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ORIGINAL ARTICLE

Does the Dynamic Support Register Identify the Risk of Early Placement Breakdown in Adults With Intellectual Disabilities? Perceptions of Service Users, Carers and Professionals

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ABSTRACT

Placement breakdown is a common cause of avoidable admissions to intellectual disability inpatient services among people with intellectual disability. The Dynamic Support Register with intensive support function was introduced to help minimise these admissions. This study explored the perceptions of service users, carers and professionals of the extent to which the Dynamic Support Register identifies early risk of placement breakdown and reduces admissions. Semi-structured interviews were conducted with four service users, five community learning disability team professionals and five carers (paid and unpaid). Interviews were audio-recorded and transcribed verbatim and analysed using the constructs of Normalisation Process Theory. Key factors influencing the placement breakdown were identified. There was consensus that increasing understanding and awareness of the Dynamic Support Register with intensive support among health and social care professionals, service users and families would improve the provision of timely and appropriate support. The intensive support function provided by the community learning disability team for people on the Dynamic Support Register was viewed to have reduced avoidable inpatient admissions. The Dynamic Support Register identifies early risk of placement breakdown and, with intensive support from the community learning disability team, could minimise avoidable inpatient admissions. However, limited awareness among primary care, health and social care professionals highlights the need for increased training to optimise its impact.

1 | Introduction

One in six people worldwide has a significant disability according to the World Health Organization (2023). There are approximately 1.5 million people in the UK with intellectual disability, of whom 1.1 million are adults, representing 2.16% of the UK population (Mencap 2020).

People with disabilities have the right to choose where and with whom they live and be included in their local communities (United Nations 2006). The 'Building the Right Support' national plan (NHS England 2015a) and National Service Model (NHS England 2015b) state that individuals with intellectual disabilities and/or autism should stay in hospital only as long as necessary and have choice over where and with whom they live (NHS England 2015a). Many developed countries introduced legislation and policies to encourage choice, independence and improved access to services for people with intellectual disabilities (McCarthy and Duff 2019), which led to deinstitutionalisation and the development of community-based services (McCarthy and Duff 2019; Huisman et al. 2024).

The UK government launched a national review in 2011, following an expose of abuse at Winterbourne View Hospital (British Broadcasting Corporation 2011) which led to the Transforming Care report published in 2012 aimed at reducing extended hospital stays (Department of Health 2012). Despite recommendations that most inpatient stays should be under 6 months (Learning Disability Professional Senate 2017), the data from April 2022 showed that 57% ($n = 1135$) of 2000 inpatient admissions in England had an average stay of over 2 years (NHS Digital 2022).

The National Transforming Care Programme, and the Care and Treatment Review policy required health commissioners (who are responsible for planning and purchasing healthcare services for the local population) to maintain an active local register of people with intellectual disability and/or autism who are at risk of inpatient admission to a mental health hospital (NHS England 2015c). This register is called The Dynamic Support Register (DSR), which is a clinical support tool developed to identify service users at risk of inpatient admission (Bohen and Woodrow 2020). The DSR is the responsibility of the ICB (Integrated Care Board) who may delegate it to local team level, and is updated regularly with commissioners. Service users' details are added to the DSR if they present with risk factors that threaten the placement stability and are Red, Amber, Green (RAG) rated based on the risks (NHS England 2023). A 'placement' refers to a setting where an individual receives care and/or support with accommodation (i.e., supported living, residential care home, family home, etc.). Placement breakdown refers to unplanned cessation of care and support arrangements, often triggered by factors such as environmental issues, behavioural challenges, staff or routine changes and limited resources or support. Individuals with intellectual disabilities are at higher risk of placement breakdown if they display challenging behaviours (Broadhurst and Mansell 2007). Intensive support provided may include crisis response, monitoring, carer training or working collaboratively with health and social care professionals.

A community learning disability team based in an NHS trust in the Northwest of England has been using the DSR since 2016, although it has never been formally evaluated. While the NHS England (2023) DSR policy and guidance aims to reduce hospital admissions through early identification and intensive community support, there remains a lack of evidence regarding its impact. Additionally, Ince et al. (2022) highlighted the limited inclusion of family and service user perspectives in research which this study aimed to address. This study aimed to explore the perceptions of service users, carers and professionals of how effectively the DSR identifies early risk of placement breakdown and its potential role in reducing admissions. It also sought to identify further improvements that could be made to intensive community support and the DSR.

