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Navigating Challenges and Refining Methods for Randomized Controlled Trials Including Young People With Intellectual Disabilities: Empirical and Literature-Informed Insights

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ABSTRACT

People with intellectual disabilities experience poorer health than the general population, largely due to preventable non-communicable diseases. Although randomized controlled trials (RCTs) are the gold standard for evaluating health promotion interventions, they are rarely conducted with young people with intellectual disabilities because of inadequate research procedures. This methodological paper draws empirical insights from a research program and relevant literature involving co-design and an upcoming RCT of a digital health promotion intervention. Using the core RCT components, randomization, control, and trial procedures as an analytical framework, the paper integrates empirical experience and literature to examine challenges in conducting inclusive RCTs. Participation and accessibility emerged as overarching methodological considerations influencing recruitment, retention, engagement, statistical power, generalizability, and overall trial validity. Empirical experiences illustrated how relational, organizational, and methodological adaptations can address these challenges in practice. By combining evidence from the literature with empirically grounded strategies developed across the research program, this paper advances more inclusive and feasible RCT methodology for research involving young people with intellectual disabilities.

1 | Introduction

Intellectual disability is a lifelong condition characterized by limitations in cognitive and adaptive functioning (American Psychiatric Association 2013), affecting approximately 1%–2% of the population (Maulik et al. 2011). People with intellectual disabilities experience substantial and persistent health inequities compared to the general population (World Health Organization 2022) and are at risk of dying up to 20 years earlier than their non-disabled peers (Hirvikoski et al. 2021). This excess mortality is largely attributable to preventable and treatable causes, including a high burden of chronic conditions. Mental health conditions are also highly prevalent among people with intellectual disabilities (Buckley et al. 2020).

Compared to the general population, people with intellectual disabilities are more likely to lead sedentary lifestyles (Oppewal et al. 2018), have unhealthy diets (Hoey et al. 2017),

Lay Summary

- Young people with intellectual disabilities are often excluded from randomized controlled trials because standard trial methods are not designed to support their participation and accessibility.
- This paper examines methodological and practical challenges across the design and conduct of inclusive randomized controlled trials involving young people with intellectual disabilities.
- Drawing on experiences from the (Intellectual Disability Integrating Digital Intervention Technology for health) I DID IT research program, the paper describes concrete strategies, informed by co-design, to support recruitment, engagement, and ethical research practice.
- The paper provides methodological guidance to improve the inclusivity, feasibility, and quality of randomized controlled trials involving people with intellectual disabilities.

and experience limited social networks and social isolation (Harrison et al. 2021). These factors are associated with increased health risks and contribute to excess morbidity and early mortality (Hirvikoski et al. 2021; O'Leary et al. 2018). Many health risks among people with intellectual disabilities are potentially modifiable through adequate health promotion interventions (Rana et al. 2024), highlighting the distinction between unavoidable genetic conditions associated with intellectual disability and health outcomes that may be addressed through appropriate interventions.

Although systematic reviews indicate potential effects of health promotion interventions for people with intellectual disabilities, the evidence remains limited by small numbers of studies, generally weak methodological rigor, and variability in intervention techniques and outcome measures (Maine et al. 2020; Mulhall et al. 2018; Rana et al. 2024). Much of this evidence is based on adult populations, with comparatively limited research focusing specifically on young people with intellectual disabilities (Mulhall et al. 2018), highlighting an important gap in the evidence base. Furthermore, interventions are often delivered in controlled settings with intensive staff involvement, which may constrain scalability and generalizability, and few interventions have been evaluated using RCTs (Maine et al. 2020).

Digitalization offers new opportunities to enhance health behaviors through electronic health (eHealth) interventions, including mobile health (mHealth) interventions that use mobile and wireless devices for monitoring and feedback. Digital interventions can enhance independence and complement face-to-face meetings (Badawy and Kuhns 2017), particularly when designed as part of an integrated model where digital and human support interact, rather than replace essential personal support. Evidence from systematic reviews (Badawy and Kuhns 2017; Celik and Toruner 2020) and previous RCTs (Müssener et al. 2016, 2020; Seiterö et al. 2025) show that digital interventions promote healthy behaviors in young people without intellectual disabilities, but the evidence base for such interventions targeting people with intellectual disabilities remains limited and fragmented (Van Biesen et al. 2024).

