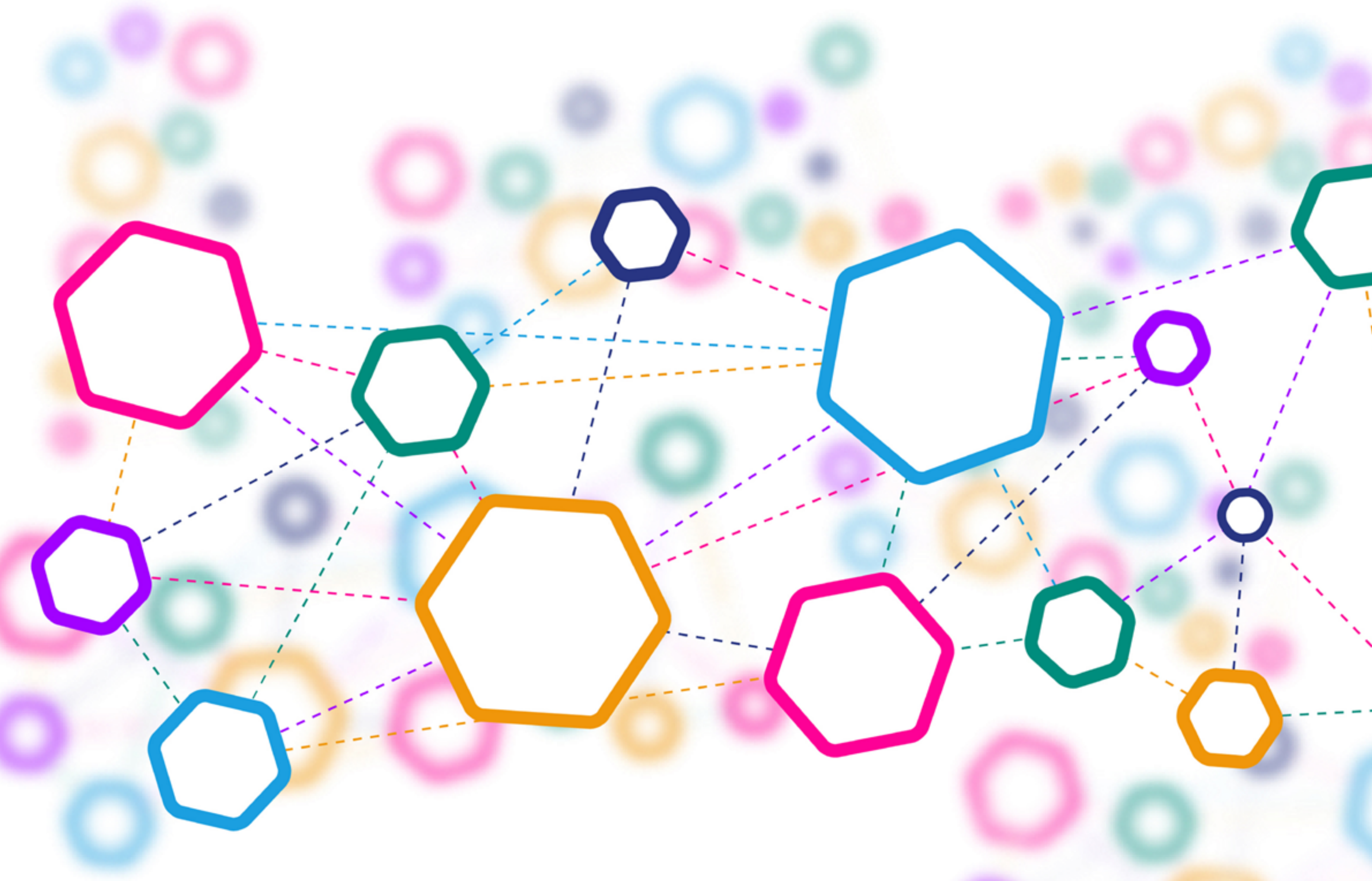
Matrics Learning Disability

Guidance for the Delivery of Psychological Interventions for Children, Young People and Adults with a Learning Disability in Wales.

April 2025



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Overarching guiding principles

To ensure the voice of people with a learning disability were central to the development of this guidance, Mencap Cymru supported Improvement Cymru with the co-design of principles to guide psychological interventions for individuals with a learning disability.

The principles have been developed in partnership with individuals with a learning disability, parents and others across Wales, through a series of focus groups and qualitative interviews.

The following five principles were informed by the themes identified:

1. Agency

Individuals with a learning disability need to feel a sense of control over the way in which psychological interventions are explained and conducted – the 'process.' In practice this means fostering open and transparent communication, allowing people to progress at a pace that is comfortable for them and supporting individuals to understand the process in order to play an active part in finding solutions.

2. Inclusive

Person-centered practice requires that psychological interventions are adjusted to best meet the needs of an individual. In practice this requires practitioners to modify their approach, explore visual alternatives to communication, create familiar and safe environments, and work together to embed concepts.

3. Relational

Building a relationship and fostering trust are central to the whole process; practitioners will need to create opportunities for connection at a pace that meets the needs of individuals with a learning disability.

4. Collaborative

Adopt a collaborative approach to psychological intervention, which acknowledges the central role and contribution of families and others who are important to the individual. In practice, this requires practitioners to be curious and consult with others around the individual's context and potential solutions.

5. Compassionate

Ensure the 'system' as a whole role models compassion for individuals, families and important others; there is often a general distrust around the mental health system and its ability to meet the needs of individuals with a learning disability.

In other words:

1. People with a learning disability must be treated as an equal when it comes to arranging support to understand their emotions and behaviours. This means communicating with us in an accessible way, allowing us to go as fast or slow as we want, and letting us be part of making decisions about the therapy.[1]

2. What works for some people may not work for people with a learning disability. You might need to change how you think, which includes how you communicate, and the space we meet. You need to work with us to make sure we fully understand how we are going to work together.

3. We can't just trust someone because they are a practitioner. We need to get to know you, this might take a little time, but this is really important to us. It will be hard for us to share things with you if we don't know you.

4. Our families and some other people are an important part of our lives. They can have an important part to play in our therapy. You will need to be interested and talk to our families and/or people we are close to, to have a better understanding of us, and what might work.

5. Taking part in therapy is a big decision for us. We need you to treat us with care and understanding. We are not just what is written about us. We don't always trust that people in power listen to us.

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[1] We have used the word therapy to describe a broad range of psychological interventions

Section 1: Introduction and Context

1.1 How to use this guidance

Matrics Cymru and Matrics Plant provide broad guidance in relation to the delivery of psychological interventions for children, young people and adults in Wales. Whilst there are common principles underlying the presentation of psychological distress, and the delivery of psychological interventions to individuals and families, there are often significant differences in the way that psychological distress presents in people with a learning disability, and in the way that psychological interventions need to be delivered.

This guidance has been designed for practitioners, managers and planners working into health, social care and third sector organisations. Its purpose is to assist in the development and delivery of a Wales-wide approach to providing psychological and psychologically-minded services to children, young people and adults with a learning disability and their families. It takes a lifespan approach across all transition points in a holistic way, to recognise the whole story of people with a learning disability, their families and support structures.

It is intended to cover those people with a learning disability who have co-existing conditions such as being autistic (around 20-30% of people with a learning disability are autistic; Emerson and Baines, 2010). This document does not cover guidance for people who are autistic or have developmental conditions and do not have a learning disability.

It is anticipated that practitioners using this guidance will have a good knowledge of psychological therapies and interventions but may wish to receive further guidance about the adjustments and contextual factors needed to ensure effectiveness when working with people with a learning disability and their support networks.

It also draws attention to the use of psychological interventions not currently referenced in Matrics Cymru/Plant Evidence tables which practitioners and therapists working with people with a learning disability and their support networks use and draw upon in their practice. It is intended that future tables will be inclusive of people with a learning disability.

The reading of the guidance in its entirety is encouraged but it is acknowledged that people may wish to access specific information at specific times.

- **Section 1** outlines the principles, context, and legal frameworks relevant to working with people with a learning disability and sets the frame for the delivery of psychological interventions.
- **Section 2** considers the social, cultural, and political context to the history and lived experience of people with a learning disability and their families, which is a vital part of the story in which people and their families arrive to services.
- **Section 3** outlines the key principles and approaches to the delivery of psychological interventions which underpins all psychological work and makes reference to how this is applied to people with a learning disabilitiy.

- **Section 4** considers what general and specific adaptions can be made to psychological therapies and interventions, whether direct or indirect, to make them most effective and meaningful in supporting people with a learning disability. This section draws on a rapid review of evidence from research studies and from practice-based experience from practitioners experienced in working with people with a learning disability, who were consulted as part of this guidance.
- **Section 5** gives a descriptive overview of direct and indirect psychological interventions that have been adapted and applied for children and adults with a learning disability.
- **Section 6** highlights the role of supervision and reflective practice in relation to working with people with a learning disability.
- **Section 7** outlines considerations related to outcome measures.

1.2 Organising principles

It is recognised that children, young people, and adults with a learning disability:

- are individuals with their own unique personality and preferences
- live in their own specific circumstances
- have their own unique developmental needs and individual strengths and challenges
- will differ in their ability to manage and make decisions about varying aspects of their life
- will differ in their ability to describe their mental health experiences and seek support
- face barriers to participating in society which can lead to inequality and discrimination
- are likely to experience higher levels of traumatic experiences than the general population
- are more likely to experience mental health difficulties
- should receive appropriate and proportional psychological services, based on the level of distress/need, rather than their diagnosis
- may be best helped by people that they know well and spend time with, rather than receiving support from professionals on a one-to-one basis

1.3 Legal and strategic context

Wales has a diverse range of people and cultures. In designing services to meet the needs of the whole population, health board planners are required to adhere to the Equality Act (2010) which specifies the protected characteristics as; age, race, gender reassignment, disability (defined to include a "mental impairment that has a substantial and long-term negative effect"), marriage and civil partnership, pregnancy and maternity, religion and belief, sex and sexual orientation. Welsh statutory services hold the Public Sector Equality Duty (PSED), which supports work to eliminate unlawful discrimination, promote equality, and foster good relations. This includes making "reasonable adjustments" to ensure people with a learning disability receive equitable access to services. Welsh policy and legislation is also committed to its legal obligation to respect, protect and fulfil human rights and within this context its international obligations under both the Convention on the Rights of Persons with Disabilities and the United Nations Convention on the Rights of the Child.

This document is produced in the context of the Welsh Government Learning Disability Strategy which supports services to be aware of mental health difficulties in children, young people and adults with a learning disability, and make reasonable adjustments to service provision. In line with the Social Services and Well-being (Wales) Act (Welsh Government, 2014) and the work of the Disability Rights Taskforce, this document will emphasise that integration and partnership working is essential to appropriately support people with a learning disability.

The Nest/Nyth framework produced by Welsh Government (2023) highlights themes, principles and values to consider when delivering psychological interventions for all children and families, and is particularly relevant for those with a learning disability. The framework recognises the importance of those closest to the child, the educational setting and the community in supporting mental health and well-being. It acknowledges that families should be able to access the right help at the right time in a way that is right for them, and that expertise should be accessible throughout the system. Children's unique developmental paths are acknowledged, and services are advised to consider the child's developmental needs rather than their age.

This document is produced in the context of the Additional Learning Needs (ALN) Act and Code for Wales (Welsh Government, 2021) creating one legislative system for children and young people between 0 to 25. This legal framework focuses on providing education that is aspirational and supports children or young people to achieve their potential, emphasising improved collaboration and information sharing between agencies.

The Trauma Informed Wales Framework (Public Health Wales, 2022) provides a Wales definition of trauma-informed approach and describes the roles people and organisations may have when supporting people affected by trauma. The Framework recognises the need to be inclusive and consider the multiple factors, including social, psychological and biological, that contribute to the development of the many presentations encountered.

1.4 Personal and social context

People with a learning disability are people first and foremost and, as would be expected, a heterogeneous group of people. There is considerable diversity among children, young people and adults with a learning disability in relation to their developmental, intellectual and adaptive functioning, life experiences and social circumstances.

> People with a learning disability may have impairment in their abilities in some, or all of, the following functions: verbal comprehension and expression, or in using alternative modes of communication, non-verbal communication, practical or visual skills, attention control, memory for words, images and actions, sequencing, problem-solving, planning or changing behaviours, stopping and starting, self-regulation, their physical, social and emotional behaviour, and perceiving and integrating sensory stimuli. In addition, children, young people and adults with a learning disability are more likely to have co-existing conditions, such as physical health problems, mental health difficulties, and neurodiversity. The prevalence of hearing loss and visual impairment is higher in people with a learning disability (McClimens et al., 2015; Emerson & Robertson, 2011; Woodhouse, 2019).

Children, young people and adults with a learning disability are also more likely to experience emotional and behavioural difficulties and mental health conditions than their non-disabled peers. Studies have found that 54% of adults and 40% of children and young people with a learning disability have mental health difficulties (Cooper et al., 2007; Totsika et al.,2022).

Significantly higher rates of emotional and behavioural difficulties are evident in children with developmental delay from as young as two or three years old, compared with their typically developing peers (Emerson and Einfeld, 2010).

Although some risk factors for psychological distress may be directly attributable to biomedical factors related to the causes of learning disabilities, there is considerable evidence that people with a learning disability may also be subject to a greater number of psychological and social/environmental risk factors for developing mental health difficulties. For example, people with a learning disability are at higher risk of experiencing adverse life events compared with the general population (Wigham & Emerson, 2015). They are three to six times more likely to experience emotional abuse, physical abuse, or neglect (Spencer et al., 2005), and one in three adults with a learning disability experience sexual abuse (Tomsa et al., 2021). Compared with the general population, people with a learning disability are more likely to experience bullying, discrimination, exclusion, loneliness, poor housing, poverty (31% compared to 18%), poor physical health, have their physical health, relationship and cultural needs overlooked, and are much less likely to be in paid employment (Alegria et al., 2018; Public Health England, 2023). Children with learning disabilities are also more likely than their non-disabled peers to enter the care system (NSPCC, 2024)

1.5 Health inequalities

People with a learning disability face a disparity in health status because of increased mortality, increased morbidity and increased negative determinants such as poverty, as well as unequal access to healthcare services (Kerr, 2004). The confidential inquiry into premature deaths of people with a learning disability found that the most common reasons for premature deaths of people with a learning disability were delays or problems with diagnosis or treatment, as well as identifying needs and providing appropriate care (Heslop et al., 2013).

Organisational barriers to people with a learning disability accessing healthcare services include scarcity of services, physical barriers to access, lack of reasonable adjustments, diagnostic overshadowing, and social stigma (Emerson & Baines, 2010). Other factors that may further enhance the vulnerability of people with a learning disability are a lack of coordination of their care and a lack of effective advocacy (Heslop et al., 2013). Good practice guidance recommends that primary and secondary healthcare teams should identify at least one member of staff who develops specific knowledge and skills in working with people with a learning disability and acts as a champion, modelling and sharing good practice. They should use the expertise of people with a learning disability to ensure the champion understands their needs (NICE, 2019).

1.6 Access to psychological interventions/therapies

There are multiple challenges to accessing appropriate psychological interventions that may be faced by people with a learning disability.

Diagnostic overshadowing is a cognitive bias or tendency to assume that any problems are due to the existing known condition of a learning disability, rather than to consider other potential causes. Similarly, a behaviour may be framed as a behaviour that challenges rather than considering the emotional distress and needs that may underpin the behaviour. These processes can result in physical and mental health problems being overlooked, and prolonged distress for the person and those around them (Lavis et al., 2019).

> For example, low mood and associated reduced interest in normal daily activities may result in the person showing aggressive behaviour towards people encouraging them to engage in those activities; this may be conceptualised by referrers and services as behaviour that challenges rather than exploring the possible underlying causes such as low mood. Similarly, a teenage boy who is feeling unwell or scared may need his mum close by to soothe him and become upset and physical when she tries to leave him; this might be conceptualised as behaviour that challenges in the form of controlling his mother, without considering the possible underlying emotional needs.

People have varying abilities to identify, label and verbally communicate their emotional experiences and distress and they may show psychological distress in ways that might not be easily recognised, making it harder for those close to them, and practitioners, to identify the distress and the reasons for it.

People with a learning disability are often reliant on the people around them to understand their communication, to know them well enough to notice changes in their well-being, and recognise that they are experiencing mental ill health. They are also likely to need help to access the appropriate help from a practical perspective, including support to navigate referral systems, remember and travel to appointments.

1.7 Welsh Language

The introduction of the Welsh Language (Wales) Measure 2011 provides that the Welsh language has official status in Wales. It includes duties on bodies (including the Welsh Government and health and social care bodies in Wales) to use the Welsh language, and ensure the treatment of the Welsh language no less favourably than the English language. The Welsh language standards exist to promote and facilitate the Welsh language – and ensure that the Welsh language is not treated less favourably than the English language in Wales. More Than Just Words is the Welsh Government's strategic framework for promoting Welsh language and culture in health and social care. The vision for More Than Just Words is for Welsh to belong and be embedded in health and social care services across Wales so that individuals receive care that meets their language needs without having to ask for it, leading to better outcomes. People with a learning disability are a priority group in More Than Just Words.

