Faculty of Medicine, The Department of Developmental Disability Neuropsychiatry 3DN

Equipping psychiatrists to meet the mental health needs of people with intellectual and development disability

Final Report

Ms Claire Eagleson
Project Officer
Department of Developmental Disability Neuropsychiatry
School of Psychiatry, Faculty of Medicine
University of New South Wales, Sydney
c.eagleson@unsw.edu.au

Dr Rachael Cvejic
Lecturer
Department of Developmental Disability Neuropsychiatry
School of Psychiatry, Faculty of Medicine
University of New South Wales, Sydney
r.cvejic@unsw.edu.au

Dr Janelle Weise
Project Officer
Department of Developmental Disability Neuropsychiatry
School of Psychiatry, Faculty of Medicine
University of New South Wales, Sydney
j.weise@unsw.edu.au

Professor Julian Trollor
Chair, Intellectual Disability Mental Health
Head, Department of Developmental Disability Neuropsychiatry
School of Psychiatry, Faculty of Medicine
University of New South Wales, Sydney
j.trollor@unsw.edu.au

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3DN DEPARTMENT OF DEVELOPMENTAL DISABILITY NEUROPSYCHIATRY

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Aims

The overall aims of this scoping study were to describe i) the current psychiatry workforce capacity across Australia and New Zealand in the area of intellectual and developmental disability (IDD), and ii) the capacity to train new psychiatrists with subspecialty training in the psychiatry of IDD.

Background

People with an intellectual disability (ID) represent approximately 1% of the population [1]. Compared to the general population, they experience very poor health status characterised by multiple morbidities [2], premature mortality [3, 4], and high rates of undetected and undermanaged medical conditions [5]. This population experiences elevated rates of psychiatric disorders [6-10], with the majority experiencing a psychiatric disability [11]. The prevalence of autism spectrum disorder (ASD) has been estimated at approximately 1-2% of the population [12-14], and other developmental disorders (DD) at 3.57% [14]. Although estimates vary, for individuals with ASD, anxiety, depressive, and obsessive compulsive disorders are especially common [15-17]. Research has shown that compared to the general population, people with an ID and co-occurring psychiatric disorders are more frequent users of health services in emergency departments [18], hospitals, and ambulatory care settings [19]. One of the main barriers to people with ID accessing quality mental health care is that mental health professionals lack adequate training in ID [20]. Given the elevated rates of undetected and undermanaged medical conditions and mental disorders, and high service use among people with an ID, it is important that the mental health workforce is appropriately equipped to meet the needs of this population.

Psychiatrists have a key role within the mental health workforce to deliver quality mental health care to people with an ID or DD and co-occurring psychiatric disorders. However, Australian psychiatrists both at a trainee and consultant level have reported that they have received insufficient education and training in this area, and lack confidence to provide quality care for people with an ID [21, 22]. Australian psychiatrists have also been found to be less knowledgeable, receive less training, and are less confident in working with this population than their peers from the United Kingdom [23]. While a study by Torr et al (2008) [24] showed that between 1994 and 2004 Victorian psychiatrists felt that they received better training in assessing and managing psychiatric disorders and behavioural problems in adults with ID, they remained concerned about the quality of care provided within generalist services, especially for people with severe ID.

To address these concerns there have been consistent calls for advanced training in the psychiatry of IDD, and the development of a specialist service to facilitate quality care [21, 22, 24]. These calls have been supported by the demonstrated advantages of specialist training models of service delivery in the area of intellectual disability mental health (IDMH) over generic mental health models [23]. In 2019, NSW Health announced that a new State-wide adult tertiary IDMH service would be established within the Sydney Local Health District.

The need for psychiatrists with specialist skills in the area of IDD is a key component of an accessible mental health service for people with an IDD. This is articulated in the National Guide developed by our Department [25]; and was one of the key elements of reform identified in Roundtables on the Mental Health of People with Intellectual Disability [26, 27]. However, there is only minimal ID and DD content included in the basic training for Australian and New Zealand Psychiatrists, and there is no recognised subspecialty in the psychiatry of IDD. At present, there is

no comprehensive workforce development strategy in place to adequately equip the psychiatric workforce to provide quality care for this population group.

The utility and feasibility of a competency-based advanced training program in the psychiatry of IDD is demonstrated by the success of the IDMH Fellowships funded by Ageing, Disability & Home Care (ADHC) [28]. These Fellowships, administered by the NSW Institute of Psychiatry, provide advanced trainees with an opportunity to develop self-directed training objectives to be undertaken within the Fellowship year. Thus far, 11 trainees have completed IDMH Fellowships while completing advanced training in varied areas including neuropsychiatry, forensic psychiatry, child and adolescent psychiatry, and adult general psychiatry. Previous Fellows describe a rich and diverse training experience, resulting in the acquisition of specialist skills required to address the significant health inequalities encountered by people with an ID [28]. Although an informal curriculum for the IDMH Fellowships has been developed under the supervision of the Chair of IDMH, the scheme would be strengthened by the development of a formal curriculum with specified competencies and assessments. Such an approach would be in line with international developments in this area, such as the provision of formal subspecialty training in the psychiatry of ID for trainees in the United Kingdom and Ireland. To determine the need and capacity to introduce subspecialty training in the psychiatry of IDD within Australasia, the current scoping project i) examined the current capacity of psychiatrists in the area of IDD ii) surveyed the potential capacity to implement subspecialty training in the psychiatry of IDD; and iii) consulted the Royal Australian and New Zealand College of Psychiatrists (RANZCP) around the process for developing subspecialty training in the psychiatry of IDD and augmenting IDD content in existing the existing curriculum.

Project Phases

Phase 1- Review of current RANZCP training curricula and international curricula

Phase 2- Analysis of RANZCP 2014 workforce survey data and Section of Psychiatry of IDD (SPIDD) membership

Phase 3- Survey of Australian and New Zealand psychiatrists with expertise/interest in the area of IDD and short survey of RANZCP Faculty/Section Chairs and Trainee Representative Council members.

Phase 4- Consultation with the RANZCP around future subspecialty training in the psychiatry of IDD

Phase 5- Development of draft curriculum for advanced training in the psychiatry of IDD and enhanced IDD content in the Stage 2 syllabus

Phase 1: Review of intellectual and developmental disability content in the RANZCP Fellowship Program

The first phase of the project involved a review of current ID and DD content in the RANZCP Fellowship Program, and a review of selected international subspecialty training curricula.

Intellectual and developmental disability content in the RANZCP Fellowship Program

There are no specific mentions of IDD within the Stage 1 syllabus. Some items are particularly relevant to people with an IDD, such as the principles of stigma, role of consumer and advocacy groups, relevant legislation, and importance of working with patients, families and carers. However, education around these areas would not necessarily be specific to people with IDD. There is IDD content within the Stage 2 syllabus, relating to interviewing with sensitivity to intellectual abilities, neurodevelopmental disorders during childhood and adolescence, and IDD specific items relating to assessment, consideration of aetiology of the patient's disability, and issues of management including psychotropic drug regimens. Some Certificate of Advanced Training (CAT) curricula make brief mention of ID (e.g. Psychiatry of Old Age, Forensic Psychiatry), cognitive impairment and disability (e.g. Consultation-Liaison Psychiatry), or development issues (Child and Adolescent Psychiatry). If trainees do not undertake any rotations in which they have contact with people with an IDD, or complete a CAT in an area that regularly sees people with IDD using services, it is likely that they will complete their psychiatry training with only a rudimentary understanding of the mental health needs of this population group.

