of not receiving reimbursement for time spent reviewing previous medical records and files, ongoing liaison with service providers, telephone consultations or travel (Bennett 2000). A significant proportion of mental health services for the Australian general population is delivered via private (rather than publically funded) services, unlike the UK. Unlike the UK respondents, the most common setting for Australia's respondents was an acute admission unit in the public sector. This possibly suggests that in Australia, people's needs become more severe before they are able to access psychiatric care, unless primary care services are better able to meet health care need than they are in the UK. An educational needs analysis of Victorian general practitioners found the most frequently identified areas of educational need were

Table 4 The views of respondents on access to multidisciplinary working for people with intellectual disabilities

Statement	*Mean score of UK respondents (n = 294)*	*Mean score of Australian respondents (n = 205)*	*P-value (all)*	*P-value (consultants)*	*P-value (trainees)*
It is easy to refer to and liaise with social workers (disability services)	3.65	4.84	<0.001	<0.001	0.038
I can easily access multidisciplinary input for my patients with intellectual disabilities who have additional mental health needs	2.97	4.61	<0.001	<0.001	<0.001
The support required to meet the mental health needs of adults with intellectual disabilities is typically poorly co-ordinated	3.30	1.91	<0.001	<0.001	<0.001

Scale: 1 = I agree very much, through to 6 = I disagree very much.

Table 5 The views of respondents on treatments/interventions for people with intellectual disabilities

Statement	*Mean score of UK respondents (n = 294)*	*Mean score of Australian respondents (n = 205)*	*P-value (all)*	*P-value (consultants)*	*P-value (trainees)*
Individual supportive psychotherapy can be a useful intervention	2.12	2.53	<0.001	0.002	<0.001
Other types of psychotherapeutic intervention cannot be usefully undertaken	4.90	4.22	<0.001	<0.001	<0.001
Inadequacy of community social supports often makes the inappropriate prescription of antipsychotic drugs necessary	2.42	2.51	0.477	0.515	0.286
Inadequacy of community psychiatric services often makes the inappropriate prescription of antipsychotic drugs necessary	3.00	2.59	0.001	0.022	0.116
There is no role for a psychiatrist in assessing or managing problem behaviours in adults with intellectual disabilities	5.69	5.41	<0.001	0.016	0.024
Antipsychotic drugs are overused for adults with problems with aggression	2.67	2.40	0.074	0.696	0.015

Scale: 1 = I agree very much, through to 6 = I disagree very much.

behavioural or psychiatric problems, suggesting the latter to be unlikely (Phillips *et al.* 2004). There are differences between UK and Australian general practice: the extent to which these differences do or do not impact upon the response of specialist intellectual disabilities/generic mental health services in meeting the needs of people with intellectual disabilities is unknown.

The various types of additional mental health need that people with intellectual disabilities experience were all more likely to be assessed and managed within the UK specialist intellectual disabilities service model, compared with the Australian generic mental health model. Indeed, the only types of mental health needs that more than half of the Australian respondents said they worked with were problem behaviours, schizophrenia and depression, which suggests an unduly restricted pattern of practice. Such practice is difficult to understand, given the large overlap in psychopathology between categories of psychiatric disorders, and hence the need for assessment to consider differential diagnosis. It is unclear from this study

Table 6 The views of respondents on knowledge-based statements relevant to working with people with intellectual disabilities

Statement	*Mean score of UK respondents (n = 294)*	*Mean score of Australian respondents (n = 205)*	*P-value (all)*	*P-value (consultants)*	*P-value (trainees)*
Mental health needs are uncommon in adults with intellectual disabilities	5.75	5.44	<0.001	0.007	0.055
Problem behaviours are commonly a presenting feature of mental illness in adults with severe intellectual disabilities	1.89	1.98	0.052	0.242	0.179
There is seldom the need to investigate psychiatric symptoms in adults with severe intellectual disabilities	5.67	5.29	<0.001	<0.001	0.002
Psychiatric treatment of adults with intellectual disabilities is usually symptomatic, rather than based on diagnostic classification	4.06	3.12	<0.001	<0.001	0.004
Adults with intellectual disabilities who have offended do not usually need a psychiatric assessment	5.36	5.26	0.074	0.765	0.211
It is important that psychiatrists have a good knowledge of behavioural phenotypes	2.03	1.96	0.926	0.114	0.210

Scale: 1 = I agree very much, through to 6 = I disagree very much.

whether the Australian respondents failed to consider the full range of possible explanations (the differential) for a person's presentation, or whether people were excluded from accessing the service if they had certain types of mental health needs. In support of the former view, the Australian respondents (unlike the UK respondents) did agree with the statement that psychiatric treatment of adults with intellectual disabilities was usually symptomatic, rather than based on diagnosis. Conversely, there was support for the latter view from anecdotal experience that Australian public generic mental health services do not provide services for people with problem behaviour – hence labelling a mental health need as problem behaviour (even without necessarily conducting an assessment) means the mental health service can avoid responsibility for the person's care.