The More Than Just Words Framework seeks to drive progress under the overarching theme of "culture and leadership" – and the three themes of Welsh language planning and policies including data; supporting and developing the Welsh language skills of the current and future workforce; and sharing best practice and an enabling approach. At the heart of More Than Just Words is the principle of the Active Offer, which places a responsibility on health and social care providers to offer services in Welsh, rather than on the patient or service user to have to request them. More Than Just Words complements the implementation of the Welsh Language standards in health and social care.

One of the specific actions in More Than Just Words is to enable the development of standard Welsh language diagnostic assessments and resources to support Welsh speakers in identified priority areas such as mental health, learning disabilities, speech and language therapy, and dementia. This new guidance on the delivery of psychological interventions for children and young people and adults with a learning disability in Wales will provide an important opportunity to support this action, recognising that receiving services in Welsh, especially when people are at their most vulnerable, is an integral component of person-centred care.

1.8 Accessibility

Specific consideration should be given to the All Wales Standards for Accessible Communication and Information for People with Sensory Loss. The All-Wales Standards for Communication and Information for People with Sensory Loss were implemented in 2013 to dismantle barriers to healthcare for people with sensory loss. In 2023, Welsh Government reviewed the effectiveness of the Standards and explored the barriers faced by people when accessing healthcare. In collaboration with representatives from NHS Wales and external partners, Welsh Government developed recommendations and actions aimed at removing barriers and ensuring the communication and information needs of patients, service users, parents and carers are consistently met. The renewed standards (due to be published shortly) will now also include patients whose main language is not English or Welsh; patients who have language and communication barriers due to disability, dementia, mental health conditions or learning difficulties; patients who have language and communication barriers arising from neurodivergence; patients who have language and communication barriers arising from low literacy; and parents and carers (of patients) who have language or communication barriers. The planned implementation of the renewed standards will support key recommendations in the Disability Rights Action Plan, due to be consulted on in Spring 2025.

A study Sheehan and Hassiotis (2017) describe the use of digital technology to aid access and inclusion around physical and mental health, often under used by people with a learning disability. They assert that many people with a learning disability are able, and willing, to use digital technologies but experience barriers in access that can lead to exclusion and perpetuate the health inequalities already experienced. Using principles of universal design improves access not only for people with a learning disability but also for those with other cognitive limitations, sensory impairments and reduced literacy or technical know-how. Development and further research on digital interventions should include people with a learning disability and their carers at the development and evaluation stages of the innovation pathway

1.9 Intersectionality

In line with the aims of the new Mental Health and Well-being Strategy, the new guidance includes a focus on supporting equity of access, experience and outcomes without discrimination – and ensuring that services and support are accessible and appropriate for all. Marginalised groups who experience discrimination, racism or exclusion solely based on age, race, sex, sexual orientation, disability or other characteristics are protected by the Equality Act 2010. As highlighted in the new Mental Health and Wellbeing Strategy, it is important to remember that often people are not just members of one of these groups, and within these groups, individuals' experiences can be very different. We need to ensure that attention is paid to the intersection of different inequalities, and that policies and services are designed to take account of the whole person. Services should adopt an approach consistent with the social model of disability focussed on the removal of barriers – structural, cultural, and ableist, which hinder disabled people's participation. In so doing, the guidance will be aligned with wider nation equality plans, including the Anti-racist Wales Action Plan, the LGBTQ+ Action Plan for Wales, the new Child Poverty Strategy for Wales, the Violence Against Women, Domestic Abuse and Sexual Violence Strategy, the Neurodivergence Improvement Programme, and the work of the Disability Rights Taskforce.

Section 2: The importance of history and context in the lives of people with a learning disability

There are several factors that have a significant impact on the mental health of people with a learning disability. When working with people with a learning disability professionals need to be mindful of the individual's context and cultural and societal discourses about disability.

2.1 Stigma and prejudice

There are people within our communities who find it harder to learn, understand, and/or communicate, which can make everyday activities more difficult and may mean that they require support. People diagnosed with and 'labelled' as having a learning disability should always be described first as being, amongst many other things, friends, relatives, partners, parents, and community members.

People who are described, as having a learning disability too often experience oppressive and disadvantaged circumstances throughout their lives. This disempowered position is well documented: longstanding and multifaceted discrimination has produced such circumstances where people diagnosed with a learning disability are more likely to be disadvantaged (Tyrer et al., 2022).

Health and social care services often require a formal diagnosis as proof of eligibility for support (Whitaker, 2004). Thus, as a label, 'learning disability' can positively benefit people by providing access to services, but importantly it can equally act to exclude, stigmatise, and disempower (Cluley et al., 2022; Thomas, 2021).

2.2 Attachment, relationships, and the role of grief and loss

A learning disability does not preclude the development of secure attachment relationships, although a learning disability may add challenges to the process. Guidance by the British Psychological Society (BPS, 2017) has recognised the important role an attachment perspective can offer to those working and supporting people with a learning disability. Attachment and relationships are key for all and are often an aspect in mental health regardless of learning disability. However, for the person with a learning disability, their attachments, as they develop through the life course, are often highly populated with relationships with paid carers and professionals, sometimes in the absence of other more naturally occurring relationships such as partners and friends.

Some authors suggest that the arrival of a child with a learning disability into the family may evoke a 'grief reaction' as the parents mourn the loss of the 'imagined' child. It may also be that what is experienced by families is a process of adjustment, which will be important to explore. The subsequent adjustment as a result of that grief and perceived loss can create a different pathway for the development of attachment behaviours. Research suggests that most families adapt, often by being able to recognise and value their child's actual abilities, rather than holding onto ideas of 'wished-for' abilities (Fernández-Ávalos et al., 2021). Not all families will identify their experience as a grief process and therefore to impose this would be unhelpful.

2.3 Transition and the life cycle

When a member of a family has a disability, the sequence of life-events tends to be different from families without such disabilities (Black, 1987; Vetere, 1993). Issues faced by families with a learning-disabled member may be more difficult to negotiate than for other families. The most striking difference is that families with a disabled member may experience lifecycle transitions in a different sequence from that of the previous generation. McGoldrick and Carter (2003) describe that families go through transition stages where they may require some adjustment, for example, recognisable life cycle transition points are experiences such as leaving home or retirement. It is suggested that for the family with a child, adolescent or adult with a learning disability, the life cycle transition may come at a different time and in a different sequence. It is not unusual for families and people with a learning disability to come into services at a time of transition for the whole family.

2.4 Systemic factors

The context within which people with a learning disability live their lives and the relationships between those providing support are often complex and multifaceted. Learning disability services provide support to a diverse community of people with a learning disability and their support networks, including paid staff, families, and health and social care professionals. It is often more likely that people with a learning disability are referred by others into services rather than self-referral, for reasons outlined above such as lack of agency. In this context, the systemic need to address the “problem of the referring person” (Palazzoli et al., 1980) becomes central and working with the problem-determined system (Anderson et al., 1986) need not always involve the referred person. Systemic thinking underpins much of the work in learning disability services whatever that work looks like (Kaur et al., 2009), and is central to therapeutic involvement whether that be directly with the referred person or indirectly with their system.

2.5 Relationship with services

Some people access their local Community Learning Disability Team (CLDT) for the first time later in life, due to a significant life event or change, but for many they have long relationships with their teams. This is an evolving picture across Wales, and some services with high levels of demand report long delays in the transition from child to adult services. It is also not unusual that a number of professionals within the CLDT will all be working with the individual at the same time and interventions are often most effective when multi-layered. The involvement might not be intense, and there may be periods of time where there is very little support needed, but it is important to note that individuals and families often value the close connections they build with their local specialist service. Being able to easily ask for help when they need it, enables earlier intervention.

2.6 Trauma and Learning Disability

It is now universally accepted that trauma during early childhood has a detrimental effect on all areas of a person's development including self-regulation, cognitive skills and IQ, language skills and social skills (Bremner, 2006). People with a learning disability are particularly vulnerable to experiencing trauma (e.g. Frankish, 2020) and this has been historically overlooked and under-recognised. More recently, it is acknowledged that some care systems have, and continue to create, traumatic and invalidating experiences. Children, young people and adults with a learning disability often require higher levels of support in life which increases vulnerability to trauma. Care systems can perpetuate trauma, for example, people are often moved suddenly without thought for the human need of attachment security.

Research suggests that after exposure to a traumatic event, children with a learning disability often respond in a different way to their peers (Thomas-Skaf & Jenney, 2021), making it harder for those around them to identify that they are exhibiting a trauma response (Mevissen & De Jongh, 2010). People with a learning disability may develop trauma-related symptoms following less severe incidents than those described in the diagnostic criteria for Post-traumatic Stress Disorder (PTSD; Martorell & Tsakanikos, 2008; McCarthy, 2001, Mevissen et al., 2016).

Section 3: General principles of, and approaches to, psychological intervention

3.1 Person-centred

Providing psychological interventions for people with a learning disability requires consideration of the systemic and structural context described earlier in this document. The approach taken should always be person centred. This should include a focus on whether the person's preferred language is Welsh. Care should be taken to understand the person's view of the problem and the expert knowledge and views of those close to the person. It will often be important to have information from a range of clinical specialisms about the individual's functioning in domains such as daily living skills, health, sensory needs, mobility, hearing and eyesight. It is particularly important to have a good understanding about how a person receives, understands and communicates information, and this should form the basis of communication during the work (e.g., whether British Sign Language, Makaton, through an interpreter). Formulation should consider the physical health of the person and any possible co-occurring problems (Guidance for working and supporting people with a learning disability in their physical health, BPS, 2023). Whilst the individual's specific characteristics and situation are central, having an awareness of behavioural phenotypes associated with genetic syndromes may be helpful (Waite et al., 2014).

3.2 Assessment and formulation-driven

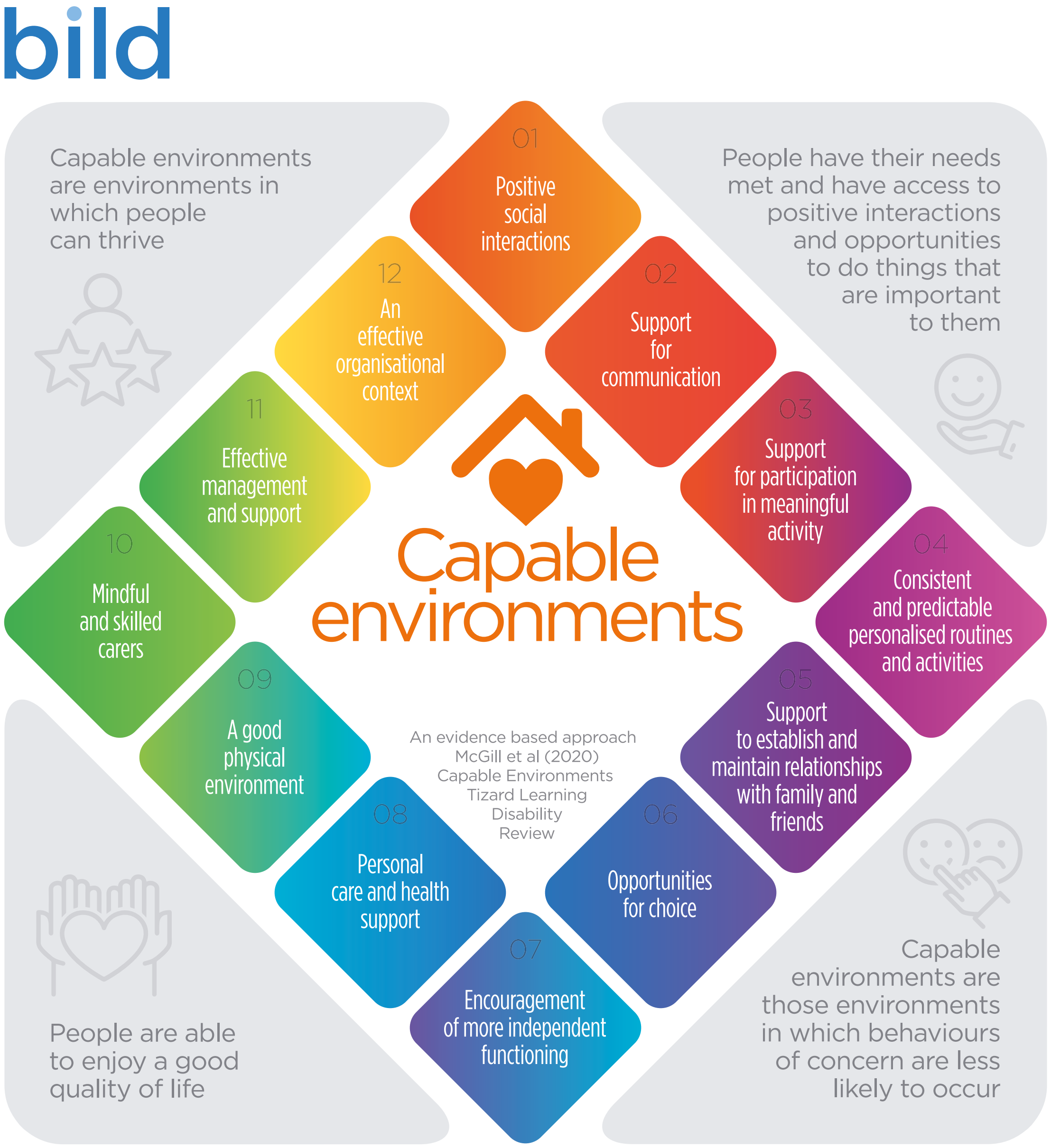
A psychological formulation can be used in addition to, or instead of, a diagnostic process. It details the matters that have come together to create the presenting need, what might be maintaining it, whilst recognising challenges and strengths. A neuropsychological and/or functional assessment to explore the individual's profile of strengths and difficulties may support practitioners to formulate and adapt psychological interventions appropriately. The formulation should guide practitioners about where in the person's system an intervention can be most effective for improving psychological resilience and well-being.

3.3 A whole-system, multi-layered approach

The stepped care model for mental health may be described as pyramidal in structure, with high volume low intensity interventions being provided to the people at the base of the pyramid with least severe difficulties. Steps up the pyramid are usually characterised by increasing levels of case severity being offered increasingly intensive forms of intervention, rather than characterised by levels of contextual complexity. This model of service organisation generally fits well where the primary model is direct work with the referred individual where the referred individual is seeking help on their own behalf and has the agency to make changes in their environment. This model can still work well with indirect working, particularly for those people with less levels of complexity. Children, young people and adults with a learning disability however are often referred due to the concerns of others, and have less agency to make changes in their environment. There may thus be a wide range of contextual complexity in the delivery of services to people with a learning disability.

All practitioners working with children, young people and adults with a learning disability and their families should be able to assess, formulate and respond to expressions of distress within a relational, contextual, and developmental framework. The 'Capable Environments Framework' (British Institute of Learning Disabilities [BILD], 2022) outlines 12 things found to be needed by all people to have a good life with minimal distress. Access to the appropriate specialist services should be based on distress, need or contextual complexity rather than always requiring a mental health, learning disability or other diagnosis.

Below is a picture depicting the Capable Environments Framework (BILD, 2022)



Many people are best supported in settings within their own communities and networks by people with whom they already have relationships. It may often be most appropriate for specialist services to support people who are already present in the system to provide psychologically informed support. One model is through embedded services (see Matrics Plant, Improvement Cymru, 2020) whereby expertise and support are available throughout the tiered system to intervene with the system first to create an environment where the individual can thrive. As such, psychological interventions encompass a wide range of courses of action including:

- Targeted training to upskill key members of a person's system
- Network consultation to support the development of a shared framework for understanding and responding to the person's specific presentation
- One off or ongoing consultative support to an individual or specific team
- Intervention with main carers/parents
- Intervention directly with child, young person or adult

3.4 Based on sound theoretical principles and available evidence

The National Institute for Health and Care Excellence (NICE) provides a number of guidelines specifically for people with a learning disability around specific situations, and where they exist, they should be followed. NICE (2017) also provides a quality standard [QS142] for the management of mental health issues in people with a learning disability, and states *"standard evidence-based psychological interventions are not designed to take account of the cognitive, communication or social impairments associated with learning disabilities."*

For people with a learning disability there are further limitations to relying on evidence-based practice alone. This population is often excluded from research trials of mental health treatments, and research specifically with this population has been rare (Hastings, 2014). Furthermore, there are few specifically validated tools to help clinicians identify mental health problems and monitor change, especially with those with more severe disability. While funded research on psychological therapies for people with a learning disability is taking place in small numbers, it is unlikely that this alone will produce sufficient volume of evidence for some time (Beail, 2016). The quality of research on effectiveness of relational therapies in learning disability has been particularly criticised for lack of empirical rigor; case studies dominate the field (Symington, 1981; Beail, 1989, 1994; Frankish, 1989a,b; Sinason, 1992; Sinason & Svensson, 1994).

The aforementioned quality standard (NICE, 2017) states that *"the care setting and interventions need to be adapted and tailored to each person's preferences, level of understanding, and strengths and needs."* Psychological interventions with a proven efficacy in the general population are often adapted for use with people who have a learning disability. The emerging evidence is encouraging, but further process and outcome research is required to establish the effectiveness of these interventions and underlying mechanisms of change. A description of different types of evidence and their limitations can be found in the Matrics evidence table's document. Section 4 will outline published adaptations to psychological interventions.