Specific modifications to practice are required to work effectively with people with an IDD, including modifying communication methods, supported decision-making, taking a person-centred approach, engaging support networks in the management stage, and managing behaviours of concern [29, 30]. Without specific mention within the syllabus of the relevant knowledge and skills required in these areas, it is likely a large proportion of trainees will not learn through the course of their training how to effectively adapt their practice to work with people with IDD. As all psychiatrists will work with people with IDD throughout their careers, this is knowledge and skills that all require.

More in-depth detail can be found in the report '*Review of Intellectual and Developmental Disability Content in the RANZCP Fellowship Program'* previously provided to the RANZCP.

International subspecialty training programs in intellectual disability psychiatry

Psychiatry trainees in the United Kingdom can undertake advanced subspecialty training in ID (years 4, 5 and 6) to obtain Certificate of Completion of Training registration. While trainees complete rotations in specialist ID psychiatry services, the majority of learning outcomes are relatively general or pertain to all areas of psychiatry. However, some reference learning disability (LD) specifically, or relate specifically to LDs (e.g. communication and partnerships). The full curriculum can be viewed here:
https://www.gmc-uk.org/-/media/documents/psychiatry-of-learning-disability-curriculum-march-2019_pdf-77960023.pdf

In Ireland, specialist training in ID is available after psychiatrists have completed their Basic Speciality Training in Psychiatry (2-3 years). The Higher Specialist Training in Learning Disability takes three years, during which time trainees must complete a minimum of 24 months in Psychiatry of LD placements. The third year may be spent in psychiatric research or another appropriate psychiatry specialty or subspecialty. The curriculum and syllabus content are available in the following document:
https://www.irishpsychiatry.ie/wp-content/uploads/2016/12/Curriculum-for-Basic-Higher-Specialist-Training-in-Psychiatry-July-2012-Revision-5-July-2016-21.07.16.pdf .

Phase 2: Analysis of RANZCP 2014 Workforce survey data

The second phase of this project aimed to provide a summary of the characteristics and workforce capacity of psychiatrists who work in the area of IDD. 3DN approached the RANZCP for existing data that could be used to examine the current psychiatric workforce capacity in Australia and New Zealand. The RANZCP provided data from the 2014 workforce survey, and a profile of SPIDD members (including age, gender and location). The methodology and main findings are summarised below. The full methodology and results can be found in the report previously provided '*Report on the workforce capacity of psychiatrists in intellectual and developmental disability mental health across Australia and New Zealand, 2014-2016*.' A profile of the workforce capacity of psychiatrists with an interest in IDD compared with the wider psychiatry workforce is detailed in Cvejic et al (2018) [31].

RANZCP Workforce Survey

Methodology

A secondary descriptive analysis was performed on data from the RANZCP 2014 workforce survey examining workforce characteristics. All RANZCP Fellows and Affiliates who completed the survey and i) listed IDD as a practice area on the workforce survey or ii) were a member of SPIDD in 2014 and/or listed IDD as a subspecialty on the Find a Psychiatrist (FAP) database in 2014 were classified as belonging to the IDD psychiatric workforce. Further analysis compared characteristics for this group to the wider psychiatry workforce who completed the 2014 workforce survey [31].

Results

Sample

Of the 1196 psychiatrists who completed the 2014 RANZCP workforce survey ([33%] of the entire RAZNCP membership), 146 (12%) were classified as the IDD workforce group.

Summary of findings

Coverage across Australia and New Zealand

In Australia, New South Wales, Queensland, and Victoria had the most psychiatrists working in IDD. While this was expected given their population size, they were also the states where there have been initiatives to build capacity in the psychiatry of IDD, such as the NSW Institute of Psychiatry IDMH Fellowships and the work of the Queensland Centre for Intellectual and Developmental Disability (QCIDD), Victorian Dual Disability Service, and Centre for Developmental Disability Health. Wellington and Auckland had the greatest representation in New Zealand. All psychiatrists, whether part of the IDD workforce or broader psychiatric workforce, were generally based in major cities, with no significant differences between the groups in distribution of primary practice by state/territory in Australia or North/South Island in New Zealand [31].

Primary work type

Primary work location was spread reasonably evenly across public and private sectors. However, a higher percentage of IDDMH psychiatrists were working in both public and private health systems compared with the broader workforce, possibly reflecting models of service in the area of IDD health [32]. This may be due to challenges meeting the needs of people with IDD within the private sector, or due to the limited number of psychiatrists specialising in IDD within the public sector. Nonetheless, working across both service types provides opportunities for affiliations, joint training, and mapping of service pathways in and out of public mental health facilities [31]. There was also a larger proportion of IDD psychiatrists working in outreach work compared to the broader workforce, which is vital in helping reduce barriers to service for those in rural and remote locations.

The three main service types IDD psychiatrists worked in were public hospitals, solo private practice, and community mental health centres (this included all areas of practice, not just in IDD psychiatry). The pattern generally corresponds with where we would expect IDD psychiatrists to be working. A larger percentage of IDD psychiatrists compared with the broader psychiatry workforce were working in neuropsychiatry, child and adolescent, youth mental health, addictions, indigenous psychiatry, psychiatry of old age, rural, ECT and Neurostimulation, social and cultural psychiatry, forensic, and consultation-liaison [31]. However, given the overrepresentation of people with ID in the correctional system [33-36], and of Aboriginal and Torres Strait Islanders with an ID in the community [37] and Australian criminal justice system [38], there is still a need for greater capacity in these specialty areas. Only 4% of the surveyed IDD workforce sample endorsed working in correctional service types, and 22% and 12% endorsed working in the practice areas of forensic and indigenous psychiatry respectively.

Practice capacity

Examining workforce capacity, approximately three-quarters of IDD workforce respondents' hours were spent in clinical practice (in all practice areas, not necessarily IDD). Psychiatrists with an interest in IDD worked significantly more clinical hours than the broader psychiatry workforce (again in all practice areas, not just IDD) [31]. While there was only a difference of two hours per week, this may be due to a lack of psychiatrists working clinically in the area of IDD. Approximately 90% of IDD psychiatrists were working in public and/or private practice, with only a small proportion working in academic fields (5%).

Thirty-eight percent of IDD workforce respondents were working part-time, with 32% considering retirement or semi-retirement before 2019. While these figures were similar to those found for the broader psychiatry workforce, they are still of note given the already small workforce in the area and lack of subspecialty training. Some psychiatrists with an interest in IDD who are retiring now may have been trained within institutions that have since been decommissioned. Without specific training or recruitment of overseas trained psychiatrists, attrition through retirement cannot be buffered.

Summary

The workforce profile of psychiatrists who completed the 2014 workforce survey indicates that psychiatrists who are working in /have an interest in IDD are generally well represented in the Australian and New Zealand psychiatry workforce, and work in a variety of practice areas and service types. However, the potential future shortage of psychiatrists specialising in IDD highlights a considerable need to develop a formal training program and pathway for psychiatrists to specialise in this area. While psychiatrist shortages are an issue across the whole workforce, they are of particular concern in the area of IDD as at present there is no subspecialty training or pathway into practice in this area.

