

Psychotherapy and learning disability

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Executive summary

Across the UK and Ireland, policy documents have only very recently begun to recognise the mental health needs of people with learning disabilities.

People with learning disabilities need access to both generic and specialist psychotherapy, and services must be developed to ensure equality and inclusion.

The evidence

The presence of a learning disability inevitably affects psychological development and personality through various bio-psychosocial mechanisms, and rates of psychopathology are reportedly high among people with learning disabilities.

For various reasons, learning disability has traditionally been an exclusion criterion for good-quality outcome research within the full range of psychological treatments. Traditional treatments for psychological problems in people with learning disabilities have tended towards behavioural management, skills training and medication. With appropriate adaptations, other forms of psychological treatments are now being employed by enthusiastic practitioners, but research thus far has mostly been to illustrate the application and process of the therapy.

Researchers are now concentrating on outcome research, while practitioners recognise the need to widen understanding of emotional and psychological matters in people with learning disability to all health and social care agencies.

The present position in the UK and Ireland

Access to psychotherapy, when available, is through a range of provision, chiefly within learning disability services. A range of psychotherapeutic models are being employed by a variety of disciplines in some areas.

There is perceived to be a significant demand for psychotherapeutic services for this client group but there are very significant barriers to access to treatment, including attitudes of others, and lack of appropriate training and supervision. Supervision, when available, is eclectic and varies according to local service characteristics.

Developing practice is ahead of strategy. Innovative services are multi-disciplinary and cross service boundaries.

Service provision – emerging themes

Examples of current service provision range from highly-specialised services, providing individual and group psychoanalytic therapy, through to individuals or groups of clinicians within services that work at the level of facilitating psychotherapeutic understanding in the day-to-day work of carers, professionals

and support staff. To ensure a comprehensive service, it is important to have integration of a network of psychotherapy-based approaches across service areas.

The process of assessment may be more prolonged and will involve more people than in generic services. Specific issues may require more attention, such as consent or the practicalities of therapy.

Services place considerable emphasis on adequate and appropriate training and supervision, not just for therapists and other clinicians, but also for those involved in direct care and support.

Adaptation and flexibility of therapeutic approach is essential; this may often stretch or conflict with some of the common and traditional tenets of psychotherapy and has consequent implications for training, supervision, service structures and protocols.

The importance of working with the whole system around an individual is emphasised. Services may have specific operational procedures for engaging, educating or providing therapeutic support to carers and families.

Therapeutic approaches

The provision of psychotherapy for people with learning disabilities needs to address not only common mental health problems and emotional needs in this population, but also the very particular issues of impairment, disability and handicap.

These issues may be the main focus of therapy, psychological disturbance or distress being seen as secondary to the trauma and developmental impact of disability for the client and their family or carers.

For psychotherapies to be effectively delivered to this group, established models of therapy can be modified to accommodate differences in intellectual ability and the particular issues of the disabled individual that affect not only the content but also the process of therapy. Rigid adherence to established models of psychotherapy and its delivery can effectively exclude people with learning disabilities from receiving appropriate treatment.

The particular issues for therapy for people with learning disabilities may require specific training and supervision. Generic psychotherapy training is unlikely, at present, to equip a therapist to be able to work with these issues without some additional training in learning disabilities. 'Top-up' training in learning disability for psychotherapists and the availability of supervision by disability psychotherapists is likely to be the most effective way to increase access to therapy for people with learning disabilities.

Issues in professional training and development

There is a common need among all people working with people with learning disabilities for a core understanding of basic psychotherapeutic principles. At present, this is sparsely and inconsistently provided.

Modern psychotherapeutic models of psychological development do not in themselves make a clear and discriminatory distinction between people with learning disabilities and the general population. Training in the various modalities of psychotherapy will therefore have relevance to the needs of people with learning disabilities, both in their general and in their specific principles.

Because people with learning disabilities are still excluded from therapy and from being seen as 'training cases', trainees are not able to gain, or are prevented from gaining, experience of working with them. Some individuals have managed to bridge the gap between general psychotherapy training and working with people with learning disabilities, but there is no specific training or regulation of this specialist application.

Current early developments in professional training, and in regulation of training and competencies, have the potential to be more inclusive of people with learning disabilities and to address the specialist aspects of therapy for this group. The vulnerability of this client group and the specialist expertise and adaptations required, mean that standards of training and practice should at least be no less stringent and ideally more exacting than those for general training.

There are bodies of professionals whose current practice and training equips them well to work with people with more severe degrees of learning disability and whose contribution may be currently undervalued in service planning.

Professions such as nursing and social work that are in a good position to develop some basic psychotherapeutic interventions for people with learning disabilities are presently not equipped to do so by their basic training, and the lack of a strategy or career pathway in post-qualification training.

Summary of recommendations

Service planning and delivery must be based on the same principles as those for non-disabled people with the acknowledgement that special training and specialist service provision will be required to eliminate health inequalities. Services should be needs-based, focused on service users and carers, evidence-based, coordinated, accessible, user-friendly, safe and confidential.

There should be appropriate training at all levels to deliver a psychologically informed service which will have the dual effect of fostering good mental health and supporting early detection of problems and appropriate and timely referrals. There is a requirement for trained professionals with competence in the provision of psychotherapy in various modalities with this client group.