3.5 A community and social justice approach

Recognising a person's wider context, including the socio-political context a person exists within is essential. At an individual level this may involve formulating presenting difficulties and mental health distress through a systemic and social justice lens, for example, drawing from the Power Threat Meaning Framework (Johnstone & Boyle., 2018) and Bronfenbrenner's Ecological System Theory (Bronfenbrenner, 1992). When professional systems speak about mental health by focussing on the individual and ask, "What's wrong with you," this is misleading and unhelpful. The most useful question is, "What's happened to you and in your family and community?" (Winfrey & Perry, 2021). This means making sense of a person's presenting difficulties in relation to their wider context, often rooted in negative effects of power, as such, locating the presenting problem outside of an individual. Skelly (2021) presents key considerations for practitioners trying to find out about trauma in the lives of people with a learning disability.

Community and social justice approaches call for adopting a holistic, rights-based approach which attempts to address the root causes of distress for people with a learning disability. Actions to tackle specific social determinants and unfavourable social circumstances contributing to this group's vulnerability to poor mental health is a key part of this work. For example, greater risk of adverse childhood experiences (ACEs), social exclusion, discrimination, poor access to housing, lack of paid roles, poor transport and opportunity to be able to participate in society and connect with others (Emerson & Baines, 2010). Addressing social determinants of mental health is a key part of the Well-being of Future Generations Act in Wales (Welsh Government, 2015). The Mind over Matter (2018) report indicates that there is a need, as part of the evolution of mental health care, to move towards community embedded interventions and away from a focus exclusively on clinic-based interventions. This aims to create communities and conditions in which people's foundational needs to thrive as humans are met; safety, purpose, connection and belonging (Platfform, 2023) and thus promote mental health and well-being, healing and recovery.

Creating the conditions for people with a learning disability to have access to power, advocacy, awareness of what mental health support is available to them, as well as their rights and responsibilities is important to minimise the social disadvantages potentially experienced. This includes the legal obligation services have to make reasonable adjustments for protected characteristics under the Equality Act (2010), and ensuring the Welsh language is treated no less favourably than English under the Welsh Language Standards and Welsh Language (Wales) Measure 2011. As such, this might involve professionals advocating for reasonable adjustments and adaptations to be implemented within a person's system, including, health care appointments, education, workplace, and supporting a person navigating these, often complex, professional systems.

3.6 A focus on Welsh Language

The Well-being of Future Generations (Wales) Act 2015 sets out the approach to improve social, economic, environmental and cultural well-being in Wales, including the goals of a healthier Wales and a Wales of vibrant culture and thriving Welsh Language. When individuals access and receive health and social care services, it is usually when they are at their most vulnerable and this is why language is important. The Welsh language skills of the workforce are critical to effectively engaging with Welsh speakers. There are resources and tools available to support teams in relation to Welsh language – including Welsh Language Training for NHS Wales and Social Care Wales workforces, and new opportunities for being developed by the National Centre for Learning Welsh, such as the Croeso / Courtesy Level Course. Hwb Iaith is a resource that the NHS workforce and others can share and read about examples of good practice in order to understand the importance of providing Welsh language services. Health Education and Improvement Wales (HEIW) have recently published new guidance on workforce planning for the Welsh language to help teams workforce plan for Welsh language skills. The guidance will help to ensure health and social care organisations are meeting all necessary legal requirements.

Section 4: Adapting psychological interventions to meet the needs of people with a learning disability

Adaptations are of imperative importance when delivering interventions for people with a learning disability, to overcome potential barriers in terms of access and ensure a person can gain and retain therapeutic benefits (Dagnan et al., 2013; Muralidhar et al., 2024). There is a need to capture best practice adaptations used for this group to ensure positive and equitable outcomes for the mental health needs of this population. This section describes the findings of a rapid review to identify the nature of adaptations to psychological interventions for working with children and adults with a learning disability reported in published research and best practice guidelines. A Rapid Literature Review (RLR) is an alternative to systemic literature review that can speed up the analysis of newly published data (WHO, 2017). It was beyond the scope of this review to consider interventions delivered to parents and carers of children with a learning disability or to complete a systematic literature review but this is something that can be identified as a next step if needed.

Results of the review identified nine themes in terms of adaptations to psychological interventions for children and adults with a learning disability: delivery, confidentiality and consent, involvement of significant others, pre-therapy preparation work, verbal communication, working creatively, easy-read, endings, and the importance of feedback (see Table 1).

The findings suggest a range of adaptations and modification of psychological interventions that may be offered as reasonable adjustments when working with a person with a learning disability, in line with the Equality Act (2010).

Key principles that emerged were; the use of a tailored and individualised approach, that leverages pre-existing strengths, takes into account the uniqueness of every person with a learning disability and is guided by a person's ability (both cognitive and emotional developmental level). There is no 'one size fits all' with respect to adapting psychological therapies. It is essential that these are developed through a collaborative relationship between therapists, the individual and significant others. Partnership working and empowering the person with a learning disability and significant others is crucial, as they are often best placed to guide adaptations that support the best outcomes. Any formal neuropsychological results can be used to add to this to guide individualised adaptations, importantly the aim of such assessments being to amplify a person's strengths that can be used to compensate for other areas of cognitive weaknesses (e.g. an emphasis on visual memory strategies rather than verbal memory).

Table 1 shows a summary of the results outlining key adaptions made within the current literature. The search strategy and more detailed findings are summarised in Annexes 2 and 3 respectively (published separately).

In terms of limitations, this review reports on the nature of how adaptations have been used and reported in the literature; research on the effectiveness of adaptations is in its infancy and will be an important aspect of future work. This review did not appraise the quality of the studies included. It included studies published between 2016-2022, based on the assumption that the BPS guidance paper (Beail, 2016) captured relevant studies prior to this, and thus some studies may have been missed. Future research should represent adaptations appropriate for the full spectrum of severity of learning disability, as well as ages across the lifespan, and seek insight from the lived experience through consultation and feedback.

Table 1: Published and best-practice adaptations when working with a person with a learning disability.

These best practice adaptations also apply when working with a person whose preferred language is Welsh. They should also be underpinned by the All Wales Standards for Accessible Communication and Information for People with Sensory Loss. These Standards are currently being renewed by Welsh Government to include patients whose main language is not English or Welsh; patients who have language and communication barriers due to disability, dementia, mental health conditions or learning difficulties; patients who have language and communication barriers arising from neurodivergence; patients who have language and communication barriers arising from low literacy; and parents and carers (of patients) who have language or communication barriers.

Adaptation	Description
Delivery	
Session length and frequency	▪ Clients who have difficulty concentrating may require a greater number of shorter sessions ▪ Clients may require longer sessions to allow extra time to process ideas or complete measures ▪ Some clients are likely to require breaks ▪ Clients may require a slower pace, likely impacted by difficulties with understanding and learning ▪ Longer length of treatment may be necessary
Simplification	▪ Introduce one technique each session and focus on thoroughly ▪ Break down technique or information into smaller chunks
Structured sessions	▪ Clear and simple session structure, which remains consistent throughout treatment ▪ Same beginning and ending to sessions, e.g., a ‘fun’ activity of person’s choice or relaxation ▪ Use aids such as flip charts to create a visual agenda that is ‘ticked off’ ▪ Structure and scaffold sessions to ensure collaboration and prevent an imbalance of power ▪ Dialogue stemming from therapeutic activities
Group sessions	▪ Clients with greater difficulties may require more facilitators ▪ Value in keeping group sizes small ▪ Cover less material each session to allow more time to process information and interact with peers ▪ Groups may be set up directly in service settings and locations clients already have free transport to

Adaptation	Description
Setting	▪ Groups and 1:1 sessions delivered at; community residential and day habilitation environments, home environments, education/work environments and clinical environments ▪ Delivered on an out-reach basis ▪ Therapeutic work may need to take place in the person's every day context to support generalisation of skills ▪ Send session reminders to the person and/ or significant other via text or telephone
Session reminders	▪ Send session reminders to the person and/ or significant other via text or telephone
Adapt based on person's cognitive / emotional developmental level	▪ Use any formal neuropsychological results to guide individualised adaptations, importantly aiming to building and amplifying a person's strengths to compensate for cognitive difficulties (e.g., visual memory, as opposed to verbal memory) ▪ Assess a person's emotional development level, to guide intervention. Ensue therapeutic tasks and expectations are achievable to avoid 'over-estimation' and shame
Confidentiality and Consent	
Consent form	▪ Simplified consent form with simple language and pictorial elements ▪ Allow extended time for the client to review with a significant other (it can be helpful to provide time outside of sessions) ▪ Consider offering in an audio format
Verbal explanation of therapeutic intervention	▪ Clear explanation ▪ Repeating and rephrasing information can help understanding ▪ Check that the client has retained and understood
Confidentiality	▪ Where possible, the client should have agency regarding the sharing of information ▪ Creating the conditions for the client to think about involvement of significant others and what this will look like e.g. will they attend at the start of each session, the whole session, fortnightly?

Adaptation	Description
Involvement of significant others	
Role of significant others	▪ Facilitate engagement and understanding ▪ Support completion of inter-sessional tasks or promoting the practising of skills between sessions ▪ Generalising learning from sessions, e.g., modelling new techniques in day to day situations ▪ Provide support for any potential distress following sessions ▪ Support maintenance of changes after therapy has ended ▪ Provide information about a person's history, communication strategies and changes in presentation ▪ Work with significant others if the client is not able to engage directly in therapy, e.g., systemic family therapy
How significant others are involved	▪ Separate sessions for teaching strategies to significant others ▪ Caregiver support group running alongside clients 1:1 session ▪ Offering training to help significant others adapt their way of working with clients ▪ Supporter session held before the therapy starts to provide information on how they can support clients through therapy ▪ Providing information and education for carers, e.g., workbooks as a method of shared communication around what has been covered in each session
Wider Support Network	▪ It is important that the wider support network understand the therapy structure, therapeutic goals and the role they play in the therapy process ▪ Partnership working with key people in a client's system can promote a more cohesive circle of support ▪ Supporting a client to present therapeutic work to their professional system could aid the therapeutic intervention ▪ May also be beneficial for the client to be involved in the sharing of information ▪ Hold in mind the question, 'who needs to change?', this often involves change in systems (family or staff team), as opposed to the person with a learning disability

Adaptation	Description
Pre-therapy preparation work	
Relationship building	▪ Take time to establish a safe and supportive context and development of the therapeutic relationship ▪ Therapist as a 'secure base' ▪ Hold in mind the client's context and previous experiences of negative relationships ▪ Therapeutic work underpinned by holding in mind power and trust (McNally et al., 2021)
Foundation skills	▪ Additional 'pre-therapy' sessions focused on teaching foundational skills ▪ Time spent on key concepts, e.g., identifying feelings, thoughts, physical sensations, behaviours ▪ Session with 'supporter'
Verbal communication	
Simplified language	▪ Consider the use of a standard assessment of language at the start of interventions (Witwer et al., 2022) ▪ Shorter sentences ▪ Adjust the speed ▪ Use the same word to refer to one concept throughout ▪ Use the person's own words ▪ Concrete phrases, as opposed to more clinical/ poetic phrases, 'now become aware of sensations arising and dissolving' > 'focus on your feet' ▪ Minimise abstract language, use concrete examples e.g., examples from the person's own life ▪ Avoid jargon ▪ Avoid multi-step instructions ▪ Explain the process more ▪ Pair verbal instructions with visual aids to illustrate the point ▪ Consider the use of metaphors ▪ Consider the appropriateness of Socratic approaches or alternatives e.g., 'alternative coping statements' on flashcards ▪ Greater scaffolding using simple questions
Repetition	▪ Greater repetition of key concepts ▪ Verbal summaries ▪ Re-cap at the start and end of every session ▪ Repeat skills taught regularly

Adaptation	Description
Language around 'homework' tasks	▪ Consider a person's experiences of school ▪ Use 'between-session task' as opposed to 'homework'
Working creatively	
Visual materials	▪ Use of visual handouts alongside verbal explanation ▪ Incorporate a person's interests, hobbies ▪ Flip charts to set out agendas, key learning points for 1:1 sessions, and to note reflections during family therapy sessions ▪ Pictures used within simplified self-monitoring records ▪ Therapy skills workbooks containing written and visual summaries of key learning points and techniques from every session (e.g., left side of workbook contains space for photographs of in-session work, drawings) ▪ Wallet size prompt cards outlining skills ▪ Supporting documents to share with 'supporters' to encourage systemic action when a person is in distress ▪ Adapt self-monitoring records, e.g., adding pictures or emotion faces to circle ▪ Visual formulations in diagrammatic and simple drawing forms
Physical items	▪ Use of concrete objects, e.g., blowing bubbles for mindfulness tasks, different coloured hula hoops or ropes presented visually on the floor to represent in CFT the different emotional regulation systems (threat, drive, soothe) or in CBT 'thoughts', 'feelings', 'behaviours' ▪ A 'tool box' of multi-sensory items, e.g., a compassion or self-soothe box
Auditory	▪ Audio recordings of skills for client to take away after a session (may be helpful for a person to hear the therapists voice and individualised instructions) ▪ Watching videos to support understanding ▪ Self-monitoring, e.g., thought / behaviour records, can be completed by audio recordings (e.g., on a person mobile phone)

Adaptation	Description
Therapeutic activities	▪ Greater emphasis on experiential and practical exercises, as opposed to verbal or written tasks ▪ Role play within sessions, use of modelling by the person watching the therapist perform the skill ▪ Use of video modelling (e.g., attachment behaviours) ▪ Use of interactive tasks, to reduce verbal demands, e.g., card sorting tasks, talking mats, feeling boards, psychoeducational games or quiz at the end of sessions, life story work, social stories ▪ Drawing combined with story-telling methods to elicit cognitions ▪ Art work; painting, modelling with clay, collage, comic strips ▪ Photography to capture aspects of the client's real life ▪ Power point presentations or 'mini lectures' on topics ▪ Reading (Books Beyond Words) ▪ Use of a camera, to take pictures of clients work to aid later recall (e.g., use in therapy workbook) ▪ Rehearsal and repetition of steps within a technique, e.g., use of scripts
Examples of adapted resources	▪ 'Beat it' and 'Step up' (Jahoda et al., 2017) from NHS Scotland ▪ Cognitive Behaviour Therapy for People with Intellectual Disabilities: Thinking Creatively (Jahoda et al., 2017) ▪ 'Feeling Down' from the Mental Health Foundation (Burke 2014). ▪ 'Soles of the feet meditation' (Sing et al., 2003; Singh et al., 2011)
Easy read	
Examples of where easy read can be helpful	▪ Letters ▪ Reports ▪ Information leaflets

Adaptation	Description
Easy read key points	▪ Short sentences ▪ Break up text into manageable chunks ▪ Use a large font size (minimum of 14pt is recommended) ▪ Use bold, underline, colours, capitals to emphasise information ▪ Test aligned on the right-hand side and images aligned on the left-hand side of the page ▪ Avoid elaborate fonts and italics ▪ Repetition of a single word for a concept ▪ Avoid crowding the page with text and images ▪ Use photographs for specific people, places or objects to aid recognition ▪ Use simple illustrations for more general messages ▪ Consider alternative text for images and visual information ▪ Ensure all materials are available bilingually
Endings	
	▪ Prepare for therapy endings early: explicit communication that therapy is limited and will end, count down from the start, visual 'session tracker' ▪ Ceremonies such as use of goodbye letters, having cake or certificate for successful completion ▪ Consider gradual endings where the gaps between sessions gradually become longer ▪ Reflecting on feelings around endings ▪ Reframing ending to focus on new skills and abilities learnt ▪ Reminder of the extended professional circle around the person to prevent feelings of abandonment
The importance of feedback	
Regular feedback	▪ Frequently check in on a person's understanding ▪ Identify comprehension problems from non-verbal communication ▪ Review mechanisms in place to evaluate whether there needs to be a change in the delivery of information. ▪ Evaluation tasks, e.g., circle happy, unhappy face, traffic light colours, green/red cards for yes/no
Flexibility	▪ If a person is not making progress, adjust and adapt therapeutic approach

Section 5: Psychological interventions and psychological therapies

This section provides a descriptive overview of work that has been done in delivering psychological interventions for people with a learning disability. Some studies are presented in an attempt to describe some of the context; this section does not purport to be a fully comprehensive review of the evidence base. It is hoped that future work to review the evidence base will include people with a learning disability. The interventions described refer to psychologically informed interventions and/or psychological therapies. Psychological therapies and psychological interventions can be defined as purposeful courses of action driven by a formulation which itself will be based on an assessment of need and informed by one or more psychological theories (Matrics Plant, 2020). Psychological interventions and therapies are carried out by a wide range of practitioners and organisations across Wales.

In this document interventions have been divided according to those that are delivered indirectly to the person, through work with significant people around them and/or services, where the aim is to improve the capability of the environment to meet the person's needs, and those that are delivered directly with the person with a learning disability, whereby the aim is to support the person to develop their skills. Details of the rationale and decision-making process used to decide what interventions should be presented in this document, can be found in Annex 1.

5.1 Psychological interventions delivered INDIRECTLY for children, young people and adults with a learning disability

This section covers psychological interventions which do not involve working directly with the person with a learning disability, but rather involve working with other people and systems around the person with the aim of improving the person's mental health, well-being and quality of life. This may often be the way that interventions are delivered for people with a learning disability.

5.1.1 Indirect interventions for children and young people

Especially in the early developmental phase, parents[2] and families provide the foundational context in which the child will develop. Family members of a person with a learning disability and behaviours that challenge are usually highly committed to their relative, and perform a complex juggling act to manage demands, including daily care demands, stress associated with behaviours that challenge (for example, physical injury and fear) and feeling they have to fight services for suitable support (Griffith & Hastings, 2014).