SPIDD membership

From 2014 to 2016, SPIDD membership (Fellows and Affiliates) grew by 57%. There were 190 Fellows and Affiliates in 2016. The average age of members was relatively constant across the three years (52-53 years of age). From 2014 to 2016, there was a slight increase in the proportion of female members. In line with the 2014 RANZCP workforce data and population numbers, there was reasonably even coverage across metropolitan areas in Australia and New Zealand, but a limited number of psychiatrists working in IDD in rural and remote regions. There was a notable increase in the number of psychiatrists in Queensland from 2014 to 2016.

Phase 3: Survey of workforce and training capacity in intellectual and developmental disability mental health

The 2014 workforce survey did not examine workforce capacity in the area of IDDMH specifically. Therefore, the third phase involved the development of a survey to examine current workforce capacity in the area of IDDMH, the pathways that current psychiatrists with expertise or an interest in IDDMH took to practice in the area, and the potential for subspecialty training in this area. A summary of the methodology and results is below. The full methodology and results can be found in the *'Report on the workforce capacity of psychiatrists in intellectual and developmental disability mental health across Australia and New Zealand, 2014-2016*' and Eagleson et al (in press) [39].

A short survey of Faculty/Section Chairs and RANZCP Trainee Representatives was also conducted to examine their views on training within the area of IDD psychiatry.

3DN IDDMH Workforce and Training Capacity Survey- Consultant Psychiatrists

Methodology

RANZCP Fellows or Affiliates who i) were members of SPIDD (anytime between 2014-16), *and/or* indicated IDD as a practice area on the 2014 RANZCP workforce survey, *and/or* indicated IDD was a specialty practice area on the RANZCP 'Find a Psychiatrist' website (2014-16), were invited to participate in an online survey via RANZCP mailing lists. It was also a requirement for respondents to self-identify that they had expertise or an interest in IDD on the survey to be included in the final sample. Informed consent was obtained from all participants.

The online survey explored six key areas:

1. Demographics and characteristics of psychiatrists' practice
2. Roles and clinical practice in the area of IDD
3. Pathways to gain an interest/work in the area of IDD
4. Support for undertaking advanced training in the psychiatry of IDD
5. Capacity and interest in training future psychiatrists in the psychiatry of IDD
6. Barriers and facilitators to training future psychiatrists in the psychiatry of IDD

Ethics approval was obtained from the UNSW Sydney Human Research Advisory Panel as a Negligible Risk study (Approval no. HC16853). The study was then approved at the RANZCP Executive meeting.

Results

Sample

Eighty-nine participants responded to the survey (response rate of 13.5% from a total of *N*=660 invited to participate). Of those, 14 exited the survey early before completing the qualifier question of whether they had an 'interest or expertise in the psychiatry of IDD' and were therefore excluded. Two participants were excluded as they indicated 'no' to this question, and a further two as they were still trainees. A total of 71 participants were included in the final sample.

Summary of findings

Demographics and characteristics of psychiatrists' practice

Characteristics of psychiatrists' practice across all areas of their work was similar to the findings from the above 2014 RANZCP workforce survey. Respondents reported graduating as consultant psychiatrists an average of 17.6 years ago (*SD*=9.4). Forty-seven respondents (69.1%) working full-time said that they planned to remain in full-time work for a median of 10 more years, and potentially change to part-time work after that for another five years. The remaining respondents were working part-time and planned to continue (or return to full-time work) for a median of 10 more years. The three main practice areas for those working clinically were IDD, general adult, and child and adolescent psychiatry, and three main service settings were community mental health services,

inpatient (public hospital), and solo private practice. A smaller than expected proportion of participants said that their primary clinical role was in a hospital outpatient service (10%), despite the considerable reliance people with an IDD have on outpatient services, and their need for consistent follow-up care after discharge. Almost all respondents were working clinically at the time of the survey (98.6%) and were working a median of 32 clinical hours per week, and 9.5 non-clinical hours (all practice areas). Despite the low percentage of primary practice in hospital outpatient services, the largest proportion of clinical practice was spent in public and private outpatient services. Of those working clinically, 36.2% spent some time working in rural and remote locations (for a median of 20% of their work hours). Over three-quarters (78%) were aware of IDD psychiatry services in the regions within which they worked.

Roles and clinical practice in the area of IDD

Just over half of respondents reported that they had expertise in IDD (53.5%), while the remainder indicated that they had an interest in IDD, but not necessarily expertise. Only a fifth reported that IDD was their main area of practice. Psychiatrists working clinically with people with IDD had generally done so for a considerable proportion of their careers (average of 11.34 years; *SD*=10). However, they worked fewer hours in IDD (median 8 hours per week) versus non-IDD (median 25 hours) clinical practice, with a minority of participants seemingly responsible for a large proportion of IDD clinical work. The median proportion of respondents' time spent working in IDD psychiatry (clinical and non-clinical) was 15%. Thirteen respondents were responsible for over half of the reported hours spent working in IDD clinical practice per week. No significant differences were found between patients with ID versus DD regarding the number of referrals psychiatrists received, follow-up appointments, or percentage of patients who could benefit from additional specialist consultation.

Overall, the results indicate that a small workforce is providing the majority of mental health care to people with IDD. These individuals most likely have dual-roles, especially given that there is a lack of mainstream full-time clinical roles in IDD psychiatry. Given expected future shortages of psychiatrists, it is concerning that a small group of clinicians are providing the majority of IDD clinical care. While there are a limited number of Fellowships in IDMH and some IDD-specific rotations, there is no established means of ensuring that sufficient psychiatrists specialising in IDD are ready to replace these clinicians as they retire.

Pathways to gain an interest/work in the area of IDD

The main pathway to working in IDD for consultant psychiatrists was via practice in mainstream services that saw people with IDD (64%) or through personal interest in the area (43%), rather than completing IDD rotations (30%) or specialist training (overseas 11%; specialist fellowship training 5%). This not only reflects the lack of specialty training, but also the importance of exposure to working with people with IDD during training in choosing to practice in this area. Psychiatrists who trained in Australia or New Zealand reported that they had received insufficient education in the area of IDD, and rated the sufficiency of IDD education in several stages of training significantly lower than those who had completed their training overseas. This is in line with past research which has found lower ratings for those trained in Australia compared with the United Kingdom [23]. While the ratings provided by respondents in this study do not necessarily reflect the current 2012 Fellowship Program curriculum, the psychiatry of IDD curriculum content did not change considerably in 2012.

Support for advanced training in the psychiatry of IDD

Eighty percent of respondents agreed that the mental health needs of people with IDD would be best met with formalised subspecialty training in the psychiatry of IDD, strengthening prior calls for specialist training. Strong support was shown for various potential enhancements to training, including increased IDD-specific content in the Stage 2 curriculum/syllabus, a CAT in the psychiatry of IDD, enhanced clinical exposure to IDD psychiatry during non-specialist rotations, and specialty rotations in IDD psychiatry. As all psychiatrists will see people with IDD within their practice and thus require, at a minimum, basic skills in this area, enhancement of the IDD content in the Stage 2 syllabus would be particularly beneficial. Further, the development of a CAT curriculum would be a chance to build on the current NSW Institute of Psychiatry IDMH specialty fellowships [28], formalising a curriculum, to help ensure that there are sufficient specialists in this practice area to assume lead clinical and academic roles in the area of the psychiatry of IDD.

