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# Best practice when working therapeutically with people with learning disabilities: A brief review

## Accessible summary


- There are different ways of helping people who experience mental health problems. Psychologists need to know the best ways of working with people with learning disabilities who have mental health problems.
- To help psychologists know what works best, this paper has a summary of what we know about how to work with people with learning disabilities.
- It tells us what sort of changes psychologists may need to make to best support people with learning disabilities with mental health problems.
- This paper will be helpful to psychologists work in learning disability services, especially those who are new to working with people with learning disabilities.


## Introduction

There is an increased prevalence of psychological distress among people with learning disabilities compared with the general population (Emerson & Baines, 2011). Subsequently, they are more likely to require support from psychologists (BPS, 2012). Although people with learning disabilities may have multiple psychological difficulties (Pateraki & Macmahon, 2016), they have historically been overlooked or excluded from psychological interventions (Beail, 2016), which has a distressing impact on the individual (BPS, 2011). In accordance with professional training requirements, psychologists are expected to offer evidence-based interventions (BPS, 2019). However, while guidance from the National Institute for Health and Clinical Excellence (NICE) recommends treatment for specific mental health diagnoses, guidelines do not readily include considerations when working with individuals with learning disabilities. Instead, psychologists are expected to adapt mainstream treatment protocols, if appropriate, to ensure they meet individuals' communicative and cognitive capabilities (BPS, 2012), without clear instruction on how to do so. It would, therefore, be useful to identify best practice for working therapeutically with people with learning disabilities. This review aims to summarise recommended guidance and adaptations for working psychologically

with people with mild to moderate learning disabilities who can access psychological interventions, and hopes to provide a useful resource to psychologists who are new to working with people with learning disabilities, such as assistant psychologists and trainee clinical psychologists.

*Accessing mental health services*

Public policy recommends that people with learning disabilities access mainstream mental health services in the first instance (Irvine & Beail, 2016), but uptake remains low compared with the general population. Marwood, Chinn, Gannon & Scior (2016) suggest that mainstream stepped-care models like 'Improving Access to Psychological Therapies' (IAPT) are often a poor fit for individuals with a learning disability, with therapists identifying the need for additional training in adapting evidence-based interventions (Shankland & Dagnan, 2015). IAPT have, however, identified in the '*Learning disabilities: Positive practice guide*' that staff can offer good care, particularly in supporting people with anxiety and depression, when reasonable adjustments are made (Dagnan, Birke, Davies & Chinne, 2015). For example, this might include allowing more time to ask questions and complete forms, making information easy to understand, and allowing friends, family or support staff to join therapy sessions. Despite recommendations being in place, individuals with learning disabilities often encounter barriers to accessing services, which remain unaddressed (Chinn, Abraham, Burke & Davis, 2014). Martin (2001) suggests that barriers relate to access, advocacy and communication issues, which may be at individual, organisational and structural levels (Chinn & Abraham, 2016). The Government's '*Valuing people*' White Paper (DoH, 2001) recognises the inconsistency in service delivery (DoH, 2009; Emerson, Baines, Allerton & Welch, 2011), and acknowledges that people with learning disabilities continue to encounter unacceptable health inequalities (Turner, 2011). However, the White Paper fails to offer any recommended means of identifying and treating mental health issues in individuals with learning disabilities (Martin, 2001). Until relatively recently, guidelines on recommended treatment have been sparse, thereby placing responsibility on individual clinicians to adapt therapeutic interventions to best meet the needs of people with learning disabilities.

*Recommended guidelines*

NICE (2017) provides a quality standard for the management of mental health issues in people with learning disabilities, stating that quality care involves: (i) an annual review of mental health problems; (ii) referral to a mental health professional if an assessment is required; (iii) access to a key worker for those experiencing serious mental illnesses; (iv) psychological interventions that are tailored to individual preferences, strengths, needs and cognitive ability; and (v) an annual review if the individual is taking antipsychotic drugs. Clinicians adhering to this quality standard are therefore expected to deliver person-centred tailored interventions but need to consult NICE guidelines to establish what evidence-based interventions are recommended for people with learning disabilities.