2 | Methodology

2.1 | Study Setting

The evaluation took place at one of the community learning disability teams within the NHS based in the Northwest of England, who support adults with intellectual disabilities within a community setting.

2.2 | Study Design

A qualitative study design consisting of semi-structured interviews was used as it allowed an in-depth exploration of people's perceptions, feelings and how they make sense of the world. The study was the substantive part of an NIHR ARC NWC research internship.

2.3 | Participants and Recruitment

At the point of referral to the learning disability team, service users consent to be included on the DSR. An administrative staff member compiled a list of service users supported via the DSR over the past year. To safeguard the well-being of participants, a learning disability nurse reviewed the list to ensure the service users were safe to participate in the evaluation. Service users were given easy-read versions of the invitation letter, participant information sheet and consent forms at the outpatient psychiatric clinic. Carers, families and professionals were emailed the standard version of these documents. Participants were given 1 week to respond and consent forms were signed prior to interviews, scanned onto the trust-approved device and originals were destroyed.

A purposive sample of 14 participants (service users [$n = 4$]; carers [paid carers and family] [$n = 5$], professionals = 5) were recruited. As it was expected that the participants should have prior involvement in the DSR to be able to provide rich detailed information, a small sample size can be justified. To recruit paid carers, prior permission was sought from their managers. All participants had experience of being supported or providing support to someone on the DSR. Eligibility criteria are outlined in Table 1.

2.4 | Data Collection

Data were collected through one-to-one semi-structured interviews conducted face-to-face between October and December 2022, either at the NHS Trust premises or within the service user's homes. The interview guide informed by Normalisation Process Theory (NPT) was piloted with two public advisors with lived experience, resulting in some minor adjustments. A familiar carer was present during interviews with two service users at their request but did not intervene. The interviews lasted from 20 to 45 min and were conducted by the evaluator, who is an advanced physiotherapist in intellectual disabilities with some previous research experience and who was not involved in the DSR process or the intensive support offered to the service users recruited. All interviews were audio recorded and

TABLE 1 | Participant eligibility criteria.

Eligibility criteria
Include
Community learning disability team staff with experience of supporting service users on the DSR
Carers with experience of supporting service users on the DSR
Service users on the DSR who received support from the community learning disability team
Individuals who could consent to take part in an interview
Exclude
Individuals who lacked capacity to consent to take part in an interview
Individuals with no prior experience of the DSR

professionally transcribed; no field notes were taken, no repeat interviews were conducted and transcripts were not returned to participants for review due to resource constraints. Data were anonymised by removing personal identifiers. Participants who met the inclusion criteria were interviewed until data saturation was reached. Service users and carers were asked about their experiences with the DSR, their understanding, the information received and feedback sought. Professionals were asked about how risks were identified and communicated, decisions were made, training received and practice change since the implementation of the DSR.

Ethical approval was obtained from the University of Lancashire (Reg. no. HEALTH0351) and Mersey Care NHS Foundation Trust (Reg. no. SE2022-31). To safeguard the well-being of participants, a distress protocol was developed. If any participant exhibited signs of distress, the interview was paused or terminated and appropriate support offered.

2.5 | Data Analysis

Data collection and analysis were conducted simultaneously. Transcripts were imported to NVivo software (Version 12) to generate codes and analyse data. Coding was conducted by N.R. (principal evaluator) and verified with K.B. (research supervisor). As the DSR and intensive support offered to service users at risk of admission is an innovative approach, Normalization Process Theory (NPT) was considered a suitable theoretical framework for this study (Murray et al. 2010). The thematic analysis was structured according to the four core constructs of Normalization Process. The analysis commenced with an inductive process using the NPT theoretical framework, which enabled us to understand how participants make sense of the work (coherence), how they engage (cognitive participation), how they work together (collective action) and how they reflected (reflective monitoring). The themes identified were aligned to NPT constructs.

2.6 | Patient and Public Involvement

Five service users with intellectual disability and two public advisors with lived experience reviewed the relevance of the evaluation question, and provided feedback on participant information sheets, consent forms, invitation letters (including easy-read versions) and interview questions. Revisions were made accordingly. The findings were presented to them, and the report was shared.

TABLE 2 | Participant demographics.