The contents of this report should be widely disseminated and acted upon. A multi-disciplinary group should be established to develop evidence-based guidelines for treatment choice in psychological therapies for people with learning disabilities.

Introduction

The terms 'psychotherapy' and 'learning disability' used to be rarely included in the same sentence. Over the past 15 years, there has been a small but growing interest in extending the application of psychotherapeutic interventions to include people with learning disabilities. There is, however, no formal training for learning disability psychotherapists, little service provision and highly variable development.

A working group was established by the Faculties of the Psychiatry of Learning Disability and of Psychotherapy of the Royal College of Psychiatrists in May 2000. Its remit was to examine the present position of psychotherapy for people with learning disabilities, and make recommendations for future training and service provision. This report is a result of the work of this group.

From the outset, it was apparent that the topic could not be usefully examined by taking a purely psychiatric perspective, since practitioners in the fields of both psychotherapy and learning disability are drawn from many disciplines. The Working Group included a representative from the British Psychological Society, and an independent psychotherapist represented the two other main practitioner groups. Other disciplines have been consulted and are encouraged to consider themselves part of the picture represented here.

We have been inclusive in our view of what constitutes psychotherapy during the process of gathering information, but more specific in our recommendations. We have also adopted a broad view of the population of people with a learning disability who might benefit from psychotherapeutic approaches, including all degrees of disability. We take a broad view too of the supporting systems in which people with learning disability live and with whom they relate and acknowledge that this is often where the need for support lies.

In carrying out its work, the Group was fortunate in being able to bring together members with considerable knowledge, expertise and experience in the field. From a basis of pooled personal knowledge, we moved on to examine the literature and evidence base, and established that neither services nor training had been previously described. At this stage, one of our first tasks was to answer a request by the Psychotherapy Faculty for Guidelines for Specialist Registrars training in the Psychiatry of Learning Disability on the knowledge and skills they should gain to work psychotherapeutically with their patients. These were drafted and a consultation workshop was held at the Annual Meeting of the Faculty of the Psychiatry of Learning Disability in Cork in October 2000. It was clear from this that there would be difficulties in implementing the Guidelines without a sufficient number of trained and experienced supervisors (Appendix 1).

The next stage of our work was to undertake a nationwide survey of the practitioner groups in the UK and Ireland, to examine present practice and the

perceived issues for access to therapy for people with learning disability. This is fully reported, and although the percentage return was small and undoubtedly reflects an established interest, this in itself was important. Interest was evidently widespread and not just limited to centres of acknowledged expertise. A picture was emerging that had not been painted previously.

Members of the Working Group were subsequently involved in further activities aimed at raising awareness, education and consultation through presenting papers, posters and workshops at national and international conferences. Through this and further consultation with contacts, a number of interesting developments became known to us, and we found it illuminating to follow these up to see what might be learned to shape future service development. An added benefit was finding common themes about what is different in providing psychotherapy services for people with learning disabilities and also clarifying some of the specific aspects of training required to meet the needs of this group. We describe this work in 'The Developing Picture'. It has not been written about previously, and should considerably advance the case for specialist training and service delivery. Indeed, we believe that this section extends the relevance of our work to an international audience, by whom people with learning disability are referred to using a number of different terminologies, including 'intellectual disability', 'developmental disability', and some older terms such as 'mental handicap' and 'mental retardation'.

The Working Group acknowledged the importance of the views of users and carers, but it has been more difficult to consult with them about their views on and experience of therapy, as this is uncommon in practice. None the less, an innovative example of a user forum and illustrative extracts from qualitative research in this field are included here.

Inevitably, in describing a developing therapeutic approach for a previously excluded and vulnerable group, there are aspects that are exciting and positive, and others that are confusing and concerning. We encountered all these aspects, but to a degree that was not expected.

We believe that our recommendations are important, timely and necessary if people with a learning disability are to have respect for their rights as equal citizens through the provision of accessible, appropriate and high-quality services. They have implications for the strategic development of both psychotherapy and learning disability services. They provide information that is important and challenging to commissioners and providers of both services. Finally, they demand a response from those organisations responsible for the training of all disciplines that work with people with learning disability at all levels.

Preface

What people say

Throughout the activities of the Working Group, we have felt it most important to ensure that this report endeavoured to have at its core the lives, the experience and the opinions of people with learning disabilities. It is appropriate, therefore, to include at the outset of this document a brief report from a piece of work that examined people with learning disabilities' experience and views of psychotherapy.

There are very few studies that consider the views of people with learning disabilities about talking therapies. The Working Group's attention was drawn to an interview study carried out by a senior clinical psychology trainee (MacDonald *et al*, 2003) with users of a specialist learning disability psychotherapy service. Nine of eleven members of two weekly out-patient therapy groups agreed to be interviewed about their experiences of being in therapy. Quotes from the interviews have been used to illustrate this brief report.

A recurring positive theme was that psychotherapy created an opportunity for the participants to express themselves in a supportive environment, and that participants seemed to feel included and valued in the group.

The most negative theme seemed to relate to the participants' desire to avoid emotional pain, which they had found to increase in various ways during many group sessions.