Capacity and interest in training future psychiatrists in the psychiatry of IDD

Most respondents said that they had experience supervising psychiatry registrars (92%), with 59% either currently supervising registrars in this area, or having done so in the past. Seventeen respondents (29%) would have the time and resources to offer supervision/a rotation in their workplace if IDD psychiatry subspecialty training was introduced, and 23 (39%) said possibly. Importantly, rotations could be provided in diverse subspecialty areas and settings. Approximately 80 registrars could be offered 6-month rotations across 51 services each year. The majority of these service settings were inpatient/outpatient public services (55%) or private practice (18%). While IDDMH was the primary subspecialty focus of only two services, people with IDD still utilised the other suggested services. These findings indicate that there would likely be scope for a sufficient number of trainees to begin subspecialty training in the psychiatry of IDD. These individuals could subsequently provide specialist services within mainstream hospitals and clinics, promote service development, and provide supervision to future psychiatry trainees and education to other health professionals.

Barriers and facilitators to training future psychiatrists in the psychiatry of IDD

The top five barriers to the development of subspecialty training in the psychiatry of IDD reported by respondents were i) lack of services in general, ii) disability is separate to psychiatry/service inclusion criteria, iii) lack of funding for e.g. new services/registrar positions, iv) lack of supervisors/experts in the field, and v) lack of interest. The top five facilitators reported were i) funding, ii) increased training, iii) more services in general, iv) supervisors/experts in the field, and Improved service/interdisciplinary collaboration and interface between disability and psychiatry.

Faculty and Section Chair Survey and Trainee Representative Survey

Methodology

The Chairs of each Faculty and Section, and Trainee Representative Committee members were invited to take part in short surveys examining their views on the potential development of subspecialty training in the psychiatry of IDD. Faculty and Section Chairs were asked how the development of subspecialty training may intersect with the area of practice that they represent, and whether it would be of benefit to psychiatrists specialising in that area. The Trainee Representative survey examined how the development of subspecialty training in the psychiatry of IDD may impact

trainees, the forms subspecialty training could take, and what input trainees could have when planning for subspecialty training in this area. Invitation emails were sent via RANZCP mailing lists, and respondents completed the surveys online.

Summary of results

Faculty/Section Chairs

Chairs of five Faculties and six Sections took part in the survey. All respondents said that they did not believe the current standard training that trainees receive in the area of IDD psychiatry throughout the competency-based Fellowship Program was sufficient. There was no mandatory IDD-specific education in any CATs offered by the Faculties the respondents represented. Participants reported that the Consultation-Liaison and Forensic Psychiatry CATs do have elective ID content such as placements within forensic ID services. All but one Section Chair said that their Faculty/Section would have a collective interest in the development of psychiatry of IDD subspecialty training. Multiple Chairs responded that IDD was highly relevant for psychiatrists working within their practice area, particularly those working in rural and remote, old age, child and adolescent, and private practice psychiatry. All respondents said that IDD subspecialty training would be of benefit to their Faculty/Section members and area of focus, with advantages including enhanced skills and more resources in this area. Difficulties raised included a lack of training positions in IDD psychiatry.

Faculty/Section Chairs said that approximately 54% of their members would find some training in IDD useful. Respondents provided particularly strong support for subspecialty training in the psychiatry of IDD (*M*=8.36, 1-No support, 10-Strongly support). Regarding training enhancements, strongest support was given for enhancing IDD education within the Stage 2 curriculum/syllabus (*M*=8.73), then enhanced clinical exposure to IDD psychiatry during non-specialist rotations (*M*=8.45), specialty rotations in this area (*M*=8.27), and a CAT in the psychiatry of IDD (*M*=7.45). Respondents endorsed a number of ways in which their Faculty/Section could be involved in the development of any IDD subspecialty training, including discussion (11 endorsed), surveys (six endorsed), and interviews (three endorsed).

Trainee Representatives

Three Trainee Representatives took part in the survey. All said that they believe there is insufficient training in the psychiatry of IDD during the Fellowship Program. Two were aware of IDD psychiatry rotations in their region. All said that they were aware of trainees expressing interest in gaining more experience in IDD. This included more IDD exposure in the formal education course, completing terms in IDD psychiatry, and opportunities to complete 1-2 IDD clinics while completing a rotation in another area (e.g. consultation-liaison psychiatry). Two respondents provided strong support for subspecialty training in the psychiatry of IDD, while the third believed that working in an IDD-specific position would be a better option than a CAT for Stage 3 trainees who wish to work in IDD psychiatry. They expressed concern that the training program is already very full and adding another option to subspecialise may add additional demands to those already trying to complete all generalist requirements within the five-year program. Strong support was provided for enhanced IDD education within Stage 2, specialty rotations in the psychiatry of IDD, and enhanced clinical exposure to IDD psychiatry during non-specialist rotations. Trainee Representatives said that they would like trainees to have input into the development of any psychiatry of IDD subspecialty training (e.g. participation in working groups, focus groups and interviews).

Phase 4: Consultation around augmenting intellectual and developmental disability education in the RANZCP Fellowship Program

The consultation stage of the project aimed to i) provide feedback on the workforce surveys to the RANZCP, ii) discuss where it may be possible to augment IDD content in training, and iii) discuss the requirements and process for augmenting generalist IDD training and/or developing subspecialty training in the psychiatry of IDD.

Summary of consultation

Teleconference with RANZCP collaborators

A teleconference was held in late 2017 with RANZCP collaborators Dr Kym Jenkins, Prof Malcolm Hopwood, Dr Chad Bennett, and Mr Jon Cullum to discuss the results of the surveys, and options for subspecialty training. Attendees expressed support for both i) enhancing generalist IDD psychiatry education and ii) developing subspecialty training for those who want to specialise in this area of practice. There was some concern around the development of a CAT in the psychiatry of IDD as there is a lack of IDD psychiatry career paths in public services, and associated shortages of appropriate IDD rotation posts available. All agreed that increased funding is needed in local health districts for specialist IDD services. Despite these concerns, there was still unanimous support for the future development of subspecialty training in the psychiatry of IDD.

As the first Fellows have graduated from the new 2012 Competency-based Fellowship Program, there are plans for a formal review of the Fellowship Program curriculum. Attendees agreed that the likely priority would be to advocate for IDD content in the Stage 1 and 2 syllabuses to be reviewed and augmented. Then at a later stage, opportunities for formal subspecialty training could be considered (preferably in combination with the creation of new services and the development of policy to reflect population need). There was also support for the SPIDD to become a Faculty in the future.

The next stage of the project was discussed, with agreement that 3DN would draft curriculum items for i) generalist training and ii) advanced training in the psychiatry of IDD, which would then be distributed to the SPIDD and selected RANZCP members for comment.

It was suggested that researchers liaise with Ms Elaine Halley, Executive Manager, Education and Training, regarding i) where IDD psychiatry content could be enhanced in the generalist education curricula, ii) formal procedures for reviewing curricula, iii) procedures, requirements, and the endorsement process for developing a CAT curriculum, and iv) availability of CAT curriculum templates and contacts from Faculties that have developed CATs most recently.

Education and Training consultation

Generalist training

A teleconference with Ms Elaine Halley took place in early 2018. Ms Halley conveyed that a review of the training program syllabus (covering approximately half a day of formal education per week), learning outcomes, curriculum maps, and developmental descriptors will likely take place in the next 12-18 months (the RANZCP was convening a working group at the time). She could not advise

which section of the curriculum would be the most appropriate place to augment the Psychiatry of IDD content. With plans to review all curricula and associated documents (which were all developed at different times), the structure of the curricula may change significantly and be replaced by one integrated document.

All RANZCP Faculties/Sections will have the opportunity to contribute to the review (e.g. propose content and review draft documents). The creation of a Stage 3 syllabus will also be considered during the consultation process.