Response to identified mental health needs

Within the generic mental health service model, views on psychiatric treatment/interventions/supports were also more restricted compared with the views of respondents working within the specialist intellectual disabilities service model. The UK respondents were more in favour of a range of psychotherapeutic interventions, and Australian trainee respondents more strongly believe that anti-psychotic drugs are overused.

Views on types of service models and facilities

Both UK and Australian respondents thought there should be a speciality of intellectual disabilities psychiatry, which should provide direct psychiatric care. The UK respondents believed that their colleagues who worked only in general adult psychiatry were not able to adequately assess and manage adults with significant intellectual disabilities and mental health needs. It could be postulated that the model of service provision in the UK predetermines this, as the training and experience of such work is almost all within the specialist intellectual disabilities service, hence deskilling general adult psychiatrists. However, the findings from Australia lead us to reject this hypothesis as there are largely no such specialist intellectual disabilities services in Australia, yet the psychiatric workforce within the generic mental health service also feels untrained and inexperienced. In view of the demographics of the population this is not surprising: the number of people with intellectual disabilities and additional mental health needs using a service is only a tiny proportion of all people with such needs who are using services.

Both UK and Australian respondents favoured specialist intellectual disabilities facilities over generic psychiatric facilities, the UK respondents more so. This included units dedicated to the care of adults with intellectual disabilities when acute inpatient admission was

Table 7 The views of respondents on their training/experience to equip them to work with people with intellectual disabilities

Statement	*Mean score of UK respondents (n = 294)*	*Mean score of Australian respondents (n = 205)*	*P-value (all)*	*P-value (consultants)*	*P-value (trainees)*
My training has equipped me/is equipping me to adequately assess and manage adults with significant intellectual disabilities who have mental health needs	1.74	3.96	<0.001	<0.001	<0.001
I may not be able to competently assess the extent to which an adult with intellectual disabilities has capacity to consent to a treatment	4.52	3.88	<0.001	<0.001	0.001
My training has equipped me/is equipping me to assess and manage adults with problem behaviours	1.88	3.27	<0.001	<0.001	<0.001
Intellectual disability psychiatry should be offered as a training option for all trainee Senior House Officer's (trainee registrars)	1.43	1.76	<0.001	<0.001	0.001
I am confident in adopting a developmental approach when I work with adults with intellectual disabilities	2.03	3.21	<0.001	<0.001	<0.001
I feel confident in the management of an adult with mental health needs and epilepsy	2.05	3.10	<0.001	<0.001	<0.001
My training has equipped/is equipping me with a good understanding of the way mental health needs present in adults with severe intellectual disabilities	1.75	3.75	<0.001	<0.001	<0.001
I do not know how to assess whether an adult who may have autistic spectrum disorder has additional mental health needs	4.92	3.32	<0.001	<0.001	<0.001
I feel confident in the diagnosis and management of dementia in adults with intellectual disabilities	2.35	3.91	<0.001	<0.001	<0.001
I would prefer not to work with adults with intellectual disabilities	5.60	3.65	<0.001	<0.001	<0.001
Consultants who complete single specialty training in general adult psychiatry are sufficiently trained to adequately assess and manage adults with significant intellectual disabilities who have mental health needs	5.31	–	–	–	–

Scale: 1 = I agree very much, through to 6 = I disagree very much.

required, particularly for adults with severe intellectual disabilities, and the view that adults with intellectual disabilities were vulnerable to exploitation on generic mental health inpatient units. Older adults and younger adults with dementia were also viewed as benefiting from specialist intellectual disabilities services. The Australian respondents working within the generic mental health service model believed people with intellectual disabilities and mental health needs received poor standards of psychiatric care in that system. They could not easily access multidisciplinary input, and considered that support was typically poorly co-ordinated. They also more strongly held the view, compared with UK respondents, that it was not easy to refer to and liaise with social workers (UK)/disability services (Australia).

The stronger views of the UK respondents indicated that they strongly supported the specialist intellectual disabilities service model in which they worked, whereas the Australian view was that the generic mental health service model in which they worked could be improved upon by changing the provision to a specialist intellectual disabilities service. Similar views were held by both consultant and trainee psychiatrists.