The Developmental Systems Approach (DSA, Guralnick, 2005) is a widely-used framework to conceptualise systems of early intervention, integrating theories of child development, a systems perspective and evidence regarding interventions that improve child developmental outcomes. It describes family patterns of interaction that are affected by having a child that has a biological vulnerability or disability, how those alterations in family patterns affect the provision of an optimal developmental environment for the child, and how early intervention may bring about or restore an environment to be as optimal as possible. The DSA places the focus of intervention on strengthening the quality of parent-child interactions, family orchestrated child experiences, and health and safety provided by family.

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[2] Sometimes the term parents is used, but the work may be equally applicable to families or carers.

It describes mechanisms through which stressors related to caring for a child with disability, or related to the family's circumstances, have the potential to impact on family patterns and the child's development over time. The framework emphasises addressing a family's needs holistically and working to increase their resilience and resources to overcome challenges; although child-focused therapeutic activities may be required, they are best incorporated into the natural activities and rhythms that take place in families. It further emphasises that integration and coordination among agencies is key to reducing stressors experienced by families (Guralnick, 2001).

> *"Children with additional needs are just like any other child, that is, they are unique individuals with their own wants and desires who thrive when they are in an environment that 'fits,' with people who love and care for them. Children with additional needs and their families and carers often face extra challenges, which can impact upon the way that they develop, the life chances they have and the narratives that they hold about themselves and other people"* (McElwee & Oliver, 2024). Supporting parents, families and carers to support and advocate for their children is therefore a central aspect of working with children and young people with a learning disability, and in specialist children's services psychological intervention work is frequently with parents and carers.

For clarity, the different types of work with parents and carers have been divided according to their purpose.

a. Interventions to support parental psychological adjustment and ongoing well-being

Most parents/families do not expect to have a child with a learning disability, and there is usually a process of adjustment to work through as their child's development unfolds, in terms of their expectations for their child, their role as parents, and their own life expectations. Learning disability emerges during the early developmental period, but it may be several years before there is a diagnosis of learning disability. During this period children may have received a diagnosis of Global Developmental Delay and/or there may be a 'wait and see' approach by professionals, and for families there may be a sense of uncertainty about what this will mean for their child's future (Grech, 2021) and what services their child might be entitled to. Receiving a diagnosis of learning disability for their child is often associated with parental reactions akin to those of bereavement, such as shock, disbelief, denial and anger, and then acceptance as they adjust to the reality of their child's disability (e.g., Glidden, 2012; Singer, 2006). For parental and family well-being it is important for the parents to be able to move to a place of adaptation and acceptance of life as parents to a child with a disability (Hedderly et al., 2003; Barnett et al., 2003). Glidden et al. (2021) concluded that research indicates that most parents do move from a state of crisis to adaptation, although there are substantial individual differences in how long it takes to adjust.

Different models have attempted to account for the emotional experiences described by parents (Griffin & Gore, 2023). Glidden at al. (2021) proposed a pragmatic framework to conceptualise research on parental adjustment, which integrates theories of family and ecological systems, lifespan development and stress and adaptation. Parents and families, with their own individual characteristics and experiences, often have to integrate their internalised view of learning disability, with their experiences of their own child, whilst experiencing the views and behaviour of people in their community (which often reflect negative views of learning disability). Responses to this adjustment vary widely from family to family and parent to parent, are impacted by the cultural and historical context of the family and stage in the family lifecycle, and may unfold in the context of other challenges.

Some parents/families navigate these adjustments without the need for specific psychological intervention. For others, their emotional experiences may impact on their daily functioning and ability to provide for the additional care needs of their child, and they may need support. Parents/families may have had traumatic experiences around their child's birth or as a result of their child having health problems (e.g., feeding difficulties), especially where there are co-existing conditions. There may have been distressing experiences around finding out that their child has learning disabilities and people's attitudes to their child which may have long-lasting effects (Cadwgan & Goodwin, 2018) or being confused and unsure of how to parent their child. There may be grief around the loss of previously held expectations for their child and themselves, and for some this may be experienced as an ongoing process whereby they experience loss repeatedly throughout their child's developmental period. Some parents/families/carers have a previous history of traumatic experiences, and having a child with disabilities may reactivate earlier trauma and grief.

Being a parent is recognised as a profound and multifaceted experience, and that is the same when a child has a learning disability. Parents of children with developmental disabilities do, however, report higher stress levels than parents of non-disabled children (e.g., Lindo et al., 2016) and are considerably more likely than the general population to experience suicidal thoughts and behaviours (O'Dwyer et al., 2024). Risk factors associated with parental stress include issues related to caring for their child (e.g., coping with emotional/behavioural problems, sleep disturbance), feeling trapped, depressed, having dysfunctional coping strategies, a prior mental health diagnosis, lower socioeconomic level and social isolation (due to factors such as lack of time for self, perceived stigma and judgement) (Cheng & Lai, 2023). Better understanding of the child's progress, gaining knowledge and skills to manage behaviour and their own stress, support from professionals, family and supportive relationship between parents have been associated with lower parental stress (Cheng & Lai, 2023; O'Dwyer et al., 2024).

Parental/family adjustment difficulties, stress or mental ill health may come to the attention of services early in the child's life, at times of transition, or where parents are required by professionals to implement an intervention to support their child. Earlier experiences may affect their willingness and ability to engage with services supporting their child, and they may be perceived as being obstructive or hard to work with by teams. Teams have a responsibility to the person with a learning disability to find ways to work with their system, and there should be access to appropriate support for teams where they are finding it difficult to engage with families, including access to appropriately skilled systemic practitioners.

There should be easy and timely access to an appropriate level of support for the psychological well-being of parents/families/carers as theoretical frameworks suggest that positive parental and family well-being will likely impact positively on their ability to nurture their child and thus developmental outcomes. Particular consideration should be given to supporting parents during the crucial early developmental period (which will often be prior to the child having a diagnosis of a learning disability). Practitioners working with disabled children should be equipped with the appropriate level of clinical skills and knowledge to identify and support the specific psychological needs of parents, families and carers, and this may include competence in a range of psychological interventions for supporting adults with psychological distress and post-traumatic stress.

Interventions to support parent/family/carer adjustment and well-being can involve individual, couples, family or group interventions, depending on the individual family's situation, nature and complexity of the psychological difficulties. Group interventions rarely target only parental well-being (Glidden et al., 2021) but well-being is often an element of broader psycho-educative programmes (see section 5.1.1b). Individual psychological interventions for parents/families/carers should be selected from the recommended therapeutic approaches for adults/children according to need, ability to self-reflect, or their history of trauma. Care should be taken that the approach is appropriate/adapted to the context of families with a child with a learning disability, validates the person's experiences, and is tailored to the individual, as using standard therapeutic approaches without appropriate adaptation to the situation has been found to cause distress in parents or carers of people with a learning disability (e.g. Muddle et al., 2021; Noone & Hastings 2010). For example, expecting parents to engage in therapeutic work in the context of being exhausted or having limited childcare options might be unrealistic.

Many interventions to improve parental well-being will not be psychological in nature. For example, a Randomised Controlled Trial (RCT) where parents were taught a simple skill expected to be beneficial for their child (massage) showed improvements in their sense of self-efficacy for supporting their child's well-being (Barlow et al., 2008).

There is some evidence that Cognitive Behaviour Therapy (CBT) intervention approaches for parents of children with developmental disabilities can reduce stress and depression (e.g. Da Paz & Wallander, 2017). More recently, there has been interest in 'third-wave' psychological therapies which include mindfulness and acceptance-based interventions for parents and family caregivers, as the emphasis on acceptance of thoughts and feelings, focusing on the present, and moving in a valued direction may be seen as a good fit for the circumstances that families might find themselves in (e.g., see Whittingham et al., 2014, for a manualised approach for parents). Outcomes from these interventions are promising (Glidden et al., 2021), and one systematic review (incorporating meta-analysis) has been carried out to look at efficacy of the approach with parents of children with developmental disabilities. The results suggested that mindfulness-based and acceptance-based interventions were effective in decreasing parental stress, anxiety and depression, although it should be noted that most of the studies reviewed had a high risk of bias (Chua & Shorey, 2022).

Some parents/carers will experience mental health problems, and the additional demands of parenting may impact on their ability to manage these. NICE (2016) recommends, where a family member of a person with a learning disability has an identified mental health problem, they should be offered an intervention in line with relevant guidelines or referred appropriately. Where parents experience mental health problems enhanced/early access to psychological support services should be considered in order to support the parent's well-being, and thus the child's well-being and development opportunities. Appropriate communication between adult mental health services and children's services may be required to ensure that the family's needs are met.

Different family members adjust and cope in different ways, and there may be changes to family interaction patterns and strain on relationships. Different beliefs can lead to different fundamental choices about how to parent the child, and there may be conflict and inconsistency in managing the child's care. For example, one parent may look and plan for their child's future with anxiety, whilst the other may take a much more 'here and now' approach. Siblings of a person with a learning disability may have different roles, responsibilities and relationships compared with those of their peers, and they may be at risk of poorer psychological outcomes than other siblings (Hayden et al., 2019). There may be higher levels of worry and demands in the home, and siblings often take on caring roles in childhood. Sibling relationships may be an important source of support and friendship for people with a learning disability into adulthood (Levante et al., 2023; Hayden et al., 2023) and the role may also be very important to the sibling.

In addition to considering how to support individuals within families, services should consider how the broader family system may be supported to adjust to having a child with a learning disability. Where problems with family relational dynamics arise, consideration should be given to proportionate therapeutic interventions such as systemic psychotherapy and family therapy.

b. Psycho-educative interventions to support parental understanding and development of additional skills to support their child's development and well-being

Learning disabilities are diverse in their nature and impact on individuals, and many people in society have limited experience of getting to know people with a learning disability. It is therefore not surprising that parents and other family members sometimes struggle to understand learning disability and specific implications of their child's cognitive impairments, and hence the reasons for their child's behaviour and how to support their child. Parents are sometimes neurodivergent, or have learning difficulties or disabilities themselves, which may affect their ability to understand and parent their child. Supporting parents to be more aware of their child's specific profile of strengths and weaknesses may enable them to develop their understanding of what they can expect of their child and how they can support and encourage them to develop new skills. Professionals and services should work together and with parents to support parents to understand their child, and have confidence in their knowledge of their child, so they can support and advocate for their child as they often need to throughout their lives. This support should be available from the early identification of significant developmental delays in multiple areas of functioning which often occurs before the age when a learning disability can be diagnosed/confirmed (prior to the age of five years old).

The intensity of interventions to help parents understand their child's presentation and behaviour will vary according to the needs of the family, from signposting, group psycho-educative programmes to intensive individual work. With respect to supporting parents to understand their child's learning disability, it may sometimes be necessary to complete an individual assessment of the child's strengths and weaknesses (including, for example, cognitive functioning, speech and language needs, sensory needs, and everyday functional skills) to produce a clear picture to share with parents. It may require substantial individual work with the parents to communicate this information in an accessible way, and provide specific ways that parents can adapt their behaviour and the environment to best meet their child's developmental needs.

Children and young people with a learning disability may communicate their needs, well-being, and distress through their behaviour, in a way that is individual to them or specific environments, and the reason for the behaviour may be unclear. This can be perplexing for parents and lead to inconsistent and unhelpful ways of responding to the communicative behaviour. Some families will need individual work to enable them to have a more in-depth understanding of the functions of their child's behaviour, and will need substantial support to enable them to respond appropriately and confidently to their child's behaviour. Parents may also need individual support with issues that arise specific to their child's chronological age. For example, they may need support to know how to manage sleep difficulties in the early years or how to help their child to gain new skills related to puberty and relationships in the teenage years.

NICE (2016) recommends that parent programmes specifically designed for parents or carers of children with a learning disability are considered to help prevent or treat mental health problems in the child, and to support carer well-being. Group programmes are often offered to parents and incorporate one or more of the following areas: information about disabilities, information about services and information on parental well-being "looking after yourself" (Glidden et al., 2021). Parent groups have the benefit of possible cost-effectiveness, and have been found to increase parental self-efficacy (Hohlfeld et al., 2018), which in turn has been found to predict parental ability to implement interventions (Solish, 2010), and may improve parent-reported access to services (Picard et al., 2014). Group programmes also give parents opportunities to meet and learn from other parents 'in the same boat' and develop supportive communities which may benefit well-being. For example, Thompson-Janes et al., (2016) reported that parents felt relief and reassurance when meeting with other parents in group-based interventions.

Psycho-educative work may also aim to target 'parenting' and the parent-child relationship by reducing behavioural and/or emotional problems in the child with a learning disability. It is assumed that improving child outcomes like this will impact positively on parental psychological adjustment, and there is good evidence that both individually- and group-delivered programmes which provide psychoeducation based on social learning theory are effective in reducing problem behaviours in the child and improvement in parental adjustment (e.g. McIntyre, 2013).

Parents develop different understanding of learning disabilities and the implication for their family as their child matures, and the issues facing the parents of children with widely different degrees of learning disabilities will be different. Thus, careful thought should be given to the mix of parents included in groups, and parent programmes should be designed for the chronological age of the child. A number of parent programmes specifically designed to meet the needs of parents of children with a learning disability have been developed in recent years for children during specific chronological age periods (e.g. early years, primary school age, secondary school age) which are suitable for delivery by a range of practitioners and services, and may include coproduction and co-facilitation by expert parents (e.g. Early Positive Approaches to Support, Gore et al., 2022; 'Riding the Rapids,' Stuttard et al., 2014).

c. Interventions to support the parent-child relationship/attachment

Relationships are central to how children develop, learn and manage their emotional experiences, and many families with children with a learning disability form loving and synchronous relationships with their children. Secure child attachments develop when parents are attuned and sensitive to their child's needs (Bowlby 1988). Sometimes the kinds of experiences parents have related to their child, and features of the child's disability, such as impaired or different communicative function, may pose challenges to the formation of the parent-child relationship and interactional style. For example, children with delays or differences in reciprocal social interaction development may respond to parental initiations of interaction and affection in a different way from that expected. This can leave parents feeling rejected by their child, and impact on feelings and confidence about being able to parent their child.

There is evidence that people with a learning disability are at an increased risk of attachment difficulties (Hamadi et al., 2021). There should be attention to attachment and the relationship between children and their parents, and this should be considered in all interventions with the family. Where difficulties arise in the parent-child relationship there should be easy and timely access to specific psychological interventions to support this.

Approaches to work to promote attachment in children at risk of attachment difficulties usually aim to increase parental sensitivity to their child's attachment and communication behaviours. Some of these may be accessible to this population with relatively little adaptation. For example, Video Interactive Guidance, recommended (Scottish Matrix) for use with children at risk of attachment difficulties, uses video footage of the parent and child's interaction to highlight the strengths in the interaction and promote further reciprocity. It is highly individualised to the parent-child dyad and thus likely to be as accessible to parents of children with a learning disability as to any parents. A review of the effectiveness of interventions that targeted the quality of the relationship between a parent and their child with a learning disability concluded that they were associated with substantial improvements in the quality of the relationship and may improve child socialisation and communication outcomes (Westlake et al., 2024).

Adaptations to attachment-based interventions may require practitioners to have experience of working with children with disabilities and different attachment and communication styles in order to support parents to observe and respond to these behaviours sensitively, particularly as attachment difficulties may be more difficult to identify in children with a learning disability (e.g., Alexander et al., 2018). As with any specific intervention, such approaches may need to be part of a multi-modal approach to supporting the family. For example, it may be important to work with the parent on their adjustment and well-being before they are able to engage in attachment-focussed work.

d. Parent-mediated interventions and therapies

In some situations, a child may have psychological difficulty that is likely to be amenable to an evidence-based psychological therapy, but it is not possible for staff (who do not know the child well) to understand the child's communication style well enough or develop a close enough relationship with the child to deliver the intervention. In addition, interventions are likely to require a high frequency of repetition of the strategies for the child to learn new skills and will therefore need to be embedded in the child's daily environment to have any impact. In these cases, it may be effective to work to increase the parental/family understanding of the key psychological principles of the intervention, and support them to implement it themselves at home.

> For example, children with learning a disability may present to services with fears and phobias. In the case of a child with a phobia of buzzing insects it may be effective to educate the parents about cognitive behaviour principles (e.g., boosting emotion regulation skills and graded exposure to the feared objects) and support them to support their child to gradually develop their skills and become less fearful.

NICE (2021) recommends consideration of play-based intervention with parents, carers and teachers of autistic children to increase joint attention, engagement and reciprocal communication in the child or young person. This should use modelling and video-interaction feedback techniques, and aim to support the child's development by increasing adult sensitivity and responsiveness to the child's individual style of interaction. One such intervention, Paediatric Autism Communication Therapy (PACT) was developed for the parents of autistic children and included children with a learning disability. It has been subjected to large randomised controlled trials in two socio-cultural settings with different delivery models. PACT was found to create positive change in terms of dyadic interaction skills for minimally verbally children (Green et al., 2010; Rahman et al., 2016). A follow up study showed that gains observed in the child's communicative function were maintained several years later (Pickles et al., 2016).