Certificates of Advanced Training

At present, Ms Halley said that there are no formal guidelines/templates for developing CATs, and no specific endorsement process. All CATs to date were developed using different procedures, and no documentation detailing these procedures is available. No information could be provided on the last CAT that was developed, nor could any contacts be suggested from other Faculties that have developed CATs in the past. Therefore, we decided an appropriate approach for the next phase was to consult relevant curriculum, training plans, and core competency documents (listed below in Phase 5) with the purpose of collating items for a potential subspecialty training curriculum.

There are plans for Education and Training to discuss whether they will start a review of how CATs are developed and how Areas of Practice are recognised, and whether a uniform development procedure will be created. The potential for future CATs and the possibility of recognising additional Areas of Practice will also be considered. The review process will also consider whether CATs can only be developed by Faculties, or by Sections too. Ms Halley mentioned that the College is considering whether there should be less focus on subspecialisation, with trainees graduating as generalist psychiatrists with more broad-based skills.

Phase 5: Development of example intellectual and developmental disability syllabus and curricula items

The aims of the final phase of the project were to i) suggest enhancements to the *Psychiatry of Intellectual and Developmental Disabilities* section of the Stage 2 syllabus and ii) draft an example curriculum for reference if subspecialty training in the psychiatry of IDD was to be developed in future.

Methodology

The following documents were consulted when developing the draft curriculum:

1. IDMH Fellowship training plans
2. Addiction Psychiatry/Forensic Psychiatry/Psychiatry of Old Age Certificate of Advanced Training curricula
3. Intellectual Disability Mental Health Core Competency Manual/Toolkit
4. UK RCPsych Specialists in the Psychiatry of Learning Disability Core Competency Curriculum
5. College of Psychiatrists of Ireland Curriculum for Higher Specialist Training in Psychiatry (Learning Disability)

Suggested modifications to the Stage 2 syllabus include expanding existing points 1-3, and adding another point specifying adaptations to practice to best support people with IDD. The draft curriculum outlines the goals of advanced training in the psychiatry of IDD, then objectives (attitudes, knowledge and skills) in each area of practice relevant to the psychiatry of IDD.

Drafts of both documents were sent via RANZCP mailing lists to the following College members for comment:

- SPIDD members
- Faculty and Section Chairs
- Trainee Representative Council members

Members were asked to provide any general comments or specific feedback on the content of the two documents by email to the researchers.

Results of consultation

Nine members provided feedback on the documents. Overall, respondents supported the development of the advanced training curriculum/renewal of the Stage 2 syllabus and provided positive feedback about the draft curricula. A summary of their feedback points is below:

Stage 2 Syllabus

- Suggested additions of
    - a developmental history from parents, review of past reports, use of modified communication methods;
    - evidence-based education and skills training; and
    - the use of standardised developmental disability tools/checklists/questionnaires.

Advanced Psychiatry of IDD curriculum core competencies (for e.g. a CAT)

- Include more emphasis on modified diagnostic systems e.g. Diagnostic Manual-Intellectual Disability 2 (DM-ID-2) and the Diagnostic Criteria for Psychiatric Disorders for Use with Adults with Learning Disabilities (DC-LD), the utilisation of observation to ascertain psychopathology, and instruments to assess specific psychiatric disorders
- Include knowledge outcomes around the impact of trauma and unresolved grief issues for people with IDD and the families, and lifecycle issues (e.g. traumatic or impoverished parenting templates)
- Add the social determinants of mental health ‘at risk' factors
- Ensure trainees understand the relationship between ID and neurological disorders or conditions, and that neurological and genetic conditions that cause ID are often associated with greater incidence of certain psychiatric disorders (i.e. behavioural phenotypes).
- Include more emphasis on the development of skills in family therapy, and adapted therapies e.g. Talking Mats for young people with language difficulties, ethnographic narrative approaches
- Add knowledge and skills outcomes regarding the importance of providing cognitive support to manage behaviours of concern

- Remove duplicate knowledge and skills that advanced trainees should already possess
- Condense sections of the draft curriculum

The above feedback was used to produce the final draft curricula. See Appendix 1 for the suggested modifications to the *Psychiatry of Intellectual and Developmental Disabilities* section of the Stage 2 syllabus, and Appendix 2 for a copy of the suggested core competencies for an advanced psychiatry of IDD training curriculum.

Summary and conclusions

The results of the analysis of the 2014 RANZCP workforce survey data and 3DN's workforce and training capacity survey indicate that psychiatrists with expertise or an interest in IDD are well represented across Australia and New Zealand, share similar demographic and clinical characteristics with the broader psychiatry workforce, and work in varied areas of practice. However, more detailed analysis of the proportion of their practice spent working clinically with people with IDD revealed that a relatively small number of psychiatrists are providing the majority of clinical care for this population. This raises the question of how a small workforce with relatively few clinical hours in this area can provide effective mental health care for this population. Further, a considerable proportion of the IDD workforce reported that they plan to retire in the next 5-10 years. Although the rate was in line with the wider psychiatry workforce, with no current pathway for psychiatrists to undertake subspecialty training in the area of IDD psychiatry, there is a considerable risk that there will be even less capacity in future to manage the complex needs of people with IDD and co-occurring psychiatric disorders as psychiatrists specialising in this area retire. Thus, there is an urgent need to prioritise the development of a formal advanced training program within Australasia.

The scoping surveys indicated that RANZCP psychiatrists and Faculty/Section Chairs provide strong support for subspecialty training in the psychiatry of IDD and the enhancement of generalist education in this area for all psychiatry trainees. Trainee representatives also provided strong support for enhanced IDD education within the Fellowship Program. Importantly, there would appear to be capacity available to provide subspecialty training in this area, and experts in IDD psychiatry with the ability to provide rotations in a wide variety of service settings and practice areas. Developing subspecialty training within a generalist service model does present challenges, but people with IDD routinely use mainstream services, and our group's analysis of population representative data on people with ID in NSW indicates that they are high frequency users of both inpatient and emergency department services. Thus, trainees will likely experience sufficient exposure to people with ID even if they were completing subspecialty training rotations in mainstream services. Further, more specialist IDD health services will be available in future with initiatives such as the new Statewide adult tertiary intellectual disability mental health service being established in the Sydney Local Health District. Given the poor mental health outcomes for people with IDD, the barriers they face when trying to access quality treatment, and projected IDD psychiatric workforce shortages, there is an urgent need to act on calls for the development of subspecialty training in the psychiatry of IDD to improve equitable access to mental health care for this population group.

Recommendations

Taking into consideration the results of this scoping study, we recommend the next steps include the following:

1. In preparation for the formal review of the Fellowship Program curriculum and syllabus, a working group of key experts in this field be formed to i) review the IDD content within the current program, and ii) make recommendations for augmenting the IDD education that all trainees receive (with the suggested changes to the Stage 2 syllabus as a reference).
2. Conducting further scoping work around the potential development of a CAT and contributing to any planned review of the development of CATs within the Fellowship Program. Scoping work may include:
    a. Discussions between the RANZCP, hospitals, and government
    b. Surveying patient needs
    c. Evaluating trainee interest in completing subspecialty training
    d. Defining training goals
    e. Reviewing the resources that would be required to develop a CAT in the psychiatry of IDD
    f. Forming a working group to determine the structure and content of the advanced training program, and to drive its development
3. For both recommendation 1 and 2, further review of overseas training program curricula could inform enhancements to training within Australia and New Zealand.
4. For IDD to be formally recognised as an Area of Practice, with the formation of more rotations in this area.