RCTs are widely recognized as the most rigorous method and are considered the gold standard for evaluating health interventions (Bhide et al. 2018; Hariton and Locascio 2018). Core features of the RCT framework include randomization, control, and trial procedures. Randomization involves allocating participants randomly to intervention or control groups, thereby minimizing bias and confounding in estimates of intervention effects. Control refers to strategies used to limit the influence of extraneous variables and isolate the effect of the intervention. The trial component denotes the systematic testing of an intervention using a predefined protocol, appropriate outcome measures, and statistical methods to assess effectiveness and/or efficacy (Bhide et al. 2018).

Although RCTs are often presented as straightforward, evidence from systematic reviews shows that their implementation involves substantial methodological and practical challenges when participants have cognitive or communicative impairments, such as intellectual disability (Mulhall et al. 2018, 2021). These challenges span across all core components of RCTs (randomization, control, and trial procedures). Difficulties in achieving sufficient and timely recruitment and maintaining engagement and follow-up can compromise statistical power, increase bias, and limit generalizability (Bower et al. 2014; Natale et al. 2021; Treweek et al. 2018). Systematic reviews focusing on cognitive disability highlight recurring barriers related to informed consent, recruitment through service structures, adaptation of interventions and outcome measures, as well as staff turnover (Mulhall et al. 2018, 2021). Cognitive demands inherent in standard RCT procedures, including comprehension, memory, and adherence requirements, may further limit feasibility (Mulhall et al. 2021). A recent scoping review also identifies systemic barriers and a lack of evidence-based strategies to support consistent inclusion of people with disabilities in clinical trials (Shariq et al. 2023). Together, these reviews highlight the need for clearer methodological guidance and practical strategies to support feasible and inclusive RCTs in intellectual disability research (Berger et al. 2021).

Against this background, this paper reports on a research program conducted by the I DID IT research group, which applies a co-design approach throughout the development and conduct of a forthcoming RCT to develop and evaluate a cognitively accessible digital health promotion intervention for young people with mild to moderate intellectual disabilities.

The aim of this paper is to examine methodological considerations and practical challenges in the design and conduct of such RCT, and to describe strategies used to address these challenges, drawing on relevant literature and empirical experiences from the I DID IT research program.

2 | Methodological and Practical Challenges Undertaking RCTs Targeting People With Intellectual Disabilities: Literature-Informed Perspectives

Having outlined the health disparities affecting young people with intellectual disabilities and the role of RCTs as the gold

standard for intervention evaluation, this section examines in more detail the methodological and practical challenges encountered when conducting an RCT with this group. The section is structured around the three core components of RCT design, randomization, control, and trial procedures, as an analytical lens aligning with the structure used by Mulhall et al. (2018), while incorporating more recent literature and empirical insights from the I DID IT research program.

Before turning to the three components of RCT design, it is important to acknowledge the social and organizational contexts in which young people with intellectual disabilities live and receive support. Health promotion for this group is often shaped by service systems and everyday environments, where formal and informal support structures influence access, engagement, and sustainability (Naaldenberg et al. 2013). Accordingly, the methodological challenges must be interpreted in relation to these contextual conditions.

2.1 | Randomization

One central principle of RCT methodology is that the study sample should be representative of the population under investigation. In trials involving people with intellectual disabilities, this might be particularly challenging due to substantial heterogeneity in severity of intellectual functioning, adaptive behavior, and communication abilities. Adequate recruitment is essential for achieving sufficient statistical power to examine the effectiveness of interventions; however, trials involving this group often face recruitment challenges due to structural, procedural, and organizational barriers, creating a methodological paradox in which those most in need of evidence are also the least likely to be included in large studies (Mulhall et al. 2018, 2021).

Systematic reviews show that many RCTs involving people with intellectual disabilities struggle to achieve target sample sizes and representative recruitment. Mulhall et al. (2018) reported that only a minority of studies met recruitment targets, with small sample sizes being common. Recruitment barriers include limited catchment areas, restrictive eligibility criteria, and insufficient collaboration with service providers, all of which increase the risk of underpowered trials and limit generalizability (Mulhall et al. 2018).

Trial participation is often mediated by staff and family carers, who, despite good intentions, may face competing priorities, limited time, and varying digital familiarity that further constrain recruitment, retention, and follow-up in trials. Access to participants is frequently mediated through service systems where researchers must rely on staff, family members, or legal guardians to facilitate contact. In this context, gatekeeping can delay or prevent participation and may reflect organizational or practical constraints rather than the preferences of individuals with intellectual disabilities (Mulhall et al. 2021).