Talking characterises therapy

- Q. What actually happens when you're in there?
A. Oh we just talk about things, you know.
Q. And what does the therapist do?
A. Just like talk to us and like she stares at us and like, she like smiling at us.
Q. What do you do when you're in the group?
A. I talk too much! [Laughs]
Q. ... and what does everybody do ...?
A. Just talk, you know, it goes round in circles.
A. We just talk about it and they just talk about it with us.
Q. What do you do when you're in the group?
A. Oh, I listen to what they have to say.
Q. What do other group members do when you're in the group?
A. They talk about things and listen to them.

Feeling able to talk

Q. How was it helpful for you?

A. It was very helpful.

Q. Do you know why?

A. It makes you come out a bit more.

Q. ... express yourself?

A. Mmm.

A. Basically we just sat in the room and listened to each other's problems like ... and they heard my problems, what problem I've got. And, that's it really.

A. I find it helpful that you can go somewhere and talk to someone about problems. Because the people out there have got loads of problems and they've got nowhere to go and no one to talk to. I find the group very helpful. I've got somewhere to go and say I've got this problem, that problem.

Ability to talk contrasting with other situations

Q. And is that something that's easier to talk about in the group?

A. It's alright in the group but not with social workers.

Q. You can't talk to social workers about it?

A. No.

Q. And why's that?

A. Because they laugh at yer. Going round to them two, they're alright. I get on with them so much. [She goes on to describe a number of other experiences, which she does not feel she can share elsewhere.]

Q. You haven't been able to talk to anybody?

A. No. I haven't been able to talk to anybody about them. If I try to talk to someone, they don't want to know. So I think this group is more better for me because I can tell people how I feel. If I tell anybody else how I feel they don't care.

A. The therapist does speak a little bit, but then she goes quiet after and she goes it's our turn to talk to her. [P has described difficulties in her family.]

Q. ... and somebody can understand it?

A. Yeah, and somebody can understand what I went through and what I'm going through now.

Therapists valuing

Q. Are there any other things that you like about the group?

A. Mmm. They don't leave anybody out.

Humour in way of speaking about therapists

A. The therapists are very nice people, very nice ladies. I like them very much. Sometimes I get mixed up. I mix them up. Muck about. I call [one

therapist, other therapist] and [other therapist, first therapist] and they laugh about it.

Q. Do you do it deliberately?

A. I do it deliberately, yeah.

Q. Is there anything else they do that you find helpful?

A. Well if you tell them something really bad, they put on a soft voice [laughs], you know like 'Ooh, is it? That's terrible.' It's quite funny really that. Um, yeah, because they know, I don't know but I think they know, how we're feeling. They just know how we're feeling about ourselves.

A. It reminds me as they talk, tell their story, I can see myself with my mum, you know, I can picture it. So similar. It does make me want to cry. I get tears in my eyes. I try not to show it.

Therapists are too confrontational

A. And she [therapist] keeps staring at people ... yeah, and she keeps staring at us.

Q. What does that make you think?

A. Scared.

Q. A bit scary? When she doesn't speak then?

A. Yeah. She does speak a little bit, but then she goes quiet after and she goes its our turn to talk to her.

A. When I first went there I thought 'Oh God, they're not like me, you know'. But then, I realised, I sort of felt sorry for some of the girls there, like [name]'s one of them, I felt sorry for her.

A. And when you hear their problems you think 'am I going to get problems like they are?' I don't think when they was a teenager they had much of a life. Am I going to get these problems as well? I hope I don't.

What therapists say

We include here some brief vignettes provided by therapists working in the field of learning disability. They attempt to give a more 'lively' portrayal of how psychotherapy is being used to good effect in everyday practice:

A frequent issue raised in psychotherapy by people with learning disabilities is their painful awareness of their own disability.

Sarah, a 22-year-old woman with mild learning disability and deafness, is at her 35th session of psychoanalytic psychotherapy. It has been noted that her deafness often appears inconsistent or exaggerated. She describes a head injury suffered at the age of 6 when she was wearing a red skirt and tights and fell off a climbing frame. There was 'blood' everywhere. She remembered being in hospital and the doctors coming in with their white coats and holding up an X-ray. 'They thought I couldn't hear what they were saying, and he was saying I would never be right and that was when the decreased brains started. I lost brains, and after that couldn't keep up in school so he must have been right'. The therapist begins to make a link between Sarah's

exaggerated loss of hearing as a secondary handicap, one that prevents recognition of a more painful handicap, the loss of brains.

Amy, a 38-year-old woman with Down's syndrome, has been referred because of increasingly provocative and 'silly' behaviour towards her parents. The first four sessions of individual therapy are spent with Amy trying to engage the trainee therapist in superficial 'friendly' interactions, all the while grinning at the therapist and stating that they are 'friends'. In the fifth session, Amy goes quiet and nothing is said for a 10-minute period, during which the therapist is overwhelmed with a sense of having lost direction, being de-skilled and unable to know what to say next. Amy leans across to the therapist and speaking loudly and slowly, says 'I haven't got a brain you know'. In supervision, discussion centres on the therapist's experience of projections from the client of being 'empty headed' and stupefied, together with an intense sense of sadness and agony. The following sessions are able to concentrate on Amy's awareness of her disability and the reactions of others, including the ways in which her parents treat her as a child. Instead of an exaggerated smile, Amy weeps.

People with learning disabilities can often bring an emotional intelligence to the therapy process as they are not so handicapped by their cognitive skills:

Johnny sits quietly throughout a family interview listening to his parents debating hotly about the future of the family. At last he speaks, saying, 'Nan is dead'. The atmosphere in the room changes and the family all begin to discuss this painful issue.