These findings suggest that within Australia, the challenge of providing appropriate mental health treatments and supports for people with intellectual disabilities has not yet been met by the generic mental health service model. If the views of the respondents accurately reflect differences in quality between the two service models, they have implications also in the UK, where the policy

trend is towards 'mainstreaming' services. Such a trend may have negative consequences for people with intellectual disabilities who have additional mental health needs, unless imaginative solutions, not yet achieved in Australia, are developed to support its delivery.

Knowledge and training

The UK respondents were more confident than the Australians about their knowledge around the mental health needs of people with intellectual disabilities. This may be as a result of overconfidence of the UK respondents or reticence on the part of the Australians. A more likely explanation relates to experience and training. In view of the different service models they worked within, the UK respondents were working with a larger number of people with intellectual disabilities than Australian respondents, suggesting they would have, and would continue to gain, greater experience. For all of the statements related to training, the UK respondents had stronger and more favourable views and confidence that they had been/were being appropriately trained, and were experienced, than did the Australian respondents. This was the case for both the consultant and trainee psychiatrists. This was likely to have been a direct consequence of the additional 3 years of supervised dedicated training in intellectual disabilities psychiatry which was a requirement of practice in the UK Additionally, the lack of psychiatrists with specialist knowledge/practice in intellectual disabilities in Australia restricted access to training in this area for psychiatric trainees.

Perhaps the ambivalent view of the group of Australians compared with the enthusiastic view of the UK respondents regarding working with people with intellectual disabilities stems from a feeling among the Australians of being unskilled, unconfident and underexposed to such work. This echoes previously reported research from Australia (Lennox & Chaplin 1995, 1996). Financial disincentive may also be relevant. People with intellectual disabilities often require longer appointments, but reimbursement for this work for psychiatrists working in private (rather than publically funded) generic mental health services is at the rate for an appointment of standard length: a significant proportion of Australian psychiatrists work in such services.

Response rate

The reason for the difference in response rate is unknown, although a similar difference has been found in previous research about general practitioners' work with people with intellectual disabilities (Phillips *et al.* 2004; Williamson *et al.* 2004). The UK respondents are mainly a group who self-selected to work with people with intellectual disabilities and so may have been more interested in participating in this project than the Australians who may have considered the project of little relevance to them. If that is the case, the Australian respondents may be more interested in this area of work than their non-responding colleagues, and hence may have presented more optimistic responses than would the group as a whole. However, this is speculative.

Strengths and limitations of the study

The study compared the effect of two different models of psychiatry training and service provision to meet the mental health needs of people with intellectual disabilities. While the two countries have different service models, they otherwise have many similarities, and hence such comparison is valid. Both countries have highly developed systems of health care provision. The gross Domestic product per capita is similar for the UK and Australia (U.S.$29 900 and 30 100 respectively in 2003), with both countries spending a similar percentage of it on health care (7.6% and 8.9% respectively in 2001). There are many similarities in the populations served by the two countries. Both countries have anti-discrimination legislation, and policy aimed at reducing health inequalities. They also have a shared history and similarities in the value-base within policy for people with intellectual disabilities, such as provision of community based supports for people, and the closure of long-stay hospitals; and they share a belief in the principles that people with intellectual disabilities should be valued as equal members and contributors to society, treated as individuals, and enabled to make choices. Hence, it is appropriate to conclude that the differences found in the study relate to the different training and service models in the country, rather than to other factors.

The study also had the benefit of a questionnaire that had been previously developed and deployed in a large-scale survey, and found to have good utility (Lennox & Chaplin 1995). The characteristics of the two samples were similar in terms of gender, age and number of years since qualification, which is another strength of the study when comparing the two groups. The two groups comprised a similar proportion of consultant psychiatrists, but of the non-consultant psychiatrists there was a higher proportion of trainee psychiatrists in the Australian group; however, separate analyses for

consultants and trainees did not find any appreciable differences in findings as a result.

This study is limited in that it has sought information across a wide range of areas, and hence provides breadth rather than in-depth analysis: its findings may give direction to the areas where future in-depth research might usefully be conducted. Additionally, while it seems unlikely, it cannot be stated with certainty that factors other than the model of service did not contribute significantly to the study findings. A further limitation of this study is that it did not seek the views of service users, nor did its remit include any study of the extent to which the service models might lead to segregation or community participation of service-users.

Acknowledgments

The present authors are grateful for all the **UK** and Australian respondents who read and returned questionnaires, and the Victorian Branch of the RANZCP, and Mrs Afshan Fairley, Mrs Isobel Hodge, Ms Jenny Butler, Ms Anne O'Leary and Mrs Faye Alphonso for administrative support.

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