Challenges related to informed consent and assessment of capacity further affect recruitment and sample composition, particularly when research procedures and information materials are insufficiently adapted to diverse communication needs (Jimoh et al. 2021). Evidence indicates that exclusion is often driven not by individual-level capacity per se, but by recruitment procedures and information materials that are insufficiently adapted to cognitive and communication needs (McDonald et al. 2024).

Given the heterogeneity of functional abilities within this population, randomization may result in imbalanced groups in small samples if such variation is not adequately addressed. While some studies have attempted to adapt eligibility criteria or apply stratified randomization, these approaches are inconsistently used and poorly reported (Mulhall et al. 2018, 2021). Without careful attention to these issues, randomization may compromise both internal validity and the inclusivity of trials involving people with intellectual disabilities.

2.2 | Control

A strength of RCTs is their ability to reduce bias by controlling the influence of confounding variables (Bhide et al. 2018). In studies involving people with intellectual disabilities, however, such control is difficult because participants often share staff, services, and everyday environments. Under these conditions, contamination may occur, as information or practices may spread between study arms, thereby undermining internal validity. To reduce this risk of contamination, cluster-randomized designs, randomizing services or settings rather than individuals, are often used in trials conducted in service- and community-based contexts (Easter et al. 2021). Maintaining separation between groups is especially difficult in supported housing, where participants and support networks often interact across trial arms. For this reason, cluster-randomized designs based on natural settings, such as special schools or service homes, may be used to reduce cross-condition communication. Although effective, these designs introduce additional challenges, including intraclass correlation and increased sample size requirements.

In addition to contamination, variability in how support staff assist participants can also affect control. Differences in staff training, experience, workload, and availability influence how intervention procedures are delivered and maintained, potentially introducing variance unrelated to the intervention. Allocating sufficient time and flexibility to support meaningful participation is often necessary in trials involving people with intellectual disabilities, but this must be carefully balanced against the need for standardization and methodological rigor within RCT standards. While flexibility in how carers and staff support participation is often necessary to enable engagement and sustained participation, such individual tailoring may also introduce additional variability, challenging standardization and control within RCT protocols. Staff turnover and organizational instability further disrupt continuity and may affect adherence, follow-up assessments, and procedural consistency (Mulhall et al. 2021). These contextual factors must be anticipated during trial planning, for example through clear training procedures, structured communication routines, and mechanisms for maintaining continuity among key personnel.

Carers and staff often act as intermediaries, and limited familiarity with RCT concepts, particularly the purpose of control groups, can lead to miscommunication or reluctance to support study procedures, underscoring the need for training (Mulhall

et al. 2021). Strengthening understanding among support networks is therefore essential for maintaining procedural consistency and reducing sources of uncontrolled variance. Staff turnover and organizational instability are also frequently reported sources of data loss.

2.3 | Trial

A core element of RCT design is the delivery of a clearly specified intervention according to protocol, using appropriate outcome measures and analytical methods. In trials involving people with intellectual disabilities, this creates two recurring methodological challenges: maintaining intervention fidelity in the presence of variable support arrangements, and generating valid and reliable outcome data across diverse cognitive and communication profiles (Mulhall et al. 2018).

Interventions developed for people with intellectual disabilities often require adaptation to match participants' abilities and support needs (Mulhall et al. 2018). Common adaptations include simplifying language, using visual formats, adjusting session length or delivery mode, and involving carers or staff. However, these adaptations and their implications for fidelity are frequently insufficiently documented, limiting transparency and reproducibility. In addition, trial timelines may disadvantage participants with intellectual disabilities, as consent procedures, relationship-building, and iterative refinement of materials often require more time than conventional project periods allow (Mulhall et al. 2018). Short funding time frames may therefore function as a structural barrier, as they rarely accommodate the extended time required to build relationships, support recruitment, and clarify and enable necessary adaptations in trials involving people with intellectual disabilities.

Selecting outcome measures is another persistent challenge. Many standard instruments are seldom developed or validated for people with intellectual disabilities, and measurement procedures may be too cognitively demanding, leading researchers to modify tools or use proxy ratings. Without clear reporting and psychometric justification, such approaches risk compromising validity (Mulhall et al. 2018). A recent systematic review confirms that adaptations of self-report measures are inconsistently reported and that psychometric evaluation is often limited (Kooijmans et al. 2022).