NICE (2018a) offers general guidance on psychological interventions for individuals with learning disabilities and mental health problems. It suggests following mainstream NICE guidance on specific mental health problems whilst bearing in mind the principles for delivering psychological interventions and adapted interventions to people with learning disabilities. These include attending to individual preferences; considering physical, cognitive, communication and neurological needs; respecting privacy; and agreeing the preferred mode of delivery. Clinicians are therefore expected to adapt interventions that are recommended for the general population, but these may not always be appropriate for individuals with learning disabilities (RCP, 2008).

There are three specific interventions recommended by NICE (2018a) that have been adapted for people with learning disabilities, including: (i) adapted CBT for depression in people with mild learning disabilities, (ii) relaxation therapy to treat anxiety symptoms, and (iii) graded exposure to treat phobias or anxiety symptoms. Pateraki & Macmahon (2016) do, however, warn against rigidly adopting clinical guidelines, which may restrict opportunities for person-centred integrative practice. Meanwhile, NICE (2018b) offers guidance for the treatment of people with learning disabilities with behaviour that challenges, suggesting that specialist support should be given through community LD teams in order to meet mental health, social, communication, and behavioural needs. Aside from these four recommendations, other mental health conditions are not

mentioned; perhaps as a result of critical reviews of psychotherapeutic interventions failing to reference individuals with learning disabilities (Irvine & Beail, 2016). In the absence of further guidance, it would be useful to assess what the literature states about adapting therapeutic work for people with learning disabilities.

*Recommended adaptations*

Prior to the BPS' publication on 'Psychological therapies and people who have intellectual disabilities' (Beail, 2016), psychologists in LD services would have needed to undertake extensive literature searches to assess the evidence base for using or adapting different therapeutic approaches with people with learning disabilities. This publication covers a range of approaches, including but not limited to: psychodynamic psychotherapy, cognitive behavioural therapy (CBT), cognitive analytic therapy (CAT), mindfulness and acceptance based therapies etc. This publication provided the initial information for this review, however, wider sources were drawn on for additional approaches that were not included in Beail's (2016) publication. For example, attachment-based therapies, compassion focused therapy (CFT), dementia, eye movement desensitisation and reprocessing (EMDR), and positive behaviour support. Literature from BPS reviews, BPS position statements, a BPS conference presentation, peer-reviewed publications and NICE guidance was searched to ascertain the key considerations and recommended adaptations for each therapeutic approach. These are summarised in Table 1.

**Table 1: Overview of recommended adaptations and considerations for therapeutic interventions for people with learning disabilities**

| **Intervention** | **Source** [source type] | **Key considerations** | **Key adaptations** |
|---|---|---|---|
| **Arts therapies**<br><br>(including Art, Drama and Music Therapy) | Hackett, Rothwell, Lyle, Bourne, Downing & Morison (2016)<br><br>*[BPS review]* | • Use flexible, adaptable and individualised approach.<br>• Music is suitable for those with difficulties with verbal communication. | • Use picture symbols and communication aids.<br>• Involve support network.<br>• Use reminders re: boundaries. |