Participant ID	Category	Profession
P1	Professional	Nurse
P2	Professional	Nurse
P3	Professional	Nurse
P4	Professional	Nurse
P5	Professional	Clinical Psychologist
P6	Paid carer	Carer
P7	Family carer	Family
P8	Paid carer	Carer
P9	Paid carer	Carer
P10	Family carer	Family
P11	Service user	—
P12	Service user	—
P13	Service user	—
P14	Service user	—

3 | Results

Fourteen participants were recruited for this study: community learning disability team staff ($n=5$), paid carers from three different social care provider organisations ($n=3$), family carers ($n=2$) and service users ($n=4$) as presented in Table 2.

Several themes were identified under each of the four constructs of the NPT: coherence, cognitive participation, collective action and reflexive monitoring, which are presented in Table 3 and described below. While some overlap between themes across

TABLE 3 | Themes identified under the constructs of the NPT.

NPT construct	Themes within construct	
Coherence—*What is the work?*	What is the work within the team?	
	What is the work external to the team?	
Cognitive participation—*Who does the work?*	Placement breakdown due to:	
	• *Environment*	• *Funding*
	• *Change*	• *Resilience*
	• *Lack of accommodation*	• *Staff shortages*
	DSR process	
Collective action—*How does the work get done?*	Intensive support	
	Training	
	Collaborative working	
Reflexive monitoring—*How is the work understood?*	Avoiding admissions	
	Feedback	

constructs was observed, this reflects the interconnected nature of implementation work and is consistent with the dynamic processes described by NPT.

3.1 | NPT Construct 1: Coherence

Coherence is a sense-making of new practices or ways of working (May et al. 2022). As the DSR and intensive support function is a new way of working within the community learning disability team, all those who use it should understand the process for successful implementation. The themes within this construct explore how the DSR is understood within and external to the team.

3.1.1 | Within the Team

All professionals within the community learning disability team understood the DSR well.

> We use the DSR to highlight if someone's at risk of admission or placement breakdown so that we can offer tailored support.
>
> (P5, Professional)

Professionals were asked to compare their experiences prior to the implementation of the DSR and now. The consensus was that the DSR provided a proactive, structured MDT approach with shared responsibility.

> Prior to the DSR, certain members of the team would be holding these cases, nurses, and psychiatrists generally. Now it is an MDT approach and feels like more shared team response.
>
> (P2, Professional)

One professional described that it was not much different from how things were done before, but this new process has provided a structure.

> I don't think anything that we're doing is novel or spectacular. We have always been doing this but potentially having a structure in terms of timelines for when that needs to happen and what they focus on as people.
>
> (P5, Professional)

3.1.2 | External to the Team

One professional felt that paid carers may have a better understanding of the DSR than family carers.

> Carers probably may have a better knowledge of the DSR. I would say that families have a limited understanding of the DSR.
>
> (P4, Professional)

However, there was a lack of awareness of the DSR among health and social care services, service users, families and paid carers.

> First time I knew about the DSR was in a meeting. The nurse from the LD [learning disability] team said that my brother was put on the register, and I didn't know what it was, and social worker didn't know it either.
>
> (P7, Family Carer)

All service users were unaware of the DSR, but they recollected that intellectual disability nurses came to help them when they were in crisis.

> I don't know.
>
> (P11,12,13,14—Service Users)

3.2 | NPT Construct 2: Cognitive Participation

Cognitive participation is a planning phase where individuals get together to plan how the work is done and by whom. As the DSR aims to support the service users at risk of placement breakdown, it is vital to understand the risks associated with placement breakdown in the first place. The themes within this construct explore participants' perceptions on various interrelated factors that affect the stability of a placement and the DSR process.

3.2.1 | Environment

Environmental issues were cited as one of the main causes of placement breakdown by all participants. Noise, accessibility, space restrictions, behaviours to self and others and not getting along with other service users were cited as important contributing factors.

> We often find that the environment isn't meeting their needs either because they're living with people who they are not compatible with, or the physical environment is too noisy.
>
> (P3, Professional)

> Not getting on well with others and noisy places.
>
> (P13, Service user)

Service users preferred quieter environments, some preferred supported accommodation.

> I like living in a house with other people and carers to look after me.
>
> (P12, Service User)

3.2.2 | Change

One participant highlighted that people with intellectual disability experience a lot of changes throughout their lives. Although change can be challenging for anyone, people with an intellectual disability may respond differently, which can result in a placement breakdown.