Resulting publications

Cvejic, R. C., Eagleson, C., Weise, J., Davies, K., Hopwood, M., Jenkins, K., & Trollor, J. N. (2018). Building workforce capacity in Australia and New Zealand: a profile of psychiatrists with an interest in intellectual and developmental disability mental health. *Australasian Psychiatry*, *26*(6), 595–599. https://doi.org/10.1177/1039856218781018

Eagleson, C., Cvejic, R. C., Weise, J., Davies, K., & Trollor, J. N. (in press). Subspecialty training pathways in intellectual and developmental disability psychiatry in Australia and New Zealand: Current status and future opportunities. *Accepted for publication 22/12/2018, Australasian Psychiatry*.

Davies, K., Eagleson, C., Weise, J., Cvejic, R. C., & Trollor, J. N. (2019). Clinical Capacity of Australian and New Zealand Psychiatrists who work with People with Intellectual and Developmental Disabilities. *Accepted for publication 15/05/2019, Australasian Psychiatry*.

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Appendix 1. Suggested modifications for Stage 2 Syllabus: Section J Psychiatry of Intellectual & Developmental Disabilities

Suggested changes in red

J Psychiatry of Intellectual & Developmental Disabilities

J1.1.1 Specific issues of assessment of people with intellectual and developmental disabilities, including mental health and behaviour, relevance of severity of ~~intellectual~~ disability, diagnostic overshadowing, history taking (developmental history from family and review of past reports e.g. cognitive assessments, medical investigations including genetic testing), and use of standardised developmental disability tools/checklists/questionnaires for emotional and behavioural problems (e.g. the Developmental Behaviour Checklist).

Assessed by WK (working knowledge)

J1.1.2 Consideration of the aetiology of the disabilities in the patient, whether congenital and/or acquired, their associated behavioural phenotypes (for genetic causes), and relevance to the clinical presentation

WK

J1.1.3 Specific issues of management, including adapted psychotropic drug regimens and psychological therapies, evidence-based parent education and skills training, and importance of long-term developmental perspective

WK

J.1.1.4 Consideration of practices to best support people with intellectual and developmental disability:

- Determining preferred communication style and adapting as required (including use of modified communication methods e.g. visual mood scales, visual communication systems familiar to the patient)
- Providing information in accessible formats
- Making practical adaptations to practice that support engagement
- Facilitating supported decision-making at all stages
- Where appropriate involving the person's support network throughout assessment, management, and monitoring
- Delivering a co-ordinated assessment and treatment approach in conjunction with other health and disability services

Appendix 2. Suggested core competencies for an advanced psychiatry of Intellectual and Developmental Disability training curriculum

Goals

The goals of the advanced Psychiatry of intellectual and developmental disability training curriculum are to:

1. Acquire the knowledge and skills in the assessment, diagnosis, treatment and management of people with intellectual and developmental disability and mental ill health in order to practice competently in the psychiatry of intellectual and developmental disability.
2. Demonstrate the ability to comprehensively and competently assess and manage mental ill health in people with intellectual and developmental disability in general hospital, mental health inpatient settings, outpatient, group home, community and non-government organisational, and online (e.g. tele-psychiatry) settings.
3. Develop the ability to make adaptations to practice, particularly regarding communication, to successfully engage, assess and treat people with intellectual and developmental disability and co-occurring mental ill health.
4. Develop knowledge of psychiatric disorders and behavioural phenotypes commonly associated with conditions that cause intellectual and developmental disability.
5. Understand how mental ill health can present differently in this population.
6. Acquire knowledge of the assessment and management of behaviours of concern displayed by people with intellectual and developmental disability, and be able to provide advice and education to family and support networks and other health and disability professionals regarding how to manage the behaviour.
7. Be prepared to advocate for the needs of people with intellectual and developmental disabilities (PWIDD), and counter stigma and barriers they face when accessing services.
8. Facilitate partnerships with people with intellectual and developmental disability and their family and support persons in order to ensure their empowerment in the management of their conditions.
9. Understand issues pertaining to mental ill health for people with intellectual and developmental disability across diverse groups including ethnic, indigenous, and disadvantaged groups across all stages of life.

10. Understand the interaction between intellectual and developmental disability and mental health, including factors (e.g. genetic causes) that can both cause intellectual/developmental disabilities and increase vulnerability to mental ill health, and potential contributors to mental ill health that can arise due to living with an intellectual or developmental disability (e.g. sociodemographic and psychosocial factors).
11. Become experienced in consultation, collaboration and liaison with other health, allied health and disability professionals, and community groups involved with the support of people with intellectual and developmental disability through participation in, and leadership of, multidisciplinary teams and the development of skills and knowledge related to interdisciplinary frameworks of practice.
12. Gain experience in the organisation, planning and administration of psychiatric services for people with intellectual and developmental disorders and their interface with community resources including government programs, community organisations, voluntary agencies, self-help groups and private facilities.
13. Acquire expertise in the teaching of other health, allied health and disability professionals, people with intellectual and developmental disability and their family and support networks about the nature and appropriate management of mental ill health.
14. Acquire knowledge and understanding of research methodology and apply this by undertaking a research project in the psychiatry of intellectual and developmental disability.
15. Develop and refine skills of public advocacy to improve care in the psychiatry of intellectual and developmental disability.

Objectives

Colour key- Objective obtained/adapted from:

1. Intellectual Disability Mental Health Fellowship training plans
2. Addiction Psychiatry/Forensic Psychiatry/Psychiatry of Old Age Certificate of Advanced Training curricula
3. Intellectual Disability Mental Health Core Competency Manual/Toolkit
4. UK RCPsych Specialists in the Psychiatry of Learning Disability Core Competency Curriculum
5. College of Psychiatrists of Ireland Curriculum for Higher Specialist Training in Psychiatry (Learning Disability)

Area of practice		Objective
1. Attitudes to intellectual and developmental disability and approaches to clinical practice	1.1 Attitude	Develop awareness of the effects that stigma and biased attitudes can have for people with intellectual and developmental disabilities (PWIDD), educate colleagues and the community to reduce unhelpful attitudes, and offer support to health professionals commensurate with their level of knowledge and role
	1.2 Knowledge	Develop knowledge of historical societal attitudes, care approaches and mental health services in the area of intellectual and developmental disability (IDD) mental health in Australia and New Zealand, the current range of care approaches, and policies of inclusion and normalisation
	1.3 Knowledge	Develop knowledge of the following approaches to clinical practice to maximise the quality of services delivered to PWIDD: person-centred; proactive; strengths-based; multidisciplinary and cross agency; inclusive; and flexible
2. Health promotion	2.1 Knowledge	Develop knowledge of mental health promotion and key methods of primary, secondary and tertiary prevention of mental health issues in PWIDD, their effectiveness on a population and individual basis, and relative cost
	2.2 Skill	Develop accessible health promotion materials for PWIDD, their families and support networks e.g. utilising Easy English