5.1.2 Indirect interventions for adults

a. Direct work with parents for their adult children

When children and young people with learning a disability become adults, the work with parents and families continues but may also look different. Often the system around the individual has become bigger and more complex as they have strived for independence that comes with becoming older. In the UK, the prevalence among adults with a learning disability still living at home with family and friends in their 60s is 38% (Mencap, 2015). As this population grow older so do their parents and caregivers, so it seems essential to support people to access community provision, particularly groups that offer benefits in aiding a person's independence. The importance of the lifecycle transitions becomes central, the work with parents may need to focus on different aspects of the lifecycle. For example, helping adult children with a learning disability to leave home or have more independence from the family can be an important focus of work. This leaving home stage can be much later in life to that experienced by families without a child with a learning disability, and often coincides with parents themselves thinking about their own experience of getting older. Working closely with social care colleagues to help families navigate this important life stage is essential.

5.1.3. Indirect interventions for older adults

a. Supporting older people

As in the general population, there is a growing trend for people with a learning disability to live longer, however there is still an increased mortality rate due to health inequalities, issues around early detection of illness and inequality of access (Egan et al., 2022). As they grow older, people with a learning disability have many of the same age-related health and social care needs as other people but they also face specific challenges.

As people with a learning disability grow older it is vital that we give them, where appropriate, and their family members, carers and advocates, accessible, timely and person-centred information about all the potential care options available for end-of-life care, including hospice services (NICE, 2019). Service providers in health and social care services should ensure that all staff working with people with a learning disability have skills and knowledge in understanding the causes of early death in people with a learning disability (Glover & Ayub., 2010).

Older people with a learning disability can have particular housing and social support needs. In some instances, individuals may be caring for an older frail parent while they too are getting older. Ageing family carers may need to explore alternative care arrangements when they are no longer able to provide long-term care. A significant concern is when relationships and support ends, sometimes suddenly, through parental illness or death. Where there has not been adequate planning for this event, this can lead to several moves for the individual, during a time of acute distress for them and the wider family. Often work might be needed to help the individual manage this distressing transition or support the new home to meet the persons needs well, both practically and emotionally.

Many people with a learning disability may have support external to their family, such as through supported accommodation. As their needs change it may be that the home is considered unsuitable for them, which can lead to a move later in life that can be unsettling. Many people with a learning disability may find themselves inappropriately placed in older people's residential homes where they are much younger than the general population or where there is a lack of expertise about meeting the needs of people with a learning disability more generally (NICE, 2019).

Working indirectly with the home to better understand the needs of people with a learning disability can be an important intervention, this is best done with a joined up multi-disciplinary team approach.

As in the wider population care and thought should be given to how individuals with a learning disability experience getting older. In a paper by Fesko et al. (2012) they describe the need for retirement planning and activities that support active aging and discuss specific strategies, service options, and policy considerations to meet those needs, leading to a more active and involved experience of older age. Interventions that include partnership working with social care and third sector organisations to provide meaningful occupation is essential.

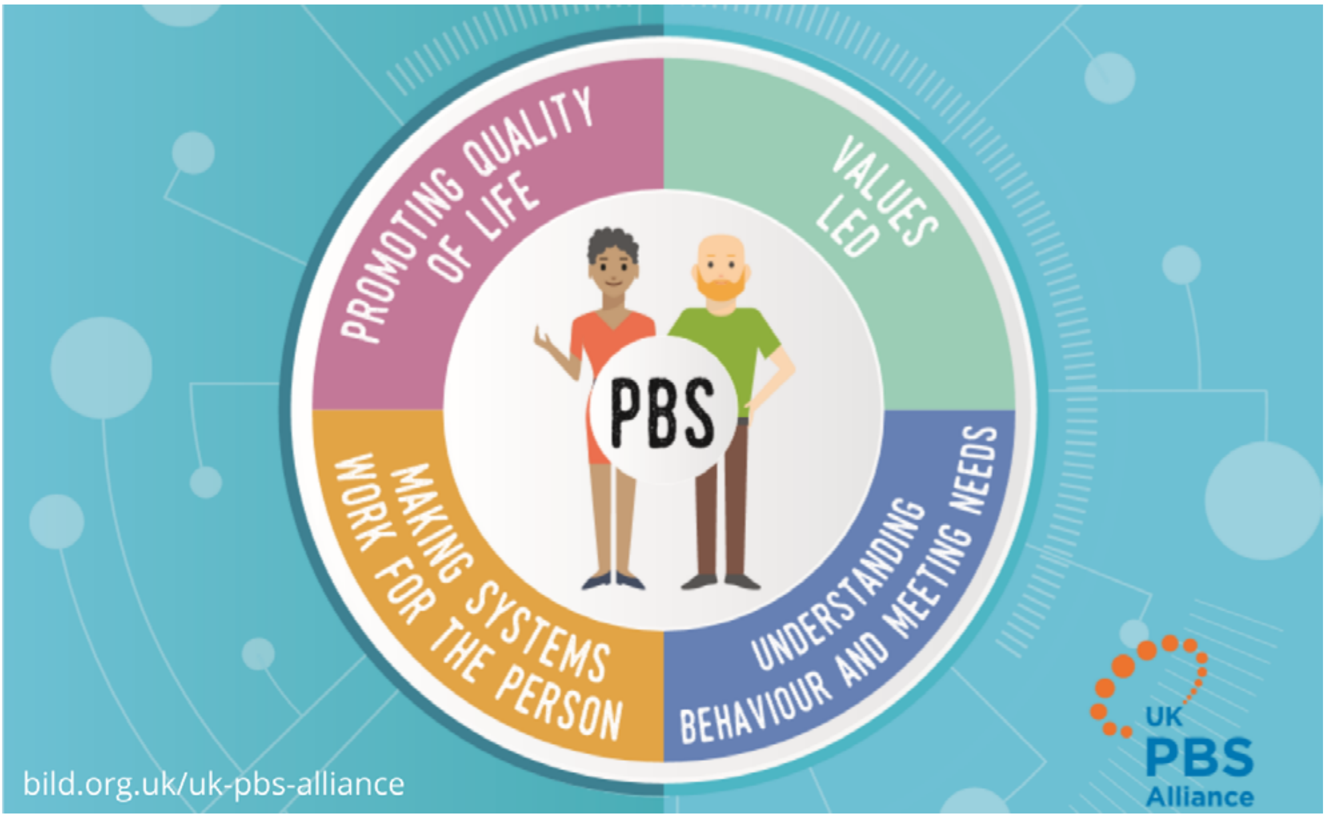
b. Interventions to support people with Dementia

Individuals with a learning disability have a higher risk of developing dementia compared to the general population, with a significantly increased risk for people with Down's Syndrome, and at a much earlier age. Specialist learning disabilities services usually take the lead with dementia assessments, diagnosis, formulation and interventions for individuals with a learning disability, rather than general memory services. However, for individuals not under secondary care learning disability services, their needs if dementia related could access generic services but this is an evolving picture. This is in part due to the complex process of diagnosing dementia in this population, and the specialism that learning disabilities services hold. Psychological practitioners have a key role in dementia assessment, diagnosis, formulation and intervention, as part of a holistic, multi-professional approach. Detailed guidance can be found in The British Psychological Society and Royal College of Psychiatrists (2015) 'Dementia and People with Intellectual Disabilities: Guidance on the assessment, diagnosis, interventions and support of people with intellectual disabilities who develop dementia.' This document has recently been reviewed and the updated guidance will be available in 2025. Work is also being taken forward to develop a nationally available set of standard assessments for Welsh speakers with dementia, in line with priorities in More Than Just Words and work to develop a new Dementia Action Plan (which will include a specific focus on Welsh Language).

5.1.4 Indirect interventions with the system across the lifespan

a. Positive Behaviour Support (PBS)

PBS is recommended as a key approach for supporting people with a learning disability with behaviours that challenge (NICE, 2018) and was developed specifically for this purpose. The focus on 'functions of behaviour' in PBS highlights that behaviours that challenge are seen to serve a purpose to the person engaging in them, that the purpose develops due to the person's experiences, and continues to occur as it serves a function. PBS aims to change the environment around the person to ensure it meets the person's needs and allows them to thrive, such that they no longer need to exhibit harmful behaviours that challenge. It is of note that PBS is a service delivery model rather than a single "intervention," which involves partnerships between person with a learning disability and key people, organisations and systems that support them (Gore et al., 2022). Changes may be required in several aspects and different levels within the system in order to establish a capable environment in which the person's needs are met.



Guidelines for the delivery of PBS models of care are available from several sources (for example see Shaw et al., 2022). A key issue is that those who are most at risk of behaviours that challenge (those with the most severe learning disabilities and impairments in communication;) are those for whom it is most difficult to choose or consent to interventions (Hastings et al., 2013). Thus, care needs to be taken around seeking informed consent for elements of PBS, engaging with people close to the individual, and consideration of the rights and best interests of the person at risk of behaviours that challenge.

Research published on the effectiveness of PBS was reviewed by Gore et al. (2022). They defined "effectiveness" in terms of positive change to quality of life and reduction in behaviours that challenge among those people at risk of behaviours that challenge. A high-quality meta-analysis of 285 single case and small-scale studies showed that the behavioural techniques used in PBS were associated with reduction in challenging behaviour with large effect sizes (Heyvaert et al., 2012, cited in Gore et al., 2022). One RCT in 2018 (McGill et al.) evaluated implementation of PBS using a cluster RCT design. 24 supported accommodation settings were randomized to experimental or control conditions: those in the control had access to individual PBS, as did those in the experimental condition, who also received multifaceted intensive support for implementing setting-wide PBS over the course of 8-11 months. There was significant reduction in ratings of challenging behaviour in the experimental group, compared with the control group, and this was maintained at follow up 12-18months later, suggesting that some behaviours that challenge can be prevented by the implementation of setting-wide PBS. In concluding their review Gore et al. (2022) stated that overall, there is support for aspect of PBS, and that attention to the overall quality of care reduces challenging behaviour. They noted that there are also indications of what may work (e.g. specialist teams or services providing high quality support) and not work (e.g. short PBS training courses) but indicated that further robust research is required, in particular in the different contexts in which PBS might be delivered. Furthermore, they recommend that work be carried out to investigate the elements that influence the success or otherwise of PBS interventions.

School-wide positive behaviour support refers to the application of a PBS framework in schools with the aim of creating a safe, equitable and inclusive environment for all students. It has been outlined as a multi-tiered approach (Horner & Sugai, 2015); tiers one and two involve systematic communication and functional skills teaching across all levels of ability, with additional intensity for those identified as having higher needs. Children needing more support are systematically identified and offered a tier 3 approach, involving more specialist and individualised assessment and intervention.

Trauma-informed and attachment-aware PBS

Understanding a person's attachment and trauma experiences should be a key part of the PBS assessment and formulation process; underpinned by the approach 'what happened to you?' as opposed to 'what's wrong with you?' (The Power Threat Meaning Framework, British Psychological Society, 2018). Trauma-informed PBS considers the relational nature of the antecedents and consequences of behaviours, and internal triggers and reciprocal roles (Ryle & Kerr, 2020) are considered alongside external triggers. In addition to short-term maintaining factors, consideration would be given to possible longer-term factors that may maintain the behaviour, such as loneliness, powerlessness and low self-esteem (Patterson, 2016).

From this perspective behaviour that challenges may be seen as the person's best way of coping, a strategy that developed in response to a trauma, and made sense at the time of the traumatic event. Thus, when assessing behaviours that challenge, there should be assessment of trauma, attachment and emotional development. This may include asking about early life, attachment, experiences of school, bullying, placement breakdowns, sudden changes to living arrangements, bereavement, loss of relationships including the care of their children, and past restrictive practice. Information may be gathered from staff teams around relationships with the client, recent life events, changes in staff, losses. Sharing trauma informed formulation with staff teams and carers can facilitate understanding around the impact of traumas, attachment traumas, can impact on a person's behavioural presentation (BPS, 2017). Importantly, formulation should consider behaviours that challenge as continued expression of attachment strategies which were developed as an adaptive response during the person's early life and based on their experiences (BPS, 2017).

Attachment-aware PBS holds the relational and trauma considerations central to understanding and intervening for behaviours that challenge. For example, attachment-informed PBS will draw on connection before correction (Golding, 2015), the rupture and repair cycle and PACE (Hughes & Baylin, 2012) in formulating and responding to behaviour. Similarly, the Pyramid of Need (Golding, 2013) and Neuro-sequential 3 R's model (Perry, 2006) helps establish the most appropriate therapeutic approach depending on needs and experiences of the person with a learning disability and their network. There is recognition that promoting the conditions for security within relationships should be focused on within PBS interventions. This includes moving away from service approaches of 'independence' when this is inconsistent with a person's emotional and cognitive readiness, challenging care that withdraws positive regard in response to difficulties, identifying poor quality relationships and intervening, and facilitating the development of naturally-occurring attachment relationships, characterised by the carer displaying warmth, predictability and affective attunement. (BPS, 2017).

Research also indicates that using care staff as a 'secure base haven' is positively related to well-being and behavioural adaptation (BPS, 2017). Specifically, carers should be encouraged to reflect on the quality of relationships and conditions for security (Skelly, 2017), including physical safety, emotional availability and predictability, warmth, mutuality of positive and new experiences and shared exploration.

For some people with a learning disability, providing an environment that follows the principles of trauma and attachment informed care will be the main focus of PBS interventions.

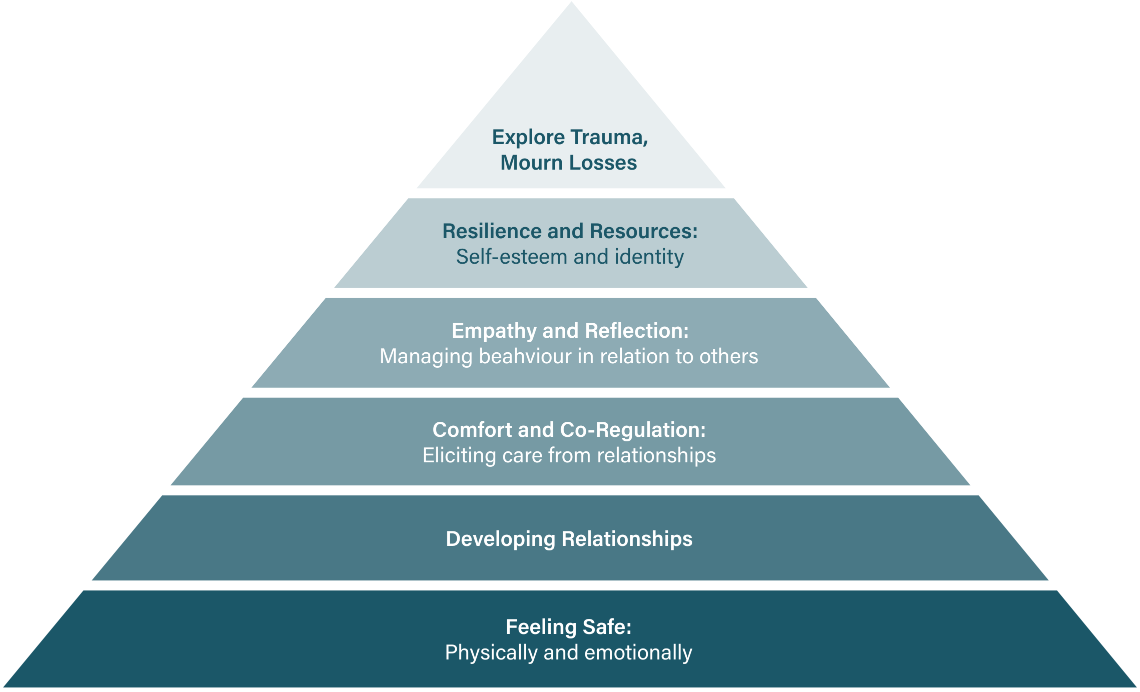


Figure 1. Golding's Pyramid of Need (Golding 2013; Figure extracted from McNally et al., 2022).

b. Models of intervention with services/teams/schools

Team-based models are increasingly used within care pathways, supporting the teams to hear and understand the service user's experiences of their difficulties and focusing on their needs in a person-centred fashion (Association of Clinical Psychologists (ACP), 2022). Some of the main forms of systemic intervention used in learning disability services are team formulation, network training, and systemic consultation. These interventions use a variety of psychological structures and format, e.g., biopsychosocial frameworks (Beardmore & Elford, 2016, Ingham et al., 2008), and behavioural framework with systemic concepts (Cooper & McElwee, 2016). The Cognitive Analytic Therapy (CAT) model has also been seen as particularly suitable for use with teams with its focus on reciprocal role patterns (e.g., Moss, 2007, as cited in Beail, 2016).

Team Formulation

Team formulation is a key competence for clinical psychologists and is recommended by the Division of Clinical Psychology (DCP) when psychologists engage in multidisciplinary teamwork (DCP, 2011). It can be carried out in a variety of ways, though it generally consists of a group process to create a shared understanding of an individual's difficulties with a group of professionals and stakeholders (Christofides et al., 2012). This shared understanding is then used to generate hypotheses and plan interventions to support the individual (Johnstone & Dallos, 2013).

The Association of Clinical Psychologists (ACP) (2022) outlines the main aims of team formulations. The complex and often lifelong systems of support that individuals with a learning disability experience mean that team formulations are particularly useful (Ingham, 2015). It is known that staff attitudes and attributions towards people with a learning disability impacts upon care (Bailey et al., 2006). The process by which a team formulation can create a shared understanding of an individual can help to alter attitudes, beliefs, and subsequent interactions (Cooper & McElwee, 2016).