> For people with learning disabilities, there is so much change because people come and go all the time, or they have to move from one environment to another to mix with new people.
>
> (P2, Professional)

3.2.3 | Lack of Accommodation

The participants shared their experiences of difficulties finding a suitable placement and inadequate respite facilities. This could be further complicated if the service user presented with behaviours. 'Behaviour can be described as challenging when it is of such intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and it is likely to lead to responses that are restrictive, aversive or result in exclusion' (Royal College of Psychiatrists 2007). Some participants also related their experiences of placing service users out of the area as there were no suitable providers locally.

> It's very difficult to find a placement especially if a service user presents with behaviours of concern.
>
> (P1, Professional)

Professionals and carers highlighted how boredom, and a lack of planned and meaningful activities, could trigger behaviours which could result in an unstable placement.

> The accommodation is right but there aren't enough activities for service users to spend time during in the day.
>
> (P2, Professional)

3.2.4 | Funding

Participants were asked regarding their experiences funding a placement or extra staffing during a crisis. Some felt there were funding issues but others felt there were not.

> I've not seen any concerns with funding, but it just seems to be a lack of carers which is causing a big issue.
>
> (P2, Professional)

One participant described their awareness of one source of funding, but this was for people being discharged from hospital as a part of the Transforming Care Programme. However, participants were unaware of any funding available in the community to minimise admissions.

> We are aware of monies from NHS England that I think only social care can apply for people currently in the hospital who needs a placement.
>
> (P5, Professional)

3.2.5 | Resilience

One carer expressed that supporting service users with complex needs can be stressful and they need support to maintain resilience.

> If I am looking after someone who is quite complex and need additional support myself to manage the situation, having that support mechanism around is really helpful.
>
> (P9, Paid Carer)

One carer described being unable to access advice and support quickly when managing a crisis over the weekend, highlighting that the out-of-hours phone was managed by mental health staff and the advice provided was unsatisfactory.

> One weekend, I couldn't get any help when we were in crisis. It would have been useful if I had out-of-hours phone number to ring the learning disability team or someone with learning disability knowledge, especially on weekends.
>
> (P6, Paid Carer)

3.2.6 | Staff Shortages

Almost all participants stated that there is a shortage of skilled carers.

> You can give us all the hours in the world, but we haven't got enough people to do them hours.
>
> (P6, Paid Carer)

Some participants expressed concern in relation to excess use of temporary and inexperienced carers which has resulted in issues like not fully trained, different staff each day and they often lacked understanding of service users' needs.

> I think a lot of staff we are getting now is bank staff. They're only here for a little bit and then they go.
>
> (P8, Paid Carer)

3.2.7 | DSR Process

All professionals were consistent and clear about their understanding of DSR. One participant described:

> Following a crisis call, triage and another practitioner will go out to determine what's causing the crisis if it is a mental health or a placement breakdown. A lead practitioner is then assigned. A professionals meeting and an urgent care and treatment review will be arranged to determine what support we can offer. We would invite family members, service user, commissioners, social care and professionals within the LD [learning disability] team, everyone involved in that person's care. The outcome would be actions of what is needed to be done to keep that person out of hospital.
>
> (P1, Professional)

3.3 | NPT Construct 3: Collective Action

The themes in this construct look at how work is done collectively to implement the DSR. This includes allocation of work, skill set, training, discussions in MDT and intensive support offered.

3.3.1 | Intensive Support

Service users on the DSR receive extra support through the intensive support function of the community learning disability team. All professionals were clear about what support they provide individually and as a team. Everyone described how a quick response and extra support made a difference to minimising admissions.

> If we can get in there quickly, we can do something about the future … I have certainly seen evidence of that happening.
>
> (P5, Professional)

All service users and carers shared an overall positive experience of intensive support received from the community learning disability team.

> They talked to me and my carers over the phone and came to see me at my place.
>
> (P11, Service User)

> Extra support from the learning disability team makes a massive difference to people. Without the learning disability team, we probably wouldn't have this service going.
>
> (P9, Paid Carer)

3.3.2 | Training

Participants expressed their views on the training delivered as part of the implementation of the DSR. Most professionals reported that while no formal training was provided on the DSR, everyone engaged in self-directed learning through shadowing colleagues and familiarising themselves with standard operating procedures. All professionals felt that formal training would be beneficial for new starters.

> I don't think I had proper training on the DSR. Someone went through the process, and I feel comfortable, but I do think that new staff, would benefit from some training.
>
> (P5, Professional)

Professionals offered person centred training to people on the DSR to improve carer knowledge and address some of the placement instability factors.