3. Medicine in relation to the psychiatry of IDD	3.1 Knowledge	Know the common causes of IDD (including genetic, environmental, and complications from illness), their clinical presentation, and physiology
	3.2 Knowledge	Be familiar with behavioural phenotypes associated with specific genetic syndromes (distinctive social, linguistic, cognitive and motor profiles that typify a syndrome)
	3.3 Knowledge	Be familiar with the classification of degree of intellectual disability and associated levels of adaptive behaviour
	3.4 Knowledge	Understand the pharmacotherapeutic implications of biological characteristics of IDD, including pharmacokinetics and pharmacodynamics
	3.5 Skill	Display a comprehensive understanding of medical investigations relevant to the physical health of PWIDD
4. IDD and co-occurring mental ill health	4.1 Knowledge	Become familiar with the incidence, prevalence, and aetiology of mental ill health in PWIDD, and mental health comorbidities associated with common causes of IDD
	4.2 Knowledge	Know the biopsychosocial risk factors that contribute to the prevalence of mental ill health in PWIDD, including social determinants such as poverty, poor housing, unemployment and job insecurity, income inequality, discrimination, social exclusion, neighbourhood deprivation, and poor access to healthcare
	4.3 Knowledge	Understand the impact of IDD on the presentation of mental ill health, psychiatric disorders, and behaviour
5. Developmental issues in IDD	5.1 Knowledge	Be aware of developmental trajectories with relevance to IDD and the needs and challenges at different developmental stages across the lifespan for PWIDD, including in relation to mental ill health
	5.2 Knowledge	Develop a life-cycle understanding of young people and families, in particular the re-experiencing of grief during periods of transition
	5.3 Skill	Employ a developmental perspective to assessment and management, and take into consideration how developmental stage impacts the presentation of mental ill health in PWIDD
	5.4 Skill	Consider lifespan issues at times of transition (e.g. from child and adolescent to adult services)
	5.5 Skill	Work with PWIDD over the long term and across settings where possible

6. Partnership, Collaboration and Integration	6.1 Knowledge	Understand the needs of family and support persons caring for PWIDD
	6.2 Knowledge	Liaise with other medical/psychiatric specialists to gain knowledge and competence in specialties with specific relevance to IDD (e.g. neurology, neurophysiology, paediatrics, clinical genetics)
	6.3 Knowledge	Become familiar with local and regional services, agencies and related policies relevant to PWIDD (e.g. mental, physical, and allied health services; disability and support services; accommodation services etc)
	6.4 Skill	Collaborate with families and support networks (where appropriate) throughout assessment, management and transition stages
	6.5 Skill	Demonstrate the ability to work with legal guardians and other substitute decision makers
	6.6 Skill	Follow local protocols for collaboration and joint work between mental health services, specialist IDD mental health services, and other services and agencies
	6.7 Skill	Be able to identify when a PWIDD requires additional services or support, and refer the individual to an appropriate service/agency in their local area
	6.8 Skill	Offer psychiatric expertise to other health professionals regarding the assessment and management of PWIDD (e.g. via teleconference or video conferencing) and offer consultative services in inpatient and outpatient settings
7. Meeting diverse needs	7.1 Knowledge	Display knowledge of complex needs
	7.2 Skill	Work with PWIDD with complex needs within a multidisciplinary framework
	7.3 Skill	Address barriers to engaging PWIDD, their family and support networks from culturally and linguistically diverse backgrounds (CALD) and deliver culturally respectful services
8. Communication	8.1 Knowledge	Develop an understanding of Augmentative and Alternative methods of Communication (AAC) and appropriate interview styles
	8.2 Skill	Determine the PWIDD's and support persons' preferred communication styles and appropriately adapt to meet the needs of each person, which may include modifying the

		environment to maximise independent and open communication, the use of assistive communication technology, and providing information written in Easy English
	8.3 Skill	Discuss and participate in the development of communication plans with speech pathologists and occupational therapists
9. Intake and Assessment	9.1 Knowledge	Develop knowledge of modified diagnostic systems for PWIDD (e.g. Diagnostic Manual-Intellectual Disability 2 [DM-ID-2] and Diagnostic Criteria for Psychiatric Disorders for Use with Adults with Learning Disabilities [DC-LD]) that provide classification systems specifically for this population, the methodology used to modify criteria, and the strengths and weaknesses of each system
	9.2 Knowledge	Become aware of appropriate diagnostic tests suitable for use with PWIDD and their psychometric properties, in particular standardised developmental disability tools assessing emotional and behavioural issues such as the Developmental Behaviour Checklist (DBC)
	9.3 Knowledge	Understand 'diagnostic overshadowing', whereby the person's current state is inappropriately attributed to their IDD rather than mental (or physical) ill health
	9.4 Knowledge	Be aware of the influence of specific factors on the assessment of psychiatric disorders in PWIDD (e.g. age, level of ID, gender, culture, spiritual beliefs, socio-economic status, psychiatric and medical comorbidity, medications)
	9.5 Knowledge	Understand the principles of functional behaviour assessment
	9.6 Skill	Prepare for an assessment, making reasonable adaptations to accommodate PWIDD e.g. - allocating adequate time to accommodate for possible complexities; - organising an appropriate environment that addresses the person's physical and sensory needs; - establishing the person's communication needs; - establishing who will be accompanying the PWIDD; - find out about the person's strengths and the support they may require to encourage participation.
	9.7 Skill	Inform the PWIDD, their family and support network of the clinical pathway through a service in a readily understood way
	9.8 Skill	Assess capacity to consent, taking into account ethical and legal implications (e.g. Guardianship Act)

	9.9 Skill	Competently conduct a biopsychosocial assessment in a variety of settings including: - history of presenting issues; psychological/cognitive history - developmental, social, educational and cultural history - functional abilities and adaptive behaviour - neurological examination (where appropriate) - seeking information from other sources e.g. family, friends, carers, schools, other health professionals and disability agencies (with appropriate consent)
	9.10 Skill	Have the ability to assess the psychopathology of this complex and varied population group through a domain-based approach including neuroimaging, genetic analysis, and cognitive science.
	9.11 Skill	Competently use standardised developmental disability tools/checklists that use informant and clinical observations (such as the Developmental Behaviour Checklist) to assess emotional and behavioural problems, especially in those with limited expressive language.
	9.12 Skill	Use appropriate diagnostic tests suitable for use with PWIDD (tailored to how an individual presents), to assess and diagnose specific psychiatric disorders, taking into account the impact of factors such as seizures and menstrual cycle on presentation
	9.13 Skill	To assess cognition, perform limited cognitive testing with appropriate instruments, use observation to give qualitative data on cognitive changes (e.g. disintegration of task initiation, sequencing, monitoring), and utilise naturalistic action methods where beneficial, tailored to individuals. When needed, refer people for neuropsychological assessment and effectively interpret and utilise the results.
	9.14 Skill	Using knowledge of diagnostic overshadowing, competently determine whether a sign, symptom or behaviour of concern may be a feature of co-occurring mental ill health
	9.15 Skill	Provide a comprehensive assessment of behaviours of concern, collaborating with disability services and support persons to evaluate the relative contribution of mental and physical health, environment, communication and skills, and stressors on behaviour through methods including clinical interview, informant questionnaires, psychometric measures, and observation
	9.16 Skill	Competently make diagnoses of psychiatric disorders or mental ill health in PWIDD, utilising modified diagnostics systems (e.g. DM-ID-2 and DC-LD) where appropriate, taking into account potential differences in presentation