Team formulation will often occur within a service context where there is a power imbalance between staff members and service users. Consent and confidentiality can be complex, choice and collaboration must be thought through (ACP, 2022).

Rowe and Nevin (2014) focus on providing a safe and inclusive space for service users to join their own team formulation sessions, using a psychologist-led process supplemented by adaptions and delivered using different modes of communication.

Geach et al. (2018) identified three elements of implementation of team formulation: sharing ideas informally; reflective practice; and formulation-focused consultation.

Network meetings

The idea behind the network meeting is to invite the referred individual, their family and the professionals involved in their care to meet. Fredman (2014) highlights the importance of separating out the listening and speaking during 'reflective processes' (Anderson & Jensen, 2018). Inviting the system to shift between these positions can offer each individual a multitude of perspectives, allowing for new stories to emerge, thus giving new meanings to old, internalised problem saturated ideas (Bateson, 1979). This systemic method offers to demonstrate the powerfulness of professionals as 'collaborative explorers' when working alongside families in co-creating new ways of viewing their situation.

Network training is often used as a model of intervention. "Network training began as a platform for sharing the results of functional analysis with an individuals' system, to ensure a consistent response to behaviours that challenge across different settings. It has developed into an approach presented by Jenkins and Parry (2006), which adds a systemic component to the training with the application of techniques such as hypothesising, circularity, neutrality and reframing to develop new understanding of the individual" (Cooper & McElwee, 2016).

Systemic consultation

Systemic consultation provides an opportunity for clinicians working with complexity to reflect on interpersonal dynamics that may be inhibiting change. They can be a useful tool to foster team collaboration and understanding (Wilcox, 2013). Pilgrim (2008) defines this form of systemic psychologist consultation as "supporting others to develop a better understanding of people, systems and situations through an individualised formulation or set of working hypotheses".

When working in learning disability services, systemic thinking and techniques offer psychological practitioners an alternative way of viewing psychological difficulties and can act as a framework to formulate 'problems' as existing within complex systems rather than individuals (Jones & Haydon-Laurelut, 2019). Working creatively and with others using a systemic frame can give voice to those who are often unheard. It also allows the practitioner to consider the Social GGRRAAACCEEESSS' (Burnham, 1992, 1993; Roper-Hall, 1998) and what ideas or narratives are being privileged.

There are themes to team formulations, systemic consultations and network training models that are shared and reflective of the ACP (2022) aims for this type of intervention. These are broadly: shared understanding (Cooper & McElwee, 2016), collaborative working to create hypotheses which could be tested (Ingham, 2011), reflective practice to discuss team difficulties, e.g. feeling "stuck", "split", or "scared" (Wilcox, 2013).

A commonly cited positive way of organising team-based interventions is using a structured and collaborative meeting using frameworks and protocols (Beardmore & Elford, 2016; Ingham, 2011; Ingham et al., 2008; Cooper & McElwee, 2016).

Working with schools

The Education Curriculum for Wales has placed health (including mental health) and well-being as a core area of learning for schools, and indeed schools may be well-placed to provide a positive environment to support children and young people with a learning disability to develop and thrive emotionally and socially, and thus provide the foundations for positive mental health and well-being. In addition, partnership working between mental health practitioners, services and schools may be helpful in a wide range of ways. For example, schools may be able to implement interventions either at the universal level (e.g. adopting a school-wide PBS framework, or specific work on understanding emotions or relationships for the whole class) or at the individual level with an identified child with specific difficulties (e.g. embed anxiety-reduction strategies into the classroom routine for an individual child; support a child to practice and use new coping strategies learned in therapy).

5.2 Interventions DIRECTLY with the child, young person or adult with a learning disability

Interventions directly with children, young people or adults with a learning disability can occur across the spectrum of need delivered by health, social care, education or third sector agencies, and can take the form of group or bespoke individual interventions. The intervention itself could range from befriending/mentoring, support with community engagement, psychoeducation, development of strategies to be tried in day-to-day life, or a formal therapeutic intervention.

It has been recognised that, regardless of the therapeutic approach, the therapeutic relationship is a key ingredient in the success of therapeutic work, and this will be the same for people with a learning disability. It may take considerably longer for practitioners to build trusting and collaborative therapeutic relationships with people with a learning disability for reasons already outlined in this document. In addition, as people with a learning disability are usually referred for therapy by others, it may be necessary for practitioners to work with the person to help them to understand and articulate what is important to them as a person, and what they want to achieve through therapeutic work, before commencing therapy.

Psychological interventions or therapies are listed below, alphabetically, with a brief description of why they might be considered and a brief summary of some of the available evidence.

5.2.1 Cognitive Analytic Therapy (CAT)

The use of CAT within the learning disability field has gained some popularity due to its perceived strengths of flexible methods, focus on issues of disability and relational approach (see Beard et al., 2016, for an overview).

The tools and process can be modified through reducing reliance on complex and abstract language through increased use of metaphor and pictures, symbols, diagrams, cartoon strips, talking mats, drawing and painting, the use of modelling materials, and story characters. Letters can be made accessible for those with limited literacy through the use of audio-visual recordings. Using non-verbal communication such as gesture, body positioning and so forth may also be a useful form of communication between the individual and therapist. Using objects to represent concepts may also be used (e.g. using different sized items to represent how a person experiences themselves). It is noted that therapy for people with a learning disability may need to begin with a 'pre-formulation' phase, in which the individual and therapist establish a relationship (Bancroft & Murphy, 2009, cited in Beard et al., 2016). The length, frequency and number of sessions may also need to be varied to meet the client's needs, although they should maintain the time-limited feature of CAT, and visual, concrete methods of tracking the progress through therapy is recommended, such as shading in a pie chart (King 2000).

To date, research is largely at the case study level, with few reporting outcomes based on standardised measures, but they give some indication of change in individuals' abilities to recognise and revise interpersonal patterns (cited in Beard et al., 2016). Case studies also provide some support for using contextual reformulation with the stakeholders around a person with a learning disability who present with behaviours that challenge to enable positive change (e.g. Fisher & Harding, 2009).

5.2.2 Cognitive Behavioural Therapy (CBT) and Behavioural Activation (BA) Approaches

CBT is recommended for a wide range of mental health difficulties in the general population, and there is a plethora of adaptations that have been made to work with specific mental health difficulties and different populations. There is a limited but growing literature around using CBT with people with a learning disability (e.g. Dagnan et al., 2023), and CBT approaches have been recommended for adults with milder learning disability and depression/depressive symptoms and adults with psychosis (NICE, 2016; Scottish Matrix). Aspects of CBT approaches have also been recommended for anxiety symptoms and phobias for people with a learning disability (relaxation and graded exposure strategies, NICE 2016).

In order to access all components of CBT a person will be required to be able to hold and articulate their perspective on the situation, engage in discussion about abstract thoughts and feelings and consider alternative perspectives from their own and engage in homework tasks (see Jahoda, 2016, for an overview). There are also assumptions about the person's agency to change their own thoughts and behaviour patterns. The degree of cognitive and communicative demand may present barriers to accessing CBT for many, although there has been work to outline adaptations to the approach which can support people with difficulties arising from cognitive impairments, including slower pacing, adapted number and length of sessions, checking in with the person frequently, and use of visual and experiential techniques like images, audio or video recordings, thought bubbles, and role plays etc. (see Surley & Dagnan, 2019, for a review) and there are adapted resources freely available for children and young people (see the Useful links and literature section).

Jahoda (2016) outlined additional considerations related to the wider context of the lives of people with a learning disability, such as their reliance on others to support them, and suggested that therapy may need to be adapted to account for these explicitly. Involving significant other people in the therapy process is one way to address some of these issues, although care must be taken to balance the goals of therapy with the ethical issues around this (Jahoda et al., 2017).

The evidence-base for the use of CBT specifically in this population largely comprises case studies, case series and some small-scale trials. One large-scale cluster randomised control trial did not find a significant reduction in self-reported anger, but did find positive effects on the use of anger coping strategies (Willner et al., 2013). In their overview of adapting CBT for people with a learning disability Dagnan et al. (2023) concluded that although the evidence to support specific adaptations to CBT for people with a learning disability is weak, there is consensus in the literature as to the kinds of adaptations likely to be useful. They also suggested that adaptations to therapy are not unique to working with this population, and that CBT therapists have the skills to adapt therapy for people with a learning disability.

Behavioural Activation (BA) is a core aspect of CBT which has been used on its own as an approach to treat depression (e.g., Dimidjian et al., 2006). It has been adapted for people with a mild to moderate learning disability, using existing guidance delivering psychological interventions to people with a learning disability, with the aim of increasing an individual's purposeful and motivating activity to address their depression and improve well-being (Jahoda et al., 2017). An RCT using this adapted BA approach has been carried out in what was purported to be the first large-scale RCT of any individually delivered psychological therapy for mental health problems in people with a learning disability. One hundred and sixty-one adults with mild to moderate learning disabilities and depression were randomly allocated to receive a 12-session adapted BA intervention (programme named BeatIt) or a guided self-help intervention (known as Step Up). Both interventions were associated with significant improvements in depressive symptoms, as reported by participants and carers, and improvements were maintained 12 months following the interventions. Outcomes from previous studies of depression were used to suggest that the improvement in symptoms is unlikely to have been due to spontaneous recovery, as depression is typically longstanding in this population and spontaneous recovery is not typically seen in those receiving treatment as usual (Jahoda et al., 2017). The BA approach has also been modified to address the needs of people with severe and profound learning disabilities (programme named BeatIt2) and subjected to a feasibility study with encouraging results. (Jahoda et al., 2024). BeatIt and BeatIt2 programmes are manualised and freely available (Jahoda et al., 2017; Gillooly et al., 2024; Jahoda et al., 2024).

5.2.3 Creative and play therapies

Art Psychotherapy, Dance Movement Psychotherapy, Dramatherapy and Music Therapy are psychological therapies which are person-centred, with a psychodynamic or humanist basis, and draw on an understanding of attachment theory and the role of trauma. They can be particularly useful interventions for people with a learning disability due to the use of the creative process in the development of a secure and co-productive therapeutic relationship, which enables and empowers the individual to work towards meeting agreed aims between therapist and client, and the accessibility of the media through which these therapies work. All provide opportunities for expression through creative means, and are not reliant on verbal expression as the sole mode of communication. This can be of benefit for some people with a learning disability, especially for people for whom verbal communication and receptive understanding are limited.

a. Art Psychotherapy

A systematic review of art therapy with adults with learning difficulties found that a diverse range of techniques and procedures are being utilised (Power et al., 2023). A common feature seen in art therapy was the modelling of specific techniques and the practice of art activities alongside the client.

b. Dance Movement Psychotherapy

When used in a psychotherapeutic context, dance movement is utilised for a range of neurological, psychological, relationship, and social problems. It also provides opportunities for people who wish to develop their own creative potential.

c. Dramatherapy

Dramatherapy uses stories, myths, play texts, puppetry, masks and improvisation to enable an individual to explore difficult and painful life experiences through an indirect approach (Bourne & Downing, 2016). Dramatherapy sessions usually follow the format of check-in, warm-up, bridge in (to main event), main event, bridge out, reflection and grounding (Bourne & Downing, 2016).

d. Music Therapy

Music therapy uses the musical components of rhythm, melody and tonality as the primary means of expression within a psychological intervention (Morison, 2016). A scoping review found that most music therapists utilised active interventions where the service-user creates music during the session, while receptive interventions involving listening to live or pre-recorded music were often used with service-users who had more severe learning disabilities (Mino-Roy et al., 2022).

e. Play Therapy

Play Therapy is the dynamic process between child and Play Therapist in which the child explores at his or her own pace and with his or her own agenda those issues, past and current, conscious and unconscious, that are affecting the child's life in the present. The child's inner resources are enabled by the therapeutic alliance to bring about growth and change. Play Therapy is child-centred, in which play is the primary medium and speech is the secondary medium.

f. Theraplay

Theraplay is an intervention which is focused on dyadic child and family therapy. It was developed for any professional working to support healthy child/caregiver attachment.

5.2.4 Dialectical Behaviour Therapy (DBT)

There has been interest in the use of DBT for people with a learning disability and in a range of populations and settings (McNair et al., 2017). The DBT model has been seen to be particularly pertinent for people with a learning disability who are so often disempowered, with its focus on understanding emotions, interpersonal processes and skills acquisition.

Lippold (2016) stated that the overall structure of the DBT programme and the hierarchy of targets (focusing first on life-threatening behaviour) are applicable to people with a learning disability. However, attention will need to be given to the way information is presented (e.g. attention to the language used, breaking down and chunking information, using visual material, using more practical exercises and role play) and to check that key concepts are understood (e.g. what is a thought, emotion and behaviour; Lippold 2016). Consideration of the format of the training in terms the length, number and frequency of sessions will also be needed. There has been one unpublished and one published manual that have adapted standard DBT for people with a learning disability (Charlton & Dykstora, 2011; Brown et al., 2013).

Early studies produced encouraging results for the use of DBT for groups of people with a learning disability and behaviours that challenge, although a systematic review (including four full programmes and three skills-only programmes) completed in 2017 (McNair et al.) found there was weak methodological rigour in all studies. This, and particularly the variation and lack of reporting of the adaptations made to the standard DBT programme, made it difficult to draw conclusions about the efficacy of the approach. The review indicated that the available research indicates that DBT and DBT skills groups can be adapted for people with a learning disability, but that high quality research is needed before conclusions about efficacy and effectiveness with this population can be made. A more recent small community-based randomized controlled trial attempted to address some of the methodological problems through using a single-blind, mixed methods design (Jones, 2021). Qualitative data suggested that it was feasible and beneficial to deliver adapted DBT in the community, although no differences in the quantitative outcomes between the treatment and non-treatment group were found.

5.2.5 Dyadic Developmental Psychotherapy (DDP)

Due to its focus on supporting the dyadic relationship (between the person and a primary attachment figure) where there has been developmental trauma, the DDP model has been seen to be appropriate for use with children and adults with a learning disability (Jones, 2021, as cited in Beail et al., 2021), specifically to create safety through strengthening relationships when the challenges with connection are due to ACEs, breaks in relationship due to hospital care/extended respite requirements or the complexities of communication linked specifically with having a learning disability or developmental delay. The systemic focus of the model makes it suitable for use through direct family work, and indirect work with workers supporting the person, such as staff teams offering respite/specialist educational settings, or supported tenancy/residential care.

For use with people with a learning disability the DDP model will need to be adapted (see Jones, 2021, as cited in Beail et al., 2021, for an overview). In practice it will be important to carefully identify a key attachment figure who can be available for this dyadic focus work. DDP weaves effectively alongside a PBS model as a way of tailoring support strategies by creating a shared understanding of how the client's relational experiences shape the way they interact with others and the environment/situations around them. This means that proactive and de-escalation strategies align with the individual's internal working model to more successfully improve regulation, connection within relationships (including repair after any ruptures/incidents) and skills development support, in order to thrive. DDP directly addresses the risks of Blocked Care that's been associated with placement or family breakdown and with inappropriate or neglectful care. When working indirectly there is a need for high quality training about attachment and trauma with the family/team, and also ongoing support and consultation while exploring ways of holding this model in mind throughout the day.

The evidence base is in development, but current practise-based evidence is positive amongst the learning disability service community. Research shows that DDP interventions improve foster placement stability, with no disruptions recorded over an 8-year period (Hudson, 2006). Other research, (with 125 families), found that using a DDP-informed approach helped foster carers to develop an improved understanding for, and empathy about, the child's experience. Children reported feeling more trust towards their carers, and having improved self-esteem. Negative interactions and behaviour were also shown to reduce as a result of DDP therapy (McGoldrick, 2016). The Department of Health (2016) and NICE guidelines (2015) have recognised DDP as a promising approach and recommended ongoing research.

5.2.6 Eye Movement Desensitisation and Reprocessing (EMDR)

EMDR is an internationally recommended first line interventions for Post-traumatic Stress Disorder (PTSD) (e.g., National Institute [England and Wales] for Health and Care Excellence, NICE; 2018; World Health Organisation, 2013).

Adaptations to the EMDR protocol to facilitate its use with people with a learning disability reported in the literature include the use of printed resources, prolonging the stabilisation phase, and using techniques from other interventions that the client learned previously. For bilateral stimulation, clients often opted for butterfly or tapping techniques rather than the eye movements; this was a common adaptation observed across studies (Smith et al., 2021). In Unwin et al. (2019)'s review clinicians also used prompts to support an individual's focus during sessions. Porter (2022) provided an example of clear and detailed reporting of adaptations to the EMDR protocol for use with people with a learning disability, and the adjustments found to be particularly useful were the use of visual supports, frequent return to target and a focus upon emotions and physical sensation rather than images or cognitions.

The evidence base for the use of EMDR with clients with a learning disability is at present limited and interpretation is difficult due to methodological weaknesses, such as small numbers of participants and inconsistent reporting of adaptations (Porter, 2022). Quantitative findings of a few studies suggest that this type of therapy can be effective in reducing trauma-related symptoms. Unwin et al. (2019) in a study found that clients reported the following benefits following EMDR: being listened to; it is nice to know you are not the only one; the importance of feeling safe; achieving and maintaining change. In what was reported to be the first randomized controlled feasibility study for this population to examine the effectiveness of EMDR therapy and standard care versus standard care alone for PTSD in 22 adults with learning disabilities, Karatzias et al. (2019) found positive effects of EMDR on general anxiety and PTSD symptoms post-treatment and at 3-month follow-up. A recent study (nine participants) by Verhagen (2023) supported this and other research findings (Mevissen et al., 2017; Quevedo et al., 2021) that EMDR therapy is a safe, feasible, and, they suggested, a potentially efficacious treatment option for people with mild learning disability, PTSD symptoms, and severe mental health and social problems.