> We may offer communication, dementia training that's more specific to that person.
>
> (P4, Professional)

Some family carers were aware of training delivered by the community learning disability team while others were not. One family carer discussed that the community learning disability team delivered bespoke training to carers, and commented that with frequent use of temporary staff, this may be ineffective.

> Learning disability team provided dementia training specific to my brother. It covered things like how to manage his evolving behaviours. There's no point doing the training if it's all agency staff because they're just not following.
>
> (P7, Family Carer)

3.3.3 | Collaborative Working

Carers, family members and other health and social care professionals were the main people who contacted the community learning disability team during a crisis.

> If we're having a crisis or see things deteriorate, we would contact the learning disability team.
>
> (P6, Paid Carer)

All professionals reported that placing a service user's name on the DSR is an MDT decision.

> It's a team decision. It would be the clinician who's closely involved would highlight it, but then it would go through MDT.
>
> (P5, Professional)

Professionals reported that service users would be informed about the risks and obtain consent. If the service users lacked capacity to consent, a capacity assessment and best interest process would be followed.

> We would explain to them in a way they understand using pictures of the environment they might be transferring to, although that might be difficult if they are presenting as unwell.
>
> (P1, Professional)

One participant said that although there is good agreement within MDT about placing a service user on the DSR, but this can be subjective and suggested piloting the DSR to clarify agreement and improve clinical discussion within MDT.

> The way we RAG [red, amber, or green] rate people can sometimes be a bit subjective. I think we are consistent and there's a lot of agreement across the team. It might be useful to pilot a tool and see if we have an agreement, on where we would rate people. I suppose to see if it improves those conversations.
>
> (P5, Professional)

3.4 | NPT Construct 4: Reflexive Monitoring

Reflexive monitoring is an appraisal of work carried out by the individuals to understand how effective the new practice has been to them and others. The themes under this construct investigate how the DSR has affected the participants in meeting its overall aim of identifying risk of placement breakdown and reducing admissions. This theme also looks at how the feedback was collected and any further improvements that were made to the DSR following this feedback.

3.4.1 | Avoiding Admissions

All participants thought that the DSR was working well and could provide examples of success. Professionals quoted some figures describing its effectiveness.

> I would say that the DSR has reduced inpatient admissions. We had two admissions in the last two years, both were recognised as inappropriate.
>
> (P4, Professional)

Two carers and one service user described the extra support from the community learning disability team as useful in reducing hospital admission.

> It helped me to get better when I was ill and stopped me going into hospital.
>
> (P14, Service User)

> There's no way I could have coped with her at home. By sending the team in daily has helped us to keep her at home and to get her back on her feet again.
>
> (P10, Family Carer)

All professionals reported a lack of understanding of the DSR among primary care services.

> One of the things that's a barrier for the DSR being successful is, if you want an early health assessment for a service user from a GP, dentist, or primary care, just because they are RAG rated red on the DSR does not enable them to jump the queues.
>
> (P2, Professional)

3.4.2 | Feedback

All service users and carers reported that no feedback was sought from them regarding the DSR.

> No one asked me for feedback.
>
> (P13 & 14, Service Users)

Most professionals said no feedback was sought since the DSR had commenced. However, one professional recollected an informal discussion within MDT, and a prompt sheet was developed to enable better recording of the information.

> We have been asked what works well and what doesn't by our team manager through MDT meetings.
>
> (P3, Professional)

However, both family and paid carers reported they were not informed and received no information prior to placing service users name on the DSR. One carer reported that she had been informed, but no further information was provided.

> It would have been useful if information about the DSR was provided to me earlier. It was quite worrying as I was thinking, what is going to happen to my brother if that placement breaks down.
>
> (P7, Family Carer)

4 | Discussion

This study explored the perceptions of service users, carers and professionals regarding how the risk of placement breakdown is identified and managed through the DSR and intensive community support function. Findings indicate that the DSR identifies risk of placement breakdown and when combined with intensive community support, can reduce admissions.

Awareness of the DSR was primarily confined to the community learning disability team, reflecting a limited shared understanding (coherence) across wider health & social care services. This limited awareness could contribute to delays in addressing physical health issues which can exacerbate mental health deterioration and increase the risk of placement breakdown. While the community learning disability team prioritise service users on the DSR and provide timely crisis interventions, the slower response from primary care due to limited awareness of the DSR poses challenges to integrated care. These findings were consistent with previous research (Kouroupa et al. 2023; Manandhar-Richardson et al. 2023) and suggest that enhancing coherence through improved communication about the DSR is critical to achieving integrated and effective care.