Mary walks slowly into the consulting room and as she takes her coat off she says 'It's my mother you know – I can't get over her dying – she died a long time ago – but I still see her. You may think this is silly but I reckon that it's because she used to go away a lot when I was little and she always came back.' Mary and her psychiatrist agree that talking about her mother more might be helpful.

Severe problems of behaviour and offending have traditionally tended to invoke more restrictive responses and 'behavioural' approaches. Evidence is emerging that individual and group psychotherapies may be surprisingly effective contributions to working with those who prove highly challenging to services and to society as a whole:

A man with learning disability, detained within forensic services, is referred to a psychotherapist for assessment. His behaviours included varied and extreme violence to himself and others, smearing of faeces and refusing to eat. He was assessed as having suffered severe emotional trauma and was psychologically isolated from other people. The therapist's recommendations were for both an individual and systemic approach, based on an emotional developmental model. The systemic approach included the availability of a 'significant other' at all times to whom his needs could be expressed. Individual therapy was twice a week and was conducted on a one-to-one basis. Difficulties were encountered inevitably in the course and provision of therapy, but after 6 months he was able to function in contact with others and to recognise the need for two-way communication. He explored, in the therapy, his past and present relationships and developed a view of himself as a good-enough person who could live with others. Within 3 years, he was deemed ready to move to a less-secure setting.

The application of psychotherapeutic models of intervention and understanding of an individual's position in life does not apply merely at the client/therapist level. The introduction of a 'psychotherapeutic' way of thinking into an organisation at all levels can bring about significant benefits for all:

A 38-year-old woman with moderate learning disability is discharged by a Mental Health Tribunal from a high-security hospital where she has lived all of her adult life. She had also been taken into long-term residential care at the age of 4 following her mother's death, break-up of the family and discovery of sexual abuse by a close relative. An escalating pattern of emotional

liability, violence to others and self-injury had led to her eventual detention in the special hospital system at the age of 18. On return to her area of origin, she is an in-patient at an assessment and treatment unit for a few months before moving into a house in the community supported by a team of staff from a care agency. This placement disintegrates as a result of her continued emotional and behavioural problems and resulting high levels of staff sickness, difficulties in recruiting and therefore lack of consistency and reliability of the staff team.

A reformulation of her problems as those of borderline personality disorder inspires the development of a care package informed by psychotherapeutic models. In addition to individual therapy for the client, based on principles of cognitive analytic and dialectical behaviour therapy, group supervision and training in psychotherapeutic ideas and strategies for the staff team is an integrated and costed part of the package. A core group of clinicians and managers is established who also meet regularly, with psychotherapeutically informed consultation to the group. A visual representation of the whole system involved is drawn up and maintained for everyone, including the client, to see. Four years later, the client continues to live successfully in her own house in the community and recently took her first foreign holiday.

The difficulty of establishing a therapeutic dialogue in the presence of communication difficulties has often been seen as a barrier to people with learning disabilities having access to, or making effective use of, psychotherapy. Arts therapists and related disciplines have a long history of working through other means of expression than speech. An understanding of the world of people with disabilities and common therapeutic issues is essential to assessment, intervention and the clarification of the meaning of communications in various forms:

Anne is 20 years of age and has moderate learning disabilities. She lives with her adoptive parents and has recently moved from a special school to college. Anne suffered neglect as a child, and was moved several times to different foster carers prior to her adoption at 6 years old. Soon after starting at college, she was being bullied, she regressed in her skills and communication and there were behavioural problems at home. In the art therapy setting, Anne gradually found it possible to use art materials to make pictures and to establish a relationship with herself through the artwork, leaving greater flexibility in the way she chose to use the relationship with the therapist. Being encouraged to begin this exploratory process from a secure base, she initially worked together with the therapist on a shared piece of paper, taking it in turns to make marks. She progressed to work increasingly on her own, taking space for herself. Her capacity to symbolise became more evident in the images as she became more engaged in the art-making process. Anne began to enact her destructive feelings in her artwork, instead of turning these feelings in on herself. This enabled Anne to sidestep some of the more elaborate defences that had been created and gradually rebuild a truer sense of self.

Weekly art therapy sessions over a 2-year period have provided Anne with a means to assist her emotional understanding and development. The recent bullying at college had brought back earlier traumatic experiences that had revealed the damage to her sense of self. As a result the depression has lifted and her behavioural problems at home have lessened. At the college, she is now able to relate again to those around her and has regained many skills.

1. The place of psychological therapies

Over the past 10 years, the Royal College of Psychiatrists, the Department of Health and the NHS Executive have provided a number of reports and guidance on the place of psychological therapies. More recently, policy guidelines have been issued for the care of people with learning disabilities in England and Scotland: *Valuing People: A New Strategy for Learning Disability for the 21st Century* (Department of Health, 2001a) and *The Same as You? A Review of Services for People with Learning Disabilities* (Scottish Executive, 2000). They share an emphasis on choice, inclusion and rational organisation of services that aims for efficient use of resources appropriate for individual needs. These separate initiatives in psychological therapies and in learning disability services make little or no reference to one another. The need of people with learning disabilities for access to both generic and specialist psychotherapy provision is only gradually becoming recognised.