Retention and missing data further complicate trial conduct in research involving people with intellectual disabilities. Attrition, incomplete follow-up, and variability in support over time can reduce data completeness and weaken confidence in trial findings (Mulhall et al. 2018). From a trial planning perspective, anticipated attrition should be considered in sample size planning, for example through over-recruitment, as illustrated in large longitudinal studies (Kearney et al. 2011). Failure to plan for attrition risks underpowered analyses despite successful initial recruitment. Addressing these issues requires proactive planning and transparent reporting of adherence, protocol deviations, and missing data, alongside clear description of the practical conditions under which the trial was delivered (Mulhall et al. 2018).

3 | Refining RCT Methods: Empirical Lessons From the I DID IT Research Program

Building on the methodological and practical challenges outlined in Section 2, this section presents empirical lessons from practice that have informed the design of recruitment, retention, and engagement strategies during the preparatory phase of our forthcoming RCT involving young people with intellectual disabilities. These lessons are primarily drawn from the I DID IT research program, which serves as the main empirical context for the examples presented below. Drawing on clinical and research experience and supported by relevant literature, it illustrates how foundational conditions for randomization, control, and trial procedures were and will be considered and addressed in research practice. While the focus is on people with intellectual disabilities, several insights may also be relevant for other populations with cognitive impairments and similar requirements for tailored support, accessible communication, and contextual adaptation.

3.1 | Relational and Organizational Conditions Supporting Recruitment, Randomization, and Control

It is well known that effective recruitment and sustained participation in RCTs involving young people with intellectual disabilities are strongly shaped by relational and organizational conditions. Therefore, engagement with stakeholders across healthcare, social services, municipal organizations, disability organizations, and families was essential in our project for establishing feasible recruitment pathways and creating conditions for representative sampling. Close and continuous collaboration helped foster trust, clarify expectations, and strengthen recruitment networks, aligning with evidence highlighting stakeholder engagement as central to recruitment and retention in trials (Bower et al. 2014; Treweek et al. 2018).

We assembled a research team including academic researchers and key stakeholders from healthcare, social services, municipalities, disability organizations, and young people with intellectual disabilities and their families. An important aspect of this collaboration was explicitly recognizing and valuing the unique expertise that each group brought to the project, including professional knowledge, lived experience, and insights into the local context.

Access to potential participants was typically mediated through gatekeepers, such as support staff, family members, and service managers; individuals who control access to research participation opportunities and can both facilitate and constrain participation. Consistent with previous research, gatekeeping reflected not only concerns about time, responsibility, and ethical boundaries but also broader attitudinal and informational drivers, e.g., mistrust of research, deprioritization of research activities, presumed incapacity of individuals with intellectual disabilities, and lack of information or resources, rather than the preferences or motivation of the individuals themselves (Brodeur et al. 2025; Mulhall et al. 2021). To address these challenges, early and ongoing dialog with services focused on clarifying study aims, consent procedures, expected time commitments, and available

support. To support understanding and continuity, we used tailored materials (e.g., simplified summaries and short videos) and established designated contact persons within services to coordinate recruitment and communication in collaboration with the research team. These efforts were associated with improved engagement in co-design activities, which may indicate that addressing gatekeeping early can facilitate recruitment in subsequent trial phases. Although resource-intensive, these efforts were critical for building trust and sustaining engagement over time, echoing findings that transparent communication and organizational support are central to inclusive trial conduct (Natale et al. 2021).

3.2 | Co-Designing the Intervention and Trial Procedures

A contributing factor to why health promotion interventions may be less effective for individuals with intellectual disabilities is that they are not always designed to reflect what is meaningful to them, potentially limiting both relevance and impact (Maine et al. 2020). Inclusive research involving end users is therefore essential, particularly for interventions targeting health behaviors (Natale et al. 2021). In contrast to traditional user-centered approaches, co-design actively involves end users and other stakeholders throughout the research process, allowing intervention content, procedures, and communication to be shaped by lived experience and support contexts (Sanders and Stappers 2008, 2014), as well as by structured frameworks for participation in design processes with people with disabilities (Johansson et al. 2023).