	9.17 Skill	Integrate biomedical, psychological and social information into a diagnostic formulation and provide feedback to the PWIDD and their family and support persons (keeping in mind that the communication style may differ for each party)
	9.18 Skill	Develop a management plan in collaboration with the PWIDD and their family and support network, working with a multidisciplinary team if applicable; facilitate supported decision making and give priority to the person's expressed wishes, as far as possible
	9.19 Skill	Take into account the experiences of the PWIDD, family members and support networks when developing plans for their involvement in management and monitoring
10. Mental health interventions and care planning	10.1 Knowledge	Develop knowledge of best practice psychopharmacological management of mental ill health for PWIDD, including the roles, interactions, effects on cognition and seizure threshold of medications commonly used in the psychiatry of IDD
	10.2 Knowledge	Develop knowledge of best practice psychological management of mental ill health for PWIDD
	10.3 Knowledge	Acquire knowledge of how issues around grief affects PWIDD and their families, and how this impacts relationships
	10.4 Knowledge	Understand the impact of traumatic or impoverished parenting templates, and the role of family therapy in these situations
	10.5 Skill	Safely prescribe pharmacological treatment for PWIDD, taking into account cardiometabolic liability of psychotropics, steps to reduce polypharmacy, use of psychotropics as an adjunct to other therapy modes, and monitoring requirements; engage the person (and support persons if appropriate) in the decision-making and monitoring processes as much as possible.
	10.6 Skill	Conduct and evaluate range of psychological therapies with PWIDD, implementing reasonable adaptations to practice (e.g. focusing on concrete and practical therapy elements, involving support persons), and using where appropriate specific adapted therapies such as ethnographic narrative approaches, Talking Mats for people with language problems and modified Dialectic Behaviour Therapy
	10.7 Skill	Develop skills in family therapy, in particular grief counselling/therapy and addressing relationships/attachment issues in vulnerable children and families
	10.8 Skill	Have the capacity to triage the urgency of a required intervention and respond accordingly

	10.9 Skill	Develop detailed behaviour support plans in conjunction with multidisciplinary teams, discuss with families and support persons, manage and provide advice around behaviours of concern, evaluate outcomes and modify if necessary
	10.10 Skill	When managing behaviours of concern, take into account a person's cognitive profile (e.g. impairments in executive functioning) and provide appropriate cognitive support and environmental design to assist people with activities
	10.11 Skill	Develop therapeutic alliances with family and support persons, involving them where possible in the implementation and evaluation of the management plan, and ensure communication between all parties
	10.12 Skill	Work with the PWIDD and their support network to integrate information into a single care plan that governs the services and support they receive, and include strategies for mental health recovery, crisis and relapse prevention, early intervention and long-term follow-up as necessary
	10.13 Skill	Work together with primary health care providers and disability services; identify needs that are not being addressed by current services and refer to appropriate services
	10.14 Skill	Provide shared care and/or advice regarding management of PWIDD under care of medical and mental health teams
	10.15 Skill	Assess and manage family and support persons' needs and stress including the provision of psychoeducation
11. Recovery focus	11.1 Knowledge	Develop awareness of the following issues that can impact recovery: physical, sensory, and motor disability; physical health problems; environmental factors; opportunities for skill development; opportunity for choice
	11.2 Skill	Support the PWIDD, their family and support network to engage in services (health and non-health related) that can meet their recovery needs
12. Transfer of care	12.1 Knowledge	Understand the principles of life span issues that affect PWIDD and how they influence the management of transitions
	12.2 Skill	Manage transitions of PWIDD between clinical settings e.g. emergency department to the ward, inpatient to residential care

	12.3 Skill	Develop with the person and other key partners strategies to manage the transfer of care at key transition points in the PWIDD's life (e.g. from child and adolescent to adult services), taking into account life span issues and potential risks
13. Ethics and legislation	13.1 Attitude through behaviour	Be prepared to enact and give advice to others on the use of mental health and allied legislation in relation to PWIDD
	13.2 Knowledge	Acquire knowledge of human rights charters, conventions and legislation and how this applies to PWIDD with co-occurring mental ill health, including the use of emergency powers and compulsory treatment orders
	13.3 Knowledge	Develop knowledge of principles and legal frameworks around disclosure for PWIDD, implications of disclosing information about the individual, diagnoses, and degree of risk, and how to discuss disclosure with PWIDD and their support networks
	13.4 Skill	Consider informed consent, capacity to consent, autonomy and confidentiality throughout all stages of care, and if required identify and work with the PWIDD's legal guardian/substitute decision maker to make necessary decisions
	13.5 Skill	Provide information on the rights of PWIDD, their families and support networks in accessible formats
	13.6 Skill	Use the Mental Health Act and Guardianship legislation appropriately in emergency and routine practice with PWIDD
	13.7 Skill	Be able to give testimony at an appropriately convened tribunal to review the detention of an involuntary/compulsory patient with IDD
	13.8 Skill	Prepare legal reports for PWIDD
14. Professional responsibility and roles of an intellectual and developmental disability psychiatrist	14.1 Knowledge	Understand the role of the IDD psychiatrist in the provision of education; knowledge of different teaching techniques; and how these can be used effectively in different teaching settings relevant to IDD
	14.2 Knowledge	Develop knowledge of the role of public advocacy in altering community attitudes and developing services

	14.3 Knowledge	Develop knowledge of the process by which policies regarding IDD are developed across a variety of groups: government, non-government, community, professional health associations, and media
	14.4 Skill	Develop skills to provide supervision in the psychiatry of IDD to junior colleagues and other health professionals
	14.5 Skill	Use a variety of teaching methods suitable for different audiences to provide education about IDD mental health
	14.6 Skill	Recognise and deal constructively with unhelpful community attitudes towards PWIDD and be willing to advocate for the needs of PWIDD
	14.7 Skill	Contribute to and comment on policy that relates to PWIDD and mental health
15. Service issues and quality improvement	15.1 Knowledge	Understand the role of PWIDD, families and support networks, primary health care providers, and consumer groups in relation to the delivery of mental health services for this population
	15.2 Knowledge	Develop knowledge of the measurement of outcomes of service delivery to PWIDD and their families and support networks, including seeking feedback from patients, family members and support networks, the public, staff and other interested groups
	15.3 Knowledge	Understand principles pertaining to the development, implementation and evaluation of new programs and services for PWIDD and their support networks
	15.4 Knowledge	Develop an understanding of different models of service delivery of IDD mental health services
	15.5 Skill	Demonstrate the ability to support PWIDD, and their family and support networks to participate in service improvement activities, and implement feedback
	15.6 Skill	Develop and adopt clinical guidelines and integrated care pathways in the area of psychiatry of IDD
	15.7 Skill	Where possible assist in the development, monitoring, and evaluation of mental health services for PWIDD
16. Research	16.1 Knowledge	Develop a knowledge of participatory and inclusive research practices that engage PWIDD, their families and advocates

	16.2 Knowledge	Develop knowledge of the ethical and legal implications of research in the psychiatry of IDD
	16.3 Knowledge	Be aware of the stages of research design including literature review, formulation of hypotheses, clinical trial design, sample selection, basic statistical techniques, and outcome assessments
	16.4 Skill	Carry out literature searches related to the psychiatry of IDD, critically analyse existing knowledge, synthesise information and summarise the relevant findings coherently
	16.5 Skill	Demonstrate knowledge of the ethical and legal issues involved in conducting clinical research with individuals with IDD who may have impaired capacity to provide informed consent
	16.6 Skill	Where possible, encourage the participation of PWIDD in the design and development of research
	16.7 Skill	Frame a research question related to the psychiatry of IDD, design a study and undertake a research project using suitable statistical methods
	16.8 Skill	Adopt the principles of evidence-based practice at a service level