The Royal College of Psychiatrists (1991, 1997, 1999) has highlighted that psychological therapy services are a vital component of effective, coordinated mental health care. The 1995 Joint Report with the British Psychological Society recommended 'the development of comprehensive, coordinated and integrated services in all the major psychological therapies'. It acknowledged in its introduction that psychological therapies are relevant to a number of client groups such as children, older people and those with learning disabilities. The document's focus was on the mental health of adults between school leaving age and retirement, which should include adults with learning disabilities, but this was not addressed in the report.

The *Review of Strategic Policy on NHS Psychotherapy Services* (Department of Health, 1996) strongly endorsed the role of psychological therapies in the treatment of mental health problems and proposed that these should be comprehensive, coordinated, client-focused, safe, clinically effective and cost-effective. The report emphasised that treatments should be targeted to the needs of the patient and be based on research evidence. A number of priorities for purchasers were identified, and the need for purchasing strategies was highlighted to ensure that patients and referrers have a choice of therapeutic interventions. Three modes of provision of psychological therapy are described in the review, using a broad definition to cover all forms of psychotherapy, psychological treatments and counselling:

Type A: Those integral to all mental health work, i.e. not stand-alone treatments, often for people with complex mental health care needs, including severe mental illness. These include basic psycho-educational and counselling treatments, and supportive psychotherapy. Every mental health professional should be able to offer this.

Type B: Eclectic psychological therapies and counselling, as stand-alone treatments. This might include a short course of structured therapy of a limited range as is currently practised in the NHS.

Type C: Formal psychotherapy.

Roth & Fonagy (1996) examined the issue of treatment choices for different conditions in *What Works for Whom*. Since then, the evidence base for treatment choice in psychological therapies and counselling has been elaborated on by the Department of Health (2001b) in its publication *Guidelines for Treatment Choice in Psychological Therapies and Counselling*. People with learning disabilities experience similar disorders to the general population, and there is a known vulnerability to mental illness and psychological problems. Although treatment choices for these conditions were not specifically considered for people with learning disabilities, no evidence was presented that psychological therapies do not work for this client group. In the older literature and folklore of psychotherapy, people with lower IQs were excluded from treatment; while recent publications have continued to disregard this group, they have not provided evidence to support this exclusion. Indeed, in *Guidelines for Treatment Choice in Psychological Therapies and Counselling* (Department of Health, 2001b: p. 7), it is stated that ‘we acknowledge that, in the case of people with learning disabilities, there is no clear boundary to identify where this guideline ceases to apply. It should not be assumed that people who have mild to moderate cognitive impairment fail to benefit from the mainstream therapies described here, where research on the impact of factors such as intelligence and educational attainment is available, it has been reviewed’.

The final summary statement in the Roth & Fonagy (1996) review emphasised that ‘there is considerable variability in the outcome of psychotherapy, even from relatively homogeneous treatments’. Given the complex nature of providing treatment for the problems experienced by people with learning disabilities, the implications are that more research needs to be done with people with learning disabilities on both process and outcome. In addition, training and supervision are of importance given that one of the conclusions of the review is that ‘therapeutic expertise rather than experience is an important predictor of the establishment of a productive treatment alliance (which is probably the single best predictor of outcome outside of client and therapeutic orientation factors)’. Some of the more specialist expertise needed for effective psychotherapy for people with learning disabilities will therefore be in establishing a productive treatment alliance through the development of an effective ‘language’ and therapeutic context.

In *Valuing People* (Department of Health, 2001a), the English White Paper on Learning Disabilities, the four key principles outlined are rights, independence, choice and inclusion. The Government has mapped out 11 objectives to progress in this required change of culture, which emphasise the centrality of the person with learning disabilities. These objectives include supporting carers, good health, fulfilling lives, transition to adulthood, and enabling people to have more control over their own lives, as well as social and education issues. The emphasis is on

equality of access to mainstream services, including specialist mental health and therapies. There is minimal recognition of the role of specialist services in these areas, which may in effect continue to deny access for people with complex and special needs. The document speaks of the lifelong responsibilities of families and carers and it needs to be recognised that family carers may well require more than is currently provided in terms of support and therapy for themselves in order to fulfil these responsibilities and maintain their own mental health.

In the above documents, the point is often made that most of the population wants more 'talking therapies' and there is increasing evidence of efficacy for these interventions. People with learning disabilities have the same rights as other citizens, including the right to access general and specialist services in ways that are tailored to their needs and that provide adequate support and ensure inclusion.

2. Psychotherapy in learning disability – the literature and evidence base

Introduction

It is important to recognise that in its development from early Freudian psychoanalytic theory, the term psychotherapy has come to encompass not only a model of therapeutic intervention, but also an underlying theoretical model of human personality and its development. Therefore, in the case of individuals with learning disabilities, there are both implications for the application of the therapy and for the psychological aetiology of the individual's difficulties.

There are a number of ways to consider psychological development and developmental psychopathology, including perspectives from epidemiology, genetics, psychiatry, psychology, neurology and sociology. Approaches include the study of causal factors in understanding the processes of development with reference to adaptive and maladaptive responses, and the links between normality and pathology. The field of learning disability is an obvious and rich area for study, given the variations that may occur in some or all of these aspects. The importance of such complex psychological factors in presenting problems strengthens the case for including a psychotherapeutic approach to assessments and treatment.