In this project, co-design informed multiple aspects of the study design and trial procedures, including intervention development and accessibility adaptations, recruitment and information materials, consent procedures, tailored communication strategies, and the refinement of trial procedures and data collection routines to support participation over time. To ensure transparency and provide a systematic account of the methodological choices guiding this work, a study protocol was published early in the program describing the co-design methodology, workshop structure, and planned procedures for developing the digital intervention (Müssener et al. 2023).

When starting our empirical work, the first step was to ensure that the digital intervention was designed so that content, structure, and language aligned with the intended users, in line with evidence showing that limited adaptation can reduce sample diversity and contribute to recruitment difficulties, misunderstandings, or early dropout, which in turn may compromise the ability to randomize a sufficiently diverse and representative sample, a cornerstone of RCT validity (Kooijmans et al. 2022; Mulhall et al. 2018). Workshops with young people with intellectual disabilities, relatives, professionals, designers, and researchers supported the identification of accessibility needs, motivational factors, and practical considerations relevant to digital health promotion. These processes contributed to adaptations such as simplified language, enhanced visual support, and clearer navigation structures, as described in a previous co-design study within the research program (Nilsson et al. 2025). Co-design also played an important role in refining communication strategies, with accessible information formats complemented by ongoing dialog tailored to different communication needs, and attention to relational and contextual aspects of participation, thereby supporting the identification of potential barriers to recruitment and participation and strengthening understanding of study procedures and expectations. This approach aligns with evidence showing that adaptations to information and consent processes must extend beyond simplified formats to include relational and contextual support (Kooijmans et al. 2022). Participation in the co-design process also appeared to hold intrinsic value for young people with intellectual disabilities and their families. Involvement itself was, in participants' reflections, described as enjoyable, meaningful, and motivating. To support trust and equitable participation, several workshops incorporated informal elements, such as shared meals at the start of sessions. We believe these moments helped reduce hierarchical distance and facilitated participation in ways that felt familiar and accessible.

Pilot and feasibility work is essential when planning RCTs involving young people with intellectual disabilities, given well-documented challenges related to recruitment, consent, stakeholder engagement, accessibility, and continuity of support. Many of these challenges can be mitigated through context-sensitive adaptations best identified during feasibility studies (Mulhall et al. 2018, 2021). In line with this, a single-arm pilot and feasibility study will be conducted in which co-design continues to guide refinement of recruitment materials, consent procedures, data collection routines, and intervention delivery. This will allow barriers to be identified early, improve contextual fit, and support progression to a full RCT that is both methodologically robust and practically deliverable, including the capacity to retain participants across follow-up.

3.3 | Practical Strategies for Participation, Retention, and Trial Conduct

Sustaining participation over time requires practical strategies to support engagement, minimize burden, and address barriers to retention. Based on our preparatory work and practical experience, respect for participants' time, effort, and lived experience guided the provision of flexible scheduling, clear communication, and practical support, consistent with evidence emphasizing the importance of reducing burden and supporting participation in trials (Natale et al. 2021). Attention to these factors was particularly important given the reliance on support networks and the additional time required for communication and decision-making. Communication and support strategies were therefore planned to acknowledge carers' and/or support persons' time constraints and differing levels of digital familiarity, with the aim of reducing burden and supporting sustained participation over time. Further, a collaboration group has also been established containing representatives from the research team, interest organizations, and the social services where the research will be conducted, in order to keep stakeholders involved for participation.

Adequate resourcing was central to enabling inclusive trial conduct. A central strategy in this research program was therefore to secure external funding, explicitly recognizing that inclusive

RCTs involving people with intellectual disabilities are substantially more time- and resource-intensive than conventional trials. Long-term external funding has been secured to support the planned RCT. While not all requested funding was obtained, the study can be carried out as planned, although further development will require additional resources. Recruitment and retention activities were explicitly budgeted for, including staff time, participant compensation, travel support, and necessary accommodations. Previous research shows that such costs are frequently underestimated, despite their importance for effective recruitment and sustained engagement (Bower et al. 2014). Evidence also indicates that modest financial compensation can improve response and consent rates, although ethical considerations regarding incentives require careful reflection (Abdelazeem et al. 2022). Within our study design, compensation is framed as recognition of participants' contributions rather than as an inducement. Participation in the study closely resembles paid work, and everybody, including individuals with intellectual disabilities, received hourly compensation to ensure fair conditions during the co-design work, combined with ongoing communication and support.