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| **Attachment based therapies** | BPS (2017)<br><br>*[BPS guidance]* | • Attachment studies on non-LD populations may not be generalizable to wider LD population.<br>• Consider impact of LD on development of attachment relationships.<br>• Consider individual's experience of secure base in context of LD. | • May need multiple sources of information during assessment.<br>• Interventions need to consider the number and quality of beginnings and endings e.g. placements. |
| **Cognitive Analytic Therapy (CAT)** | Beard, Greenhill & Lloyd (2016)<br><br>*[BPS review]* | • Consider using DVD of people with learning disabilities asking therapists questions to engage in therapy.<br>• Consider reciprocal roles in context of dependency.<br>• Consider Zone of Proximal Development of people with learning disabilities.<br>• Contextual reformulation working with staff teams and/or alternative framework for understanding behaviours that challenge. | • Increase length & frequency of sessions (24-32).<br>• Verbally simplify the psychotherapy file.<br>• Use symbols of dilemmas and traps.<br>• Draw reciprocal roles and interpersonal patterns.<br>• Stress recognition over revision goal.<br>• Use visual tracker to prepare for ending therapy.<br>• Use clear language in goodbye letters. |
| **Cognitive Behavioural Therapy (CBT)** | Jahoda (2016)<br><br>*[BPS review]*<br><br>[See also Surley & Dagnan (2017) for a review of adaptations] | • Do not assume emotional difficulties are caused by cognitive deficits thus require problem-solving or assertiveness training.<br>• Take account of wider context, explicitly address self-efficacy in relation to therapeutic change.<br>• Self-monitoring relies on literacy skill to complete diaries. | • Avoid reliance on memory – use aides such as flip chart to set agenda; may require slower pace; consider ability to generalise learning outside of sessions.<br>• Involve significant others in homework to achieve real life change. |
| **Compassion Focused Therapy (CFT)** | Cooper & Frearson (2017)<br><br>*[Published case study]* | • Consider asking people with learning disabilities to frequently summarise to check understanding.<br>• Consider reducing depth and complexity of psychoeducation around CFT concepts. | • Use colourful, visual diagrams.<br>• Repeat verbal summaries.<br>• Reduce speed and content of sessions.<br>• Use visual prompts given as homework to build a physical "toolbox" of strategies. |
| **Dementia framework for psychological therapies** | Kalsy-Lillico et al. (2012) cited in DCP (2015) | • Use a tailored approach for each individual. | • Simplify multi-step activities/skills.<br>• Use range of prompts to aid communication. |

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| | *[BPS guidance]* | • Consider level of demand and match with current capacities.<br>• Capitalise on individual's strengths. | • Modify environment to compensate for deficits. |
| **Dialectical Behavioural Therapy (DBT)** | Lippold (2016)<br><br>*[BPS review]*<br><br>NICE (2009) | • Comorbid mild LD and BPD should access same services as others with BPD.<br>• Consider renaming skills training modules.<br>• Emphasise practical mindfulness exercise | • Shorten group from 2.5 to 2 hours.<br>• Use pictures in diary cards.<br>• Increase use of role-play.<br>• Use visual presentation of materials.<br>• Check for understanding. |
| **Eye Movement Desensitisation and Reprocessing (EMDR)** | Porter (n.d.)<br><br>*[BPS conference]* | • Need to attend to process issues (including avoidance, anxiety, timing and systems).<br>• Consider splitting trauma into smaller components.<br>• Use auditory stimulation. | • Adapt language used.<br>• Simplify SUDS.<br>• Use main body parts (avoid abstract concepts).<br>• More verbal input from therapist. |
| **Group interventions** | Rossiter, Heneage, Gregory & Williams (2016)<br><br>*[BPS review]* | • Pitch at developmental level<br>• Consider using flexible methods.<br>• Use creativity to engage. | • Simplify content.<br>• Adapt language.<br>• Involve caregivers.<br>• Use visual materials.<br>• Use concrete objects. |
| **Mindfulness and Acceptance Based Therapies** | Gore & Hastings (2016)<br><br>*[BPS review]* | • Experiential exercises rely less on verbal reasoning and power differences are minimised in this approach.<br>• Orient to structure and body sensations in initial sessions.<br>• Graded physical prompts may be needed, e.g. blowing bubbles for mindful breathing. | • Take time to create a safe and supportive context.<br>• Allow additional time/breaks to process ideas and practice skills<br>• Language should be simple, brief and clear, and minimise abstract language (e.g. focus on primary body regions).<br>• Provide adapted leaflets/CDs if required |
| **Positive Behaviour Support (PBS)** | BPS (2018)<br><br>*[BPS position statement]*<br><br>NICE (2015)<br><br>*[NICE guidance]* | • There is evidence for the following components:<br>• Functional assessment;<br>• Personalised intervention based on behavioural principles;<br>• Psychological interventions prior to antipsychotic medication;<br>• Training for staff providing direct support in proactive interventions in | • Family, developmental and environmental factors need to be considered during initial assessment prior to functional assessment.<br>• Focus on social values and rights of people with learning disabilities. |