The psychological consequences of disordered development

All early psychological processes and emotional development are inevitably affected by the presence of a learning disability. Development may be further compromised by the sensory and physical impairments that can accompany intellectual disabilities. These can both directly and indirectly affect communication and the quality of physical contact with a primary caregiver (Gaedt, 1995). Major contributors of theoretical knowledge and experimental evidence concerning early psychological development support the presence of, and describe, abnormal developmental processes in children with a learning disability. Different authors place different emphasis upon specific points. There is broad agreement, however, that emotional attachments can be fragile, there is slower development of self and object constancy, symbol formation is impaired, and separation-individuation from the caregiver is significantly affected (Levitas & Gilson, 1988; Gaedt, 2001; Whittaker, 2001).

The lifelong dependency upon others and the demands of society upon individuals with a learning disability as they grow up can further burden already fragile psychological defences (Menolascino, 1990; Hessel, 1998). Individuals with learning disabilities are more vulnerable than others to abuse (Cooke & Sinason, 1998), with significant psychological sequelae. Such situations are further

complicated by a limited intellectual capacity for solving problems and limited ability to adopt appropriate and effective coping mechanisms. Additionally, families of people with a learning disability may have their own psychological problems, which will impact upon the individual. Parents and other family members can have difficulties responding to their grief for the loss of the 'perfect child' that was hoped for but never arrived. This grief can be recapitulated at later times when they face the loss of other previously held expectations, for example the prospect of no grandchildren (Bicknell, 1983; Davis, 1987; Oswin, 1991). The sequence of life and family events, the 'life cycles', tend to be different in families with a learning disabled member compared to other families (Black, 1987; Vetere, 1993). This in itself can produce further stresses and indeed losses for individual family members.

It is not surprising, therefore, that individuals with early intellectual impairments are particularly vulnerable to psychiatric disturbances, and share some of the same difficulties as those with borderline personality or psychotic disorders. Such difficulties include conflicts of identity, a capacity to symbolise and a tendency to deny certain aspects of inner or outer reality.

The mental health literature has a long history of recording high prevalence rates of psychopathology and emotional disturbance in persons who are learning disabled. Typically, figures of five times that of the general population have been recorded (Penrose, 1938; Primrose, 1971). The quoted prevalence of actual psychiatric illness varies widely between 10% and 39% (Borthwick-Duffy, 1994). Poor diagnostic criteria, sampling errors and the lack of standardised assessment methods have hampered attempts to establish precise incidence rates (James & Snaith, 1979). The recent publication of a diagnostic classification system for use in people with learning disabilities is expected to improve diagnostic agreement and facilitate clinical practice and research (Royal College of Psychiatrists, 2001). The criteria are drawn from those currently used with the general population (World Health Organization, 1992), but in addition represent a consensus of professional opinion in areas specific to learning disability psychiatry.

History of psychological treatments for people with a learning disability

The application of psychoanalytic theories to the field of learning disability has a history dating back to the 1930s. Interest, however, was sporadic until the 1980s, when interested clinicians eventually raised awareness of the therapeutic needs of the learning disabled child and proposed that these needs could be addressed by psychodynamic approaches (Sinason, 1992). Previously, traditional treatment of psychological problems within the learning disability population had been almost exclusively through behavioural management combined with skills teaching and medical approaches (Waitman & Conboy-Hill, 1992). The research methodology supporting this behavioural approach was superior to that of the early dynamically orientated studies, and success using behavioural means was seen across a broad range of problems (Matson & McCartney, 1981). Outcome

research of the time reflects this position. A meta-analysis of intervention studies with problem behaviour revealed virtually all treatments as behavioural or centred around medication. Among other factors, given this tendency towards behavioural approaches, the broad range of other psychotherapies attempted with other patient populations, such as gestalt therapy or transactional analysis, were not typically employed with people with learning disabilities (Matson, 1984).

Evidence base for psychological treatments

Even in the population who do not have a learning disability, the effectiveness of psychotherapy, particularly relational therapies, has historically been a controversial issue. In the light of recent high-quality research, there is now broad agreement as to the general efficacy of psychological treatments (Department of Health, 2001*b*). Learning disability, however, has been routinely used as an exclusion criterion to such research (Matson, 1984) and there have been relatively few studies that demonstrate effectiveness of psychotherapy for people with learning disabilities.

In the past, many professionals have assumed that people with learning disabilities are immune to emotional problems, stress and psychiatric disorder (Fletcher, 1993). There is no basis for this opinion, but as the need for research has become evident, major ethical problems, such as the issue of consent, still deter the inclusion of people with learning disabilities. Given the diversity of this population, practical problems remain in research design such as finding homogeneous groups for evaluation. Funding and regulatory agencies for mental health and learning disability are often so split that people with learning disabilities are not in a position to be offered therapy in the services where the bulk of the skill and evidence base exists (Butz *et al*, 2000). The diagnostic overshadowing of emotional symptomatology by intellectual deficits may be another reason why mental health professionals have not included those with learning disabilities in effectiveness studies.