5.2.7 Group interventions for people with a learning disability

Psychosocial interventions can be defined as interventions that emphasise psychological, behavioural, or social factors rather than biological factors, such as pharmacotherapy. Their benefits include interpersonal, informational activities, and techniques that target biological, behavioural, cognitive, emotional, interpersonal, social, or environmental factors to improve a person's health function and well-being (Willner, 2005; Rossiter et al., 2016). They have a potential to support people, improve quality of life, reduce risks of hospitalisation, and placement breakdown (Department of Health, 2016, 2017).

Psychosocial groups for adults with learning disabilities can support social and interpersonal issues whilst providing people with a setting where they can build their confidence and improve their self-esteem. Group work provides a platform for people to link with similar people and to experience extended networks outside their own families or paid support systems (Bourne et al., 2018). Additionally, community groups can give people insight into occupational benefits, choices, and options that they might not have previously considered including home life changes and the need or wish to be independent alongside psychological support. Group environments allow people to share experiences, receive validation or encouragement, develop socioemotional intelligence (Goad, 2023) and learn new ways of coping (Bates, 2005), which may help reduce shame.

A recent study aimed to investigate what interventions were being delivered in community group settings and to identify their effectiveness, including components that might support engagement (Bourne, 2022). Over half of the group-based interventions being delivered had a focus aligned with specific presenting problems of the participants, which included: anger, self-esteem, bereavement, anxiety, hearing voices, psychosis, and depression and tailored with interventional activities to support that area of need. Several different methodologies were used that included quantitative, qualitative, and RCTs. Findings from the qualitative data, embraced psychosocial groups as offering places to develop relationships, improve self-worth, improve decision making, make social connections, develop friendships, improved self-esteem, and have a peer group. The review also highlighted that groups might be more beneficial if they ran for a longer period of time to support learning and change behaviours. The review also highlighted a lack of provision particularly for people with varying abilities. Groups that produced best outcomes adopted a creative aspect with multiple activities over a brief period, with breaks and group rules.

Examples of group-based programmes include Busfield et al.'s (2024) study which aimed to describe and evaluate an 11-week CFT group attended by adults with a learning disability. Several benefits were noted; for instance, helping people understand why self-compassion is important, helping people to understand theirs and others' emotions and helping to increase confidence. The structure and content of the group provided a framework for participants to share their experiences of social rejection, discrimination and subsequent feelings of worthlessness, inferiority, and powerlessness. A number of adaptations were made to resources used in the group therapy (see Busfield et al., 2024).

Other examples include The Standing up for Myself (STORM) intervention (Scior et al., 2022) which draws on cognitive behavioural therapy (Beck, 1978; e.g., examining the benefits and disadvantages of different ways of responding to stigma); narrative therapy (White & Epston, 1990; e.g., by separating oneself from a problematised label and developing new stories about oneself); and liberation psychology (Martín-Baro, 1994; acknowledging acts of oppression). Peer support throughout the STORM intervention was seen as crucial with hypothesised benefits for well-being, sense of self-worth, and responses to stigma (Pistrang et al., 2008; Puschner, 2018). At the personal level, participants in the current study vocalised beliefs in line with stigma resistance, such as having equal rights and rejecting negative judgements by others. At the peer level, participants spoke about the importance of hearing the experiences of other people with a learning disability and standing up not only for themselves but also peers. Finally, at the public level, participants fed back their plans to educate others and to speak out against discrimination. Some participants decided post-STORM to become actively involved in self-advocacy.

5.2.8 Intensive Interaction

Intensive Interaction was developed in the 1980s as a communication approach to meet the needs of people with severe or profound learning disabilities and/or severe autistic spectrum disorder. Intensive Interaction recognises the pre-verbal nature of adults with a profound learning disability and mimics the early attachment process to develop the very beginnings of communication and sociability (Elgie & Maguire, 2001).

There is little written about the psychological theory that might underpin Intensive Interaction (Berry et al., 2014) but many psychologists refer to using Intensive Interaction to promote 'psychological contact with people who are difficult to reach' and doing this through finding ways of communicating together in a way which was totally at the person's pace. Berry et al. (2014) conducted a study into the views of clinical psychologists on Intensive Interaction and most reported the benefits to attachment relationships for people with a learning disability but also a need to develop more research into its efficacy. In this study those using Intensive Interaction used it to establish psychological contact with people who are difficult to reach due to their developmental disabilities.

The approach is characterised by regular, frequent interactions between an adult and a person with a learning disability in which there is no task or outcome focus. Also, the 'style' permeates the adult's whole way of being with the person. Intensive interaction is a 'process-oriented approach with the process of interacting becoming the object of ongoing, careful reflection so that the interactions become purposeful and progressive' (Nind & Powell, 2000). Staff need to work collaboratively with the person so individual differences in interactive style are observed and evaluated and so that a problem-solving approach to difficulties in the interactive process can be adopted.

5.2.9 Mindfulness and acceptance-based therapies

Mindfulness and acceptance-based therapies have proliferated in use over the past 20 years, and are now considered mainstream psychological approaches. Approaches include Acceptance and Commitment Therapy, Mindfulness Based Stress-Reduction, Mindfulness-based Cognitive Therapy, Mindfulness of the soles of the feet, and sometimes considered to include Compassion Focused Therapy interventions. Dialectical Behaviour Therapy also draws heavily on mindfulness and acceptance-based principles, but is covered separately within this document.

Mindfulness and acceptance-based approaches typically acknowledge the normality of human suffering, disputing the notion that mental health and well-being is to be equated with an absence of symptoms. Patterson et al. (2019) completed a systematic review of third wave therapies for people with a learning disability. 22 studies were identified focusing on common mental health difficulties and anger / aggression. Analysis of the results demonstrated a promising, albeit still emerging evidence base. A summary of each of the main mindfulness and acceptance-based approaches is described below, with reference to the relevant evidence base for the individual approaches.

a. Acceptance and Commitment Therapy (ACT)

An ACT approach aims to increase psychological flexibility and help the person to live a vital and personally meaningful life. ACT is often described as comprising of six interrelated processes: Defusion (which can be described as getting unstuck from thoughts); Acceptance (developing a willingness to experience whatever emotions arise); Present Moment Awareness (being aware of each moment as it unfolds); Self as Context (developing a sense of the observing self), Values (identifying what matters most), and Committed Action (actions in line with values).

There is a broad and increasing evidence base for ACT, but the evidence for people with a learning disability is limited to date. Byrne and Mahony (2020) completed a systematic review of ACT interventions for adults with a learning disability. The results identified eight relevant studies. All of the studies were small and had design limitations, but provide a basis for future research. In terms of resources, Williams and Jones (2022) developed an ACT informed guided self-help workbook to support psychological well-being.

b. Compassion Focused Therapy (CFT)

CFT is a motivational multi-modal therapy that focuses on helping people access and stimulate affiliative motives, emotions and competencies. These underpinning compassion skills play important roles in threat regulation, well-being and prosocial behaviour (Gilbert, 2015). Thus, CFT supports people to empathically engage with their own suffering (engagement) and take wise action in dealing with reducing and preventing suffering (alleviation). Roberts (2023) conducted a review of CFT studies, identifying eight relevant studies including group and individual interventions.

Gore and Hastings (2016) summarised adaptations made across different protocols, and Patterson et al. (2019) similarly summarised adaptation themes identified in a systematic review. Key themes included:

- Suitable orientation sessions to support understanding and encourage future attendance
- Creation of safe and supportive delivery contexts
- Use of simplified language
- Making abstract concepts more concrete using examples and other creative means
- Chunking information
- Using physical/visual prompts
- Providing additional time to process information, and fine tune mindfulness practise skills
- Regularly checking participants' understanding
- Using role play and experiential exercises
- Adjusting duration of sessions to suit individual needs
- Involving caregivers where possible and appropriate

There is evidence for utilising mindfulness and acceptance-based approaches to support supporters and family caregivers. For example, Noone and Hastings (2009, 2010) piloted ACT based support for NHS Learning Disability staff, showing promising results. Williams and Jones (2023) described how the principles of ACT can be beneficial to support workers and practitioners to improve their own well-being and thus the quality of support provided.

There is increased use of mindfulness and acceptance-based approaches with children and adults. There are a range of small-scale studies using different models and approaches, with the largest evidence base being for soles of the feet mindfulness approach. There is a need for further high-quality research across, and a particular need for an increase in research with children and young people with a learning disability.

5.2.10 Psychodynamic Psychotherapy

Psychodynamic psychotherapy has been adapted for use with adults with a learning disability (see Beail, 2016 for a review) and features of the approach have been seen to make it particularly applicable to people with a learning disability, such as the careful attention to and interpretation of all forms of communication, the use of psychodynamic theories of development to understand the origins of the person's difficulties, and using the therapeutic relationship to provide the opportunity for a reparative and safe relationship to be experienced by the person with a learning disability (Frankish, 2013).

Adaptation of psychodynamic psychotherapy should be based on the individual's needs, preferences, communication and cognitive abilities. Consideration should be given to where the therapy will take place; a set therapy room can help to maintain the therapeutic frame whilst for others a more flexible approach such as going for a walk or car ride may be more accessible (Berry, 2003). Flexibility may be required around the duration and frequency of sessions according to the individual's needs (Beail & Newman, 2005).

Therapists may need to take a more problem-focused approach than typically, with less emphasis on free association (Beail, 2016). People with a learning disability may require support to communicate what is on their mind, such as the therapist suggesting ways the patient can label their feelings, or by utilising techniques such as drawing or puppets to reduce the reliance on verbal communication, depending individual communication styles (Upton, 2009). Interpretations shared with the person will need to be tailored in ways that the individual can tolerate (Alvarez, 2012). Where appropriate, interpretations should be formulated into short, easy to understand sentences, (Beail, 2016) and given in a timely manner (Jackson & Beail, 2013) so that the patient may make best use of them.

A systematic review (Shepherd & Beail, 2017) of the approach for people with a learning disability found evidence of the effectiveness of psychodynamic psychotherapy, with reduction in problematic symptomology (and in particular in interpersonal difficulties) and increased self-esteem. They noted, however, that to date the quality of the research in this population was generally poor. A systematic open trial of 30 participants with a mild to moderate learning disability and a history of adverse childhood experiences was reported in 2018 (Skelly et al.). Individuals has weekly psychodynamic psychotherapy (mean number of sessions was 22) and both self-report and independent ratings indicated significant and large reduction in psychological distress and challenging behaviour, and improvements in mood and relationships, with these gains maintained 6 months post-therapy.

5.2.11 Systemic Psychotherapy and Family Therapy (SPFT)

The systemic psychotherapy and family therapy focus on context, relationship, communication and interaction, and the conceptualisation of problems as happening between people rather than being located within the individual may be particularly helpful for people with a learning disability, who are vulnerable to assumptions being made about problems being located within them and their disability, and as such the contributions of others within the systems to the presenting situation are not taken into account (Baum & Lynggaard, 2016). Additionally, people with a learning disability often live within complex networks of family, other people with a learning disability, carers and professionals and thus systemic approaches may be particularly relevant.

SPFT may be used with family systems of with wider networks or professional systems. It may be particularly helpful when a system is adjusting to a life cycle transition (Vetere, 1993) or when a system is striving to balance the need to safeguard an individual with a learning disability with their desire for independence (Fidell, 2000).

Adaptations will look different for each unique system. Thought should to be given to whether the person with a learning disability should attend sessions. Including them in sessions can help to draw the system's attention to their role within the system, and ensures that therapy does not perpetuate a cycle of their views and opinions not being considered. If they do not attend, methods of including their voice in sessions should be used. For example, Iveson (1990) suggests encouraging other members of the system to speak from the individual's position. It may be useful to first work with individual parts of a system (e.g. just parents or just the referred individual) before bringing the system together for sessions (Donati et al., 2000). This can help each member of the system to think through what they would like to say and how to say it. If the person does attend, consideration of how to support them to communicate their points will be needed. The use of nonverbal techniques such as drawing, using puppets or role play can be helpful to draw out the person's opinions and views, or to make abstract ideas (such as externalising problems) more concrete (Baum & Lynggaard, 2016). Families that include a member with a learning disability may require adaptations to the pace of session and may require more sessions (Fidell, 2000). If a reflecting team is used care should be taken to ensure the family is fully briefed on what will happen and why (Anslow, 2014) and that the number of ideas presented is minimised (Cardone & Hilton 2006).

There is a good evidence base for the use of SPFT approaches with people with a range of presenting difficulties, although the research specifically with people with a learning disability is mainly at the case study level to date (Baum & Lynggaard, 2016).

5.2.12 Solution-Focussed Brief Therapy

Solution-focussed brief therapy (SFBT), which covers solution-oriented work, solution-focussed practice, thinking, consultation and practice (Lloyd et al., 2016), has been found to be effective and efficient in a range of therapeutic settings (Lohuis et al., 2017). Various aspects of this approach have been seen to make it particularly relevant to working with people with a learning disability, particularly that it focusses on using the person's own strengths and resources, thus naturally adopting an empowering stance for the person with learning disabilities. This stance may contrast with previously held 'problem-focussed' narratives around the person, and thus bring its own challenge (Lohuis et al., 2017). In addition, features such as the focus on the future (rather than the past) and the pragmatic nature of the work (encouraging simple, adaptive solutions based on 'doing what works') have been seen to be particularly relevant to this population, lending the approach high face validity.

SFBT has been used in several ways for people with a learning disability: in face to face work between a therapist and person with a learning disability with or without a supporter; 'by proxy', whereby a supporter seeks help for themselves as a carer to manage the situation (solution-focussed consultation); and solution-focussed coaching whereby the SFBT approach is taught to staff to alter interaction styles and thinking experienced by the person with a learning disability in their environment (Lloyd et al., 2016).

Lloyd et al. (2016) noted that the core assumptions of SFBT do not need to be adapted when working with people with a learning disability. Adaptations to delivery described in the literature include adapting language to the person's receptive language skills and supporting language with visual materials and role play (e.g. Banting et al., 2018). For those with difficulties with memory or abstract concepts, focussing on the here and now, concrete observable details of everyday life may be helpful. Adapted rating scales and tools to illustrate progress towards goals can be created. Careful consideration of the language used (e.g. connotations associated with 'homework'), how questions are framed, particularly the 'miracle question', and how to work with different views between the person and their supporter may be needed.

The research into the efficacy and effectiveness of SFBT specifically for people with a learning disability is at an early stage, and whilst encouraging, more clinical trials with outcome data and controlled trials are needed (Lloyd et al., 2016).

Section 6: The role of supervision and reflective practice

Practitioners working with people with a learning disability are often required to integrate complex information in order to adapt therapeutic approaches to the individual's requirements, as well as work within systems at multiple levels, through different modalities. Supervision and reflective practice are therefore vital to support the individual to perspective-take and manage the complexity of their work safely.

Supervision is a complex process that encompasses teaching, skills coaching, modelling, encouraging reflective practice, corrective feedback, gatekeeping and ensuring the safety of clients (Falender et al., 2004).

The Department of Health (1993) defines supervision as, 'A formal process for professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety in complex situations. It is central to the process of learning and scope of the expansion of practice and should be seen as a means of encouraging self-assessment, analytical and reflective skill.'

Supervision is identified within a range of documents in relation to the governance of professional practice, for instance, the Care Quality Commission's Essential Standards of Quality and Safety (2010) and the Health and Care Professions Council Standards of Practice 2c.2 (HCPC 2016). Recent guidance also published by the BPS relating to supervision by clinical psychologist's (BPS, 2024).

Making use of supervision is a generic skill that is pertinent to all practitioners at all levels of seniority because clinical work is demanding and usually requires complex decision-making. Supervision allows practitioners to keep their work on track and to maintain good practice. Being an effective supervisee is an active process, requiring a capacity to be reflective and open to criticism, willing to learn and willing to consider (and remedy) any gaps in competence which supervision reveals. The ability to monitor relationships, identify and repair any ruptures is also associated with better outcomes. These competences are common to all who provide psychological therapy.

Barriers to good supervision include a lack of time and heavy workload, a lack of resources, unsupportive management and colleagues, a lack of supervisor training, and a lack of trusting relationships and ongoing support.

In addition to the skills and training requirements, it will be necessary for anyone providing supervision for a practitioner working with people with a learning disability, their families and wider support structures to have a good knowledge and understanding of development (physical, emotional, social and cognitive), systems around the person including family and life cycle transitions. Practitioners should have role appropriate level of skills and awareness regarding trauma informed practice and the impact of developmental trauma.

Where the intervention being carried out by practitioners working with people is other than formal psychological therapy, the requirements for model specific clinical supervision is less pertinent, but the knowledge outlined above and an understanding of the system in which the professional is working, the resources available to them, a compassionate and relationally informed approach are essential. The nature and focus of this supervision should fit for the particular scenario and staff group, and could include reflective practice and case discussion as well as personal reflection.