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| | | conjunction with high-quality supervision;<br>• Use of routine outcome measures and periodic monitoring. | |
| **Psychodynamic Psychotherapy** | Beail (2016)<br><br>*[BPS review]* | • Identify non-verbal communication.<br>• Consider different levels of interpretation. | • Suggest words for actions or feelings.<br>• Use alternative means of communication.<br>• Bring back to reality if client acts out. |
| **Solution-Focused Brief Therapy (SFBT)** | Lloyd, Macdonald & Wilson (2016)<br><br>*[BPS review]* | • SFBT can be taught to staff to change interaction styles, e.g. coaching staff in a care home).<br>• Consider taking a 'one down' position of curiosity to collaborate rather than direct.<br>• Use client resources over technique (Raffensperger, 2009).<br>• Stress strengths, resilience and compliments.<br>• Hypothetical future (abstract concept) can be challenging for those with LD and ASD. | • Work 'by proxy' with carers if person is not able to engage in therapy (i.e. solution-focused consultation).<br>• Use shorter sentences, commonly used words, visual materials and cues (e.g. sand timer) to show time.<br>• Reduce rating scales (e.g. 10 to 3-pont) (Stoddart et al., 2001).<br>• Avoid term 'homework' as it may have negative connotations for people with learning disabilities. |
| **Systemic Psychotherapy** | Baum & Lynggaard (2016)<br><br>*[BPS review]* | • To create space where all voices are heard, adaptations may include:<br>• Think about acting on feedback and regularly check understanding.<br>• Consider enlisting support and advice of people who know the person.<br>• Think about limiting comments from the reflecting team. | • Use simplified language and concepts.<br>• Avoid jargon.<br>• Slow the pace.<br>• Use pictures and objects to augment understanding.<br>• Invite people to stand in e.g. if the person could not speak, ask 'what would they say?' |

## Summary

This brief review sought to summarise what is written in the literature regarding best practice for working with people with learning disabilities. Policy guidance and psychological literature recognised the increased prevalence of psychological distress among individuals with learning disabilities, whilst also acknowledging the additional

difficulties in accessing mental health services. The evidence base is relatively sparse, comprising general guidance on the management of mental health issues for people with learning disabilities, and recommendations to follow mainstream guidance on specific mental health problems, whilst considering the principles of working with people with learning disabilities. There are limited recommendations from NICE specifically for this population, aside from CBT for people with mild learning disabilities, relaxation therapy for anxiety, and graded exposure for phobias or anxiety symptoms.

The literature recommends a broad range of adaptations that can be made when working with individuals with learning disabilities, which will undoubtedly be familiar to those working in learning disability services but may serve as a useful resource for trainee psychologists or others starting work in this area. Although the specific needs and strengths of service-users will vary, broad recommendations include:

- Offering individualised approaches
- Being flexible and adaptable
- Challenging one's own assumptions about the individual's capabilities
- Adjusting the speed and content of sessions and allowing additional breaks if required
- Using clear language, avoiding multi-step instructions, minimising abstract language
- Avoiding terms that may have negative connotations, such as 'homework'
- Avoiding reliance on memory and frequently checking for understanding
- Using visual aids and prompts, such as suggestions for feelings
- Involving others, including caregivers, where appropriate
- Adapting written information, such as service leaflets and letters
- Highlighting strengths and resilience.

This review has highlighted issues faced by psychologists working in learning disability services, associated with limited evidence-based guidance and the onus placed on psychologists to adapt existing models to best meet the needs of service-users. It also highlights some of the barriers faced by people with learning disabilities that need to be navigated. It is hoped that this review serves as a useful summary resource to psychologists working in LD services, particularly for those who are new to working with people with learning disabilities.

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