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, 1998; Beail, 1989, 1994; Frankish, 1989*a,b*; Sinason, 1992; Sinason & Svensson, 1994). The aim of most of the reports seems to have been to illustrate the application and process of therapy rather than to provide outcome data. A review of a wide range of reports on the use of psychotherapy with people with learning disabilities from 1968 to 1998 found 92 studies. Only nine of these studies included a no treatment control condition and reported sufficient information to be included in a meta-analysis. The majority of the studies concerned behavioural treatments. None concerned psychodynamic interventions. The meta-analysis found that good outcome had been achieved. An analysis of all 92 reports, carried out by a panel of expert judges, similarly concluded that psychotherapy could be effective and beneficial for people with learning disabilities. However, few conclusions could be drawn about the

comparative benefit of different treatments. Many of the studies were poorly described and the treatment could not be classified in terms of theoretical orientation in over a third of the studies (Prout & Nowak-Drabik, 2003).

Professionals who use counselling and psychotherapeutic interventions for people with learning disabilities see value in their work and report significant client benefit. Certainly, the existing, albeit small, outcome studies on psychoanalytic treatment have been promising (Sigman, 1985; Beail, 1989, 1998; Frankish, 1989*b*; Bichard *et al*, 1996). Small case studies have powerful face validity for anyone working within the field. It has been suggested that there should always be a place for these valuable case studies with good qualitative and descriptive material. Such process research is valuable in understanding the impact of learning disabilities on individuals and families (Hollins & Sinason, 2001).

In looking beyond the general and psychodynamic-based studies to more structured therapeutic interventions, schema-focused cognitive work has been shown to have a lasting effect on people with moderate learning disabilities (Lindsay, 1999). General procedures employed for treating depression with cognitive therapy can be simplified for use with a person with a learning disability; role play and role reversal are particularly effective techniques for eliciting relevant thoughts in people with a mild learning disability (Lindsay *et al*, 1993). All the required elements of therapy, such as eliciting underlying assumptions, can be maintained if they are simplified in a way that is appropriate to the patient. In addition, cognitive behavioural principles are now also being applied to parents of disabled children to enable them to change unhelpful cognitive attribution patterns and to enable them to acquire coping strategies (Turk, 1998). No controlled studies have been reported; evaluations of cognitive approaches have so far been concerned with anger management within a cognitive deficit model (Whittaker, 2001).

A number of authors have described family therapy based upon structural and problem-solving approaches to effect change in families who have a learning disabled member, but no controlled studies have been reported (Black, 1987; Shulman, 1988; Vetere, 1993). Other authors have taken a more reflective stance, suggesting that treatment requires the therapist and the reflecting team to join the family in a series of increasingly complex and recursive hypotheses in order to work out what is preventing that family from moving to the next family life cycle stage (Andersen, 1987; Goldberg *et al*, 1995).

Future developments in research and practice

General recommendations have been made that practitioners should attempt to bring their studies and interventions more in line with contemporary standards of clinical outcome research (Prout *et al*, 2000). Research is needed to establish predictors of outcome in terms of patient characteristics in order that therapeutic efforts can be targeted as effectively as possible (Hollins & Sinason, 2001).

However, there are major methodological and design questions that need to be addressed. The randomised controlled trial (RCT) gives the clearest indication of the efficacy of treatment. In RCTs, participants are randomly allocated to different conditions (e.g. treatment or no treatment) and a high degree of control is exercised over factors such as demographic variables, symptomatology, and its severity and level of functioning. The aim is to achieve homogeneous groups so that the outcomes can be attributed to the treatment and not other factors. Also, studies have to have sufficient numbers of participants in order to have the statistical power to detect any differences that exist. In recruitment, we also have to allow for attrition. Achieving truly comparable groups of adequate size is much more problematic for research evaluating treatments with people with learning disabilities. The pool of potential participants is limited to a very small sector of the population and then only those with psychological problems. To ensure homogeneity, only those suffering from one psychological problem with no other comorbidity should be included. It is also argued that other factors such as age and degree of intellectual impairment should be controlled for.

A further problem for researchers is the need to obtain informed and voluntary consent, both for treatment and for research participants. This is particularly problematic when randomisation has to be explained, retained and comprehended by potential participants.

There is a lack of reliable and valid measures to evaluate change. Observable behaviour is the most frequently used outcome measure (Prout & Nowak-Drabik, 2003). Further research is needed on the evaluation of treatment change to complement the work on diagnosis (Royal College of Psychiatrists, 2001). Despite the lack of established methods, one team has described the use of outcome measures in the routine monitoring of a psychotherapy out-patient service (Beail & Warden, 1996; Newman *et al*, 2003). Furthermore, attempts are underway for a large, multi-centred group of UK clinicians and researchers to stage an observational study that will document the effects of individual psychotherapy for people with learning disabilities.

It has been proposed that education and training about the emotional needs of people with learning disabilities should be more widely available for all health and social care professionals (Hollins & Sinason, 2001). If basic emotional needs are acknowledged, some psychopathology and behavioural disturbance may be avoided. For example, people with learning disabilities are especially vulnerable to a delayed and/or prolonged grief reaction following bereavement. Those individuals whose grief is not fully acknowledged and who do not receive a bereavement-related intervention are especially at risk (Bonell-Pascual *et al*, 2001). An understanding and focus upon emotional matters should be at a primary care level to enable the majority of clients with learning disabilities, as well as their families or carers, to encourage and maintain a sense of well-being (Hollins & Sinason, 2001). The recent English Government White Paper, *Valuing People* (Department of Health, 2001a), directs health and social care agencies to properly train their workforce in all matters of care, thus endorsing this most important final point.