In all cases, one of the focuses of supervision will be supporting, educating, and enabling the supervisee in understanding the presenting needs in the context of relationships and development and to support the practitioner to deliver the most appropriate intervention competently and safely. Where an intervention is being led or delivered by a professional working outside of a core mental health service, careful consideration needs to be given as to how supervision can be provided and accessed. It is likely that multiagency agreements and protocols will need to be developed and practitioners employed within core mental health services will have a lead responsibility in this. The model of having highly skilled psychological practitioners embedded within other services also addresses this need.

Supervision is vital for staff working in isolated community-based services for people with learning difficulties (Sines & McNally 2007). Being able to reflect on power imbalances and the social cultural context in which people with a learning disability live and access interventions is vital. The Social Graces (Social GGRRAAACCEEESSS) framework developed by John Burnham (1992, 1993) and Alison Roper-Hall (1998) is increasingly being used within training institutions, as a means of encouraging learners to critically explore issues of social difference. Attending to issues of power and diversity is believed to help supervisees become more alert to any biases that may impact on therapy or their work more generally with people with a learning disability.

Reflective practice

Working both within the National Health Service as a practitioner, and with people with a learning disability requires critical reflection on experience. To effectively learn from one's experience is seen as critical in developing and maintaining competence across a practice lifetime.

As one's professional identity is developed, there are aspects of learning that require understanding of one's personal beliefs, attitudes and values, in the context of those of the professional culture; reflection offers an explicit approach to their integration (Epstein, 1999). Building an integrated knowledge base requires an active approach to learning that leads to understanding and linking new to existing knowledge. These capabilities underlie the development of a professional who is self-aware, and therefore able to engage in self-monitoring and self-regulation (Bandura, 1986).

Reflective practice is about thinking things through from our clinical work and experiences, from many angles and perspectives. Working with people with a learning disability and their systems involves working with difference and power, and it is essential that these are reflected upon in the building of relationships and in supporting anti-discriminatory practice and decisions relating to particular interventions. Reflective practice can be part of individual supervision or reflective practice groups can be important vehicle for support, professional development, and accountability.

Section 7: Outcome measures

Outcome measures are tools which can be used to describe the progress of care, support and treatment. Prior to providing interventions, an outcome measure can provide baseline data. Measuring outcomes enables services to monitor changes, support understanding what matters to a person, and keep interventions focussed. Over time this will also allow better understanding of the psychological needs of the people services work with and ensure the approaches continue to be appropriate.

An All-Wales framework describes the importance of effectively using 'patient' reported outcome and experience measures in mental health and learning disability services has been developed in consultation with service users, carers and practitioners. These tools are often known as Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs). Tools have been placed in three clusters, those that measure improvements in well-being, achieving goals, and satisfaction with services. A systematic review by Townsend et al (2012) details available Quality of Life measures for people with a learning disability with the aim of identifying psychometrically sound measures that can be routinely used for service evaluation.

Many learning disability services already use tools that capture information that will allow services to better understand the impact that their interventions are having on addressing the determinants of poor outcomes for people with a learning disability. These measures include the learning disability variation of CORE-OM (CORE-LD), Glasgow Depression (GDS-LD) (Cuthill et al., 2003) and Anxiety Scale (GAS-ID, Mindham & Espie, 2003) and Psychological Therapies Outcome Scale - Intellectual Disabilities (PTOS-ID). The use of cue cards alongside these measures may support completion.

Where parents and carers are the main recipients of interventions for their child, appropriate outcome measures to evaluate their experience and outcomes should be chosen. These may relate to specific intended outcomes of the intervention (e.g. confidence to manage their child's behaviour) or their own or their child's well-being. Measures recommended for adults may be relevant, or specific measures to assess the outcomes for parents and carers of children with a learning disability may be used. Parents and carers will also be well-placed to report on the outcomes for their child or young person, where the child is unable to, or in addition to the child's report. For children and young people (up to age 16) there is the Sheffield Learning Disability Outcome Measure (SLDOM) which measures their parents' perception of their child's difficulties and their ability to cope with them.

Where measures have been developed and validated for individuals with a learning disability, these should be used to ensure validity and reliability. There are several systematic reviews available which include different measures (e.g. see Flynn et al., 2017; Kumar et al., 2024; Baker & Daynes 2010) including a review specifically focussed on measures for children and young people with a learning disability (Halvorsen et al., 2023). Should adaptation of measures be needed, there is some guidance in the literature about how to do this (summarised in Table 2).

Table 2: Summary of considerations regarding outcome measures for people with a learning disability

Outcome Measures	
Usually, where possible, use measures specifically designed/adapted for adults/children with a learning disability	See Improvement Cymru recommended Outcome Measures
Where there is not a suitable measure available adapt the format of measures	▪ Reduce sentence length ▪ Remove unnecessary words, simplify phrasing ▪ Remove double negatives ▪ Make abstract language more concrete ▪ Reduce number of response options (e.g., 5-point Likert scales to 3 points on a scale) ▪ Present options as questions rather than statements ▪ Change the tense from past to present ▪ Use visual images/prompts to represent the meaning of items and response options (e.g., using clear containers with different amounts of liquid to represent different response options ‘no,’ ‘a little,’ ‘medium,’ ‘a lot’)
When necessary adapt the process of administering the measure	▪ Train or demonstrate the use of pictorial response options, to model and check understanding ▪ Read questions out loud, offer one item at a time ▪ Offer support from caregivers or staff ▪ Allow additional time before the session to complete measures

Annex 1: The decision-making process for what interventions to include in this guidance

There has been an increasing range of psychological therapies become available and increasing recognition that people with a learning disability should be offered psychological interventions adapted to their needs (Beail, 2016). There are tens if not hundreds of interventions listed in Matrics Cymru and the Scottish Matrix, and it is beyond the scope of this guidance to comprehensively consider all interventions that might be offered to people with a learning disability. The selection process as to what to include is outlined here.

Protocol for inclusion

1. What is recommended by NICE for people with a learning disability?
2. What interventions, listed in Matrics Cymru and the Scottish Matrix tables as recommended for the general population, have been adapted and evaluated for people with a learning disability? What interventions have been included in published literature reviews?
3. What interventions have been designed specifically for people with a learning disability? What interventions for people with a learning disability should be considered due to the quality of the evidence and practice-based evidence available that are not listed in Matrics Cymru or the Scottish Matrix?

1. NICE recommendations

NICE (2017) provides a quality standard [QS142] for the management of mental health issues in people with a learning disability, and states *“standard evidence-based psychological interventions are not designed to take account of the cognitive, communication or social impairments associated with learning disabilities”* and *“the care setting and interventions need to be adapted and tailored to each person’s preferences, level of understanding, and strengths and needs”.*

Further guidance on the delivery of psychological interventions for people with a learning disability and mental health problems (NICE 2018) suggests following NICE guidance on specific mental health problems for the general population, whilst taking into account the principles for delivering psychological interventions (use the assessment to inform the psychological intervention and any adaptations to it; collaborate with the person’s family, carers or paid workers as appropriate; be aware that people might need more structured support to practise and apply new skills to everyday life).

There are four specific recommendations from NICE (2018) relating to psychological interventions for mental health treatment for people with a learning disability:

- adapted CBT for depression in people with milder learning disabilities
- relaxation therapy to treat anxiety symptoms
- graded exposure techniques to treat anxiety symptoms or phobias

- parent programmes specifically designed for the parents and carers of children with a learning disability “to help prevent or treat mental health problems in the child, and to support carer well-being”

When specifically considering behaviour that challenges (NICE 2015), recommends early intervention for children and their parents or carers, specifically to consider for those with emerging or at risk of developing behaviour that challenges

- programmes for parents of children under 12 years (with guidelines for features of the programmes)
- preschool classroom-based interventions for children aged 3-5 years (to include curriculum design and development, social and communication skills training for the children, skills training in behavioural strategies for parent or carers and how to adapt the interventions for preschool teachers

In terms of the psychological intervention strategies specified, it goes on to state that considerations would be

- personalised behavioural interventions that include addressing environmental factors and the responses of those around the person to behaviour that challenges
- cognitive-behavioural interventions for adults with an anger management problem (individual or group)

2. What interventions are listed in published literature reviews of adapted interventions?

Two published reviews have considered the adaptation of a range psychological interventions for adults with a learning disability (Beail, 2016; Birdsey et al., 2021) and these were used to guide and categorise the therapies that were selected from Matrics Cymru and the Scottish Matrix to be considered for inclusion in this document.

3. Interventions specifically designed for people with a learning disability that are not mentioned in Matrics Cymru or Scottish Matrix

The advisory group and a range of practitioners across Wales were consulted about other interventions that might be included.

The above process generated a list of psychological therapies and interventions for children, young people and adults with a learning disability, their parents and carers. For each of these, a rapid review of the evidence base for the population with a learning disability and their parents/carers was conducted.

Glossary / Footnotes

Active offer - An 'Active Offer' means providing a service in Welsh without someone having to ask for it. The Welsh language should be as visible as the English language.

All Wales Standards for Accessible Communication and Information for People with Sensory Loss - The All-Wales Standards for Communication and Information for People with Sensory Loss (the standards) were implemented in 2013 to dismantle barriers to healthcare for people with sensory loss. The standards are being reviewed and will now also include patients whose main language is not English or Welsh; patients who have language and communication barriers due to disability, dementia, mental health conditions or learning difficulties; patients who have language and communication barriers arising from neurodivergence; patients who have language and communication barriers arising from low literacy; and parents and carers (of patients) who have language or communication barriers.

Behaviour that challenges / Behaviours of concern - Some people with a learning disability display behaviour that challenges or is of concern to the people around them. Emerson and Einfeld (2011) defined behaviours that challenge as "culturally abnormal behaviour(s) of such intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities." The term 'behaviour that challenges' is used in this document, and it is recognised that behaviours may challenge services, family members or carers, and may serve a purpose for the person with a learning disability (for example, by providing sensory stimulation, attracting attention, avoiding demands and communicating with others). Behaviours that challenge include aggression, self-injury, stereotypic behaviour, withdrawal, and abusive, disruptive or destructive behaviour. Behaviours that challenge are also referred to by other terms such as 'challenging behaviour' and 'behaviours of concern' the term behaviours of concern is also used (see Understanding 'behaviours of concern').

Context – The settings around children, young people, and adults; the things they are a part of and which have an influence on how they grow up. This includes systems in which the person has day to day relationships such as family, school, staff, peer group, community, as well as systems which influence those, such as culture, religion, politics and social media.

Distress - Sustained, rather than transient, emotional pain which may present through words or actions and may include an increase or decrease in certain behavioural patterns.

Evidence based practice – Basing the way in which you do your job on the findings of published research.

- **Practice based evidence** – Evidence generated through the systematic evaluation of the outcomes of any aspect of clinical practice, including therapeutic relationships.
- **Theory based practice** – Innovative psychological intervention based on sound theoretical principles that may not yet have generated significant published evidence.

Family - This can mean very different things to different people at different times. In this document, family can mean the people with whom a child or young person lives with and who may or may not be related to them, as well as people to whom they are related.

Global Developmental Delay (GDD) - When a young child reaches two or more areas of development, such as cognitive, motor, communication, social or self-help skills significant later than the majority of children, this may be described as Global Developmental Delay. The diagnosis is intended for use in children under the age of five years old before clinical severity can be determined (DSM-V (Diagnostic and Statistical Manual of Mental Disorders, 2013). Some but not all children with GDD will go on to meet criteria for having learning disability (e.g., Riou et al., 2009).

Intellectual Disability - The term 'learning disability' has been used in this document as opposed to the term 'intellectual disability' typically used in academic writing. This decision is in acknowledgement that 'learning disability' is the preferred language of the learning disability self-advocacy movement (Jones & Haydon-Laurelut, 2017).

Learning Disability -The term 'Learning Disability' usually refers to a diagnostic category encompassing both a significant impairment in intellectual functioning and marked challenges in adaptive functioning, both originating in childhood (DSM-V (Diagnostic and Statistical Manual of Mental Disorders, 2013) The British Psychological Society and the diagnostic manuals define learning disability in terms of three core criteria:

- significant impairment of intellectual functioning (usually taken as having an IQ lower than);
- significant impairment of adaptive/social functioning; and
- age of onset before adulthood.

Many definitions of learning disability specify that the person will have an IQ (Intelligence Quotient, as measured by standardised intelligence tests) of less than 70. In practice many people with a learning disability have not had an intelligence test administered and their IQ is not known.

The levels of disability individuals live with are often categorised as ranging from mild, moderate to severe or profound (further details of this can be found in Lavis et al., 2019). It is important to note that within these descriptive categories the strengths and needs of the individual will vary significantly.

The use of the term learning disability as a 'medical diagnosis' has been criticised as it locates the difficulties experienced by the person as being caused by their impairments or differences. It is argued that the concept is socially constructed (BPS, 2018) and that difficulties are experienced because of the social context in which people live. Individuals themselves can experience discomfort around such diagnostic terminology and tend to create personal definitions (Kenyon et al., 2014; Monteleone & Forrester-Jones, 2017; Webb & Whitaker, 2012).

Mwy Na Geiriau / More Than Just Words - This is the Welsh Government's Welsh language plan for health and social care. Receiving services in Welsh, especially when people are at their most vulnerable, should be an integral component of person centred care. Professional standards in health and social care services note that effective communication is a key requirement, highlighting the need to maintain dignity and respect. Adoption and delivery of More Than Just Words should therefore help improve the quality of care for individuals living in a bilingual country.

Parents - it is recognised that many people bring up children: biological and non-biological parents, grandparents, other family members and so forth. The term 'parent' is used here to refer to all kinds of parent figures.

Practitioner – A person who is in a professional role in relation to children and families and where part, most, or all of that role involves at the very least noticing the emotional well-being and mental health needs of the child or family.

Psychologically minded services – Services whose core business includes interacting with children and families where there are often high levels of distress and which therefore need to hold psychological principles at the forefront of what they do. These services may or may not offer specific intervention to improve emotional well-being or mental health of children and families, but the services they offer will have an impact on emotional well-being and mental health

Psychological intervention - A purposeful course of action underpinned by psychological theory and driven by a psychological formulation with the intention of improving the child's emotional well-being or mental health.

Psychological therapy - A psychological intervention derived from a specific psychological theory and formulated into a model or treatment protocol which may be verbal or non-verbal.

Specific Learning Difficulty - 'Learning disability' is distinct from specific learning difficulties, such as dyslexia and dyscalculia. These conditions affect one or more specific aspects of learning, and impact on the way in which people learn and process information. However, they are not associated with a global intellectual impairment/lower IQ.

Trauma and Developmental Trauma - The Trauma Informed Wales Framework (2022) defines trauma as: 'Any experience that is unpleasant and causes, or has the potential to cause, someone distress and/or anxiety. It is important to note that trauma can also be used to refer to the impact of a traumatic event.'

The Learning Disability Professional Senate (2021) states that trauma refers to: 'Events or circumstances experienced by an individual as physically or emotionally harmful, or life-threatening, which result in adverse effects on the individual's functioning and well-being.'

Complex or Developmental trauma "relates to abusive or threatening conditions sustained over a period of time, usually pertaining to childhood, and often occurs in (but is not exclusive to) the context of close relationships, such as sexual abuse, physical abuse, emotional abuse, or neglect. This type of trauma is not just related to the occurrence of events or experiences, but can also reflect the absence of love, safety, trust, belonging and connection." (Taken from Framework for the implementation of Trauma Informed Care in residential and supported living services for adults with a learning disability.pdf (bps.org.uk)

Useful links and literature:

Resource designed to support families to understand Positive Behaviour Support:

- NHS Wales Executive: Once for Wales Positive Behaviour Support family resource

Ingamells, B., Morrissey, C., Brotherton, N., & Ashworth, S. (2018). *I can feel good (2nd ed.): DBT-informed skills training for people with intellectual disabilities and problems managing emotions.* Pavilion Publishing:

- DBT-informed skills training for people with intellectual disabilities and problems managing emotions.

S. Bernard & J. McCarthy (Eds) 2020 Mental Health Needs of Children and Young People with a learning disability. Pavilion Publishing & Media.

Beail, N., Frankish, P. & Skelly, A. (Eds) 2021 Trauma and Intellectual Disability: Acknowledgement, Identification and Interventions. Pavilion Publishing & Media.

Williams, J., & Jones, R. S. P. (2022). *Living your best life: Acceptance-based guided self-help for people with intellectual disabilities.* Pavilion Publishing.

Open access resource/ideas derived from adapting cognitive behavioural therapy approaches to promote children's skills in emotional literacy, resilience and wellbeing (including children with more complex additional learning needs):

- PELICAN: Promoting Emotional Literacy in Children with Additional Needs. Further information can be found here in the background paper

McElwee, J., & Oliver, L. (2024). E*valuation of the Children with Additional Needs (CAN) pathway: Emotional wellbeing support for children with additional needs within Aneurin Bevan University Health Board*. Improvement Cymru.

Information about school-wide Positive Behaviour Support:

- Website

National Institute for Health and Care Excellence. (2019). Learning disability: Behaviour that challenges (Quality standard [QS101]).

National Institute for Health and Care Excellence. (2018). Care and support of people growing older with learning disabilities (Guideline [NG96]).

National Institute for Health and Care Excellence. (2019). Learning disability: Care and support of people growing older (Quality standard [QS187]).

National Institute for Health and Care Excellence. (2022). Disabled children and young people up to 25 with severe complex needs: Integrated service delivery and organisation across health, social care, and education (Guideline [NG213]).

National Institute for Health and Care Excellence. (2022). Social, emotional and mental wellbeing in primary and secondary education (Guideline [NG223]).

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