Transparent reporting of recruitment processes, retention strategies, and anticipated challenges is essential for advancing inclusive RCT methodology. In the present paper, we have sought to explicitly describe central aspects such as recruitment pathways, adaptations to materials and procedures, retention strategies, and contextual conditions anticipated to influence trial conduct. In line with previous research, we have addressed these practical and methodological considerations explicitly during the design phase of the trial, because such reflection can strengthen the evidence base, support replication, and illuminate the conditions under which trials involving people with intellectual disabilities can be conducted in ways that are both methodologically sound and ethically meaningful (Mulhall et al. 2018).

3.4 | Ethical Reflections

Conducting an RCT with young people with intellectual disabilities involves several ethical dimensions that require continuous attention throughout the research process. There are ethical implications of not conducting robust intervention studies in this field: when evidence is weak or absent, young people with intellectual disabilities risk being excluded from effective health promotion. From this perspective, investing in time- and resource-intensive adaptations and relational support is not only methodologically necessary but ethically justified, as it helps ensure equitable opportunities to benefit from evidence-based interventions.

In our project, ethical considerations were closely tied to how participation was understood and enacted in practice, rather than treated as a separate procedural component. Ethical attention centered on enabling equitable access and meaningful participation, including creating conditions in which participants felt safe to express their views and perceived that their contributions could influence the research process. Clear agreements regarding participation, including opportunities to withdraw, disengage, or adjust levels of involvement over time, were considered essential to reduce feelings of obligation, dependency, or uncertainty about participants' roles. Ethics thus emerged as relational and ongoing, shaped by trust, transparency, and the negotiation of roles and expectations among participants, families, support staff, and researchers.

These insights are consistent with previous systematic reviews, which describe ethical considerations in research involving people with intellectual disabilities as relational, process-oriented, and embedded in everyday research practices rather than confined to formal approval procedures or isolated consent events (Di Lorito et al. 2018; Hewitt et al. 2023). A recent systematic review further emphasizes the importance of ongoing ethical negotiation, supported decision-making, and the balancing of protection and participation across all stages of the research process (McDonald et al. 2024). By explicitly addressing these ethical dimensions in the design and preparation of an RCT, the present study aligns with and extends existing knowledge, contributing practical insight into how relational ethics can be operationalized within methodologically rigorous intervention research.

4 | Implications for Research and Practice

This paper demonstrates how methodological challenges commonly reported in RCTs involving young people with intellectual disabilities can be addressed through deliberate and systematic design choices made prior to trial initiation. By explicitly reflecting on recruitment pathways, retention strategies, organizational conditions, co-design processes, and ethical considerations, the paper illustrates how inclusive trial conduct can be strengthened while maintaining methodological rigor. These insights are relevant for researchers conducting or planning inclusive RCTs involving people with intellectual disabilities, as well as for funders, commissioners, clinicians, service providers, and other stakeholders involved in the design and delivery of such trials.

For research, the findings highlight the value of approaching recruitment, engagement, retention, and ethics as interrelated aspects of trial methodology rather than as isolated procedural steps. Early attention to stakeholder collaboration, accessible communication, contextual adaptation, and adequate resourcing can improve feasibility, support more representative sampling, and strengthen trial integrity. Transparent reporting of these design considerations contributes to a more practice-relevant evidence base for trials involving people with intellectual disabilities.

For practice, the study illustrates how trials can be organized in ways that support meaningful participation within the relational and organizational contexts in which young people with intellectual disabilities live and receive support. Integrating co-design, recognizing participants' contributions, and planning for tailored support and continuity may help build trust and sustain engagement over time. Together, these implications support the development of trials that are both scientifically robust and ethically grounded, and that better reflect the realities of conducting research to improve health within populations that have historically been underrepresented. The findings also highlight

the importance of supportive organizational conditions, early collaboration, and accessible communication to facilitate participation and reduce gatekeeping barriers.

These findings demonstrate that, despite existing challenges, inclusive RCTs can be designed and conducted in ways that are both feasible and methodologically robust, representing an important step toward more equitable and evidence-based health promotion for people with intellectual disabilities.

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Ethics Statement

The authors have nothing to report.

Consent

The authors have nothing to report.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Data sharing not applicable to this article as no datasets were generated or analysed during the current study.

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