Participants identified multiple factors potentially contributing to placement breakdown, including environmental issues, changes in staffing or personal circumstances, lack of suitable accommodation, funding challenges and staff shortages. These findings are consistent with those reported by Watts et al. (2000) and Washington et al. (2019). Additionally, families and carers expressed concerns regarding the lack of out-of-hours support during crises, particularly in the evenings and weekends, echoing findings from Manandhar-Richardson et al. (2023) who explored the experiences of paid carers supporting individuals with intellectual disability at risk of admission.

Although funding is currently available to support hospital discharges and intensive community support teams, some participants felt that there is a need for further funding to support crisis intervention in the community. Suggested improvements include expanding local respite care, implementing step-down/step-up care models, funding additional crisis support hours and upskilling the workforce to manage complex needs. These factors reflect the relational and structural work necessary to sustain engagement and commitment to the DSR and intensive support intervention, as conceptualised within the cognitive participation construct of Normalization Process Theory.

Participants perceived that the success of the DSR can largely be attributed to the MDT approach and collaborative working with families, as well as other health and social care organisations. This, combined with a quick response time during crises provided by the intensive support function within the learning disability team, has made this innovative practice potentially unique in minimising admissions. Additionally, training was highlighted as essential in equipping staff with the skills and knowledge necessary to support service users on the DSR. These elements reflect the operational work (collective action) required to enact and sustain the DSR, aligning with the NHS England (2023) DSR Policy and guidance, and demonstrate how collective action supports the normalisation of this innovative approach.

All participants reported that the DSR and the additional intensive support provided are working well, with most participants observing a reduction in admissions. This reflects positive appraisal and evaluation consistent with the reflexive monitoring process described in Normalization Process Theory. However, the study also revealed that no formal, systematic feedback was sought from participants, and limited information was shared about the DSR with carers, service users and families.

One participant suggested that conducting a review of the DSR tool to assess inter-rater agreement may enhance the quality of MDT discussions. Previous studies have explored inter-rater reliability and face validity of the DSR (Bohen and Woodrow 2020; Mottershead and Woodrow 2019). However, the risk stratification approach should be detailed enough to bring greater objectivity to RAG rating decisions as recommended by the NHS England (2023).

There is scope to address concerns raised by the participants. Improvements could be made by providing accessible information prior to placing a service user's name on the DSR, establishing a specialist out-of-hours support, seeking regular feedback from users of the DSR, and improving awareness of the DSR among service users, carers, families, health and social care professionals.

Finally, if the risk factors discussed in the introduction are identified early and adequately supported in the community through the DSR with intensive support, the risk of placement breakdown and subsequent admission to intellectual disability inpatient services could be minimised. Future research should collect quantitative data from a large sample size to evaluate the effectiveness of the DSR and impact of intensive support function in the community on admission rates.

5 | Strengths and Limitations

No previous studies have explored the views of families and service users about the DSR and risk of placement. Involving service users and public advisors from the outset is a strength of our study.

However, the small sample size limits generalisability, as DSR implementation may vary locally based on available resources.

We did not include people with intellectual disability who are non-verbal or unable to consent, meaning that the perceptions sought will not reflect their views. Some of the service users' responses were brief and sometimes single-word answers. To seek in-depth views from people with intellectual disabilities, future research should consider reasonable adjustments and accessible information.

6 | Implications for Policy and Practice

This study highlights that, from the perspective of staff, identifying the risk of placement breakdown and providing intensive community support can help minimise admissions of people with intellectual disability. While the DSR is primarily implemented in services in England, this innovative approach could be adapted across the healthcare systems globally to inform policy development and best practice, addressing the challenges faced by people with intellectual disability. However, implementing this best practice needs further consideration and requires global studies with a large sample size. Services should ensure that accessible information and out-of-hours contact details are provided to service users, carers and families supporting people with intellectual disability. Community learning disability teams should raise awareness about the DSR among mainstream health and social care providers. This could be achieved by offering additional training or including the DSR specific information in the existing mandatory learning disability training. Finally, regular feedback should be sought from people who regularly engage with the DSR, and necessary improvements should be made.

7 | Conclusion

Our findings indicate that, from the participants' perspective, the DSR with intensive support function within a community learning disability team has the potential to reduce inpatient admissions among people with intellectual disability, although further research is recommended.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section. **Data S1:** jppi70042-sup-0001-Supinfo.docx.