3. The present position – a nationwide perspective

Recent Government direction endorses the need for good evaluation of an individual's psychological needs and the application of the most appropriate therapy to be informed by research. In parallel with the increasing social inclusion of people with learning disabilities, the debate concerning provision of psychotherapy services must move from issues of relevance through equity to a current emphasis on effectiveness. Research in psychotherapy and learning disability has tended to focus on therapeutic process and outcomes, but the context in which this work has been developing has not been described. There is little information available on the extent to which psychotherapy is available to people with learning disabilities across the UK and Ireland, and the following issues have not previously been comprehensively examined:

- What types of psychotherapeutic approaches are employed by which professionals and within what existing service models?
- Where do psychotherapy services for people with learning disabilities fit within the many organisations (systems) that make up the whole service picture?
- Are the current, 'traditional' models of psychotherapy service delivery appropriate, accessible or effective; indeed, is there such an entity as a 'traditional' service model?
- What is the place of psychotherapeutic approaches in the present practice of psychiatrists and other clinicians in learning disability?
- What are the different levels or contexts in which psychotherapeutic skills are utilised?
- What is the current use of psychotherapeutic skills in everyday practice relative to the provision of specific psychotherapy services?

To attempt to provide some answers to these questions, the Working Group conducted a survey throughout the UK and Ireland. A brief questionnaire was circulated to:

- psychiatrists on the mailing lists of the Faculties of the Psychiatry of Learning Disability and of Psychotherapy of the Royal College of Psychiatrists
- psychologists on the mailing list of the Section for Learning Disability of the British Psychological Society.

The questionnaire comprised 6 questions with stem answers and provision for additional comments. In addition, demographic information was sought on the professional discipline, status, geographical area of work, and employing organisation of the respondent. A total of 3 800 questionnaires were distributed;

448 responses were received, of which 424 were usable (those rejected contained inadequate demographic information or had been returned uncompleted). Owing to the way in which the clinical interests of Inceptors, Members and Fellows of the Royal College of Psychiatrists is recorded, the questionnaires reached a wider target population than just psychiatrists in psychotherapy or learning disability. On occasions, the questionnaire had also been copied or passed on to relevant professional colleagues by the recipients. Respondents were categorised as follows:

Psychiatrists in learning disability	(93)
Clinical psychologists	(87)
Consultant psychotherapists	(80)
Child psychiatrists	(57)
Other psychiatrists	(99)
Other professions	(8)

Although the proportion of respondents in relation to the circulation was small, the geographical coverage appears to have been comprehensive. (See Appendix 2)

Question 1: Do people with learning disabilities have access to psychotherapy?

The majority of responses indicated that people with learning disabilities are thought to be able to access psychotherapy, mostly where individual practitioners possess these skills or from within learning disability services. A significant number of respondents said that psychotherapy could be accessed from within mental health services or psychotherapy services, though this figure is comparable with the number who believe that people do not have access to psychotherapy. Provision of psychotherapy from within the non-NHS sector was identified infrequently.

Comparing the responses of the main clinical groups, there emerge some differences in perception. It would appear that child psychiatrists in particular and, to a lesser degree, psychotherapists, learning disability and other psychiatrists, are more likely to see psychotherapy being available within mental health services than clinical psychologists. In the case of psychotherapists, they are noticeably more likely to perceive psychotherapy as coming from within psychotherapy services than are the remaining professional groups. Learning disability psychiatrists and clinical psychologists emphasise access to psychotherapy as being through the psychotherapy skills of individual practitioners.

These quantified results were supported by some of the additional comments made by respondents.

One large psychotherapy service in England was identified as maintaining learning disability as an exclusion criterion for access to therapy.

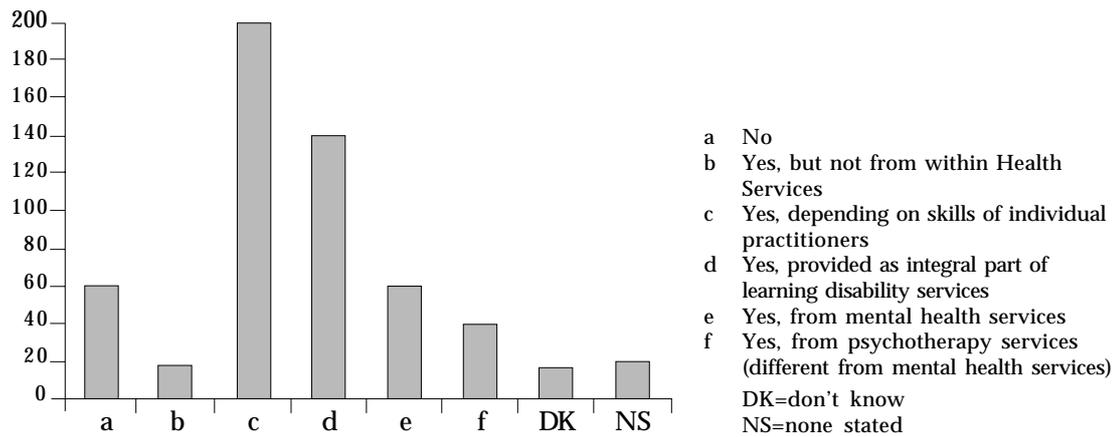


Figure 1a Do people with learning disabilities have access to psychotherapy? (All responses $n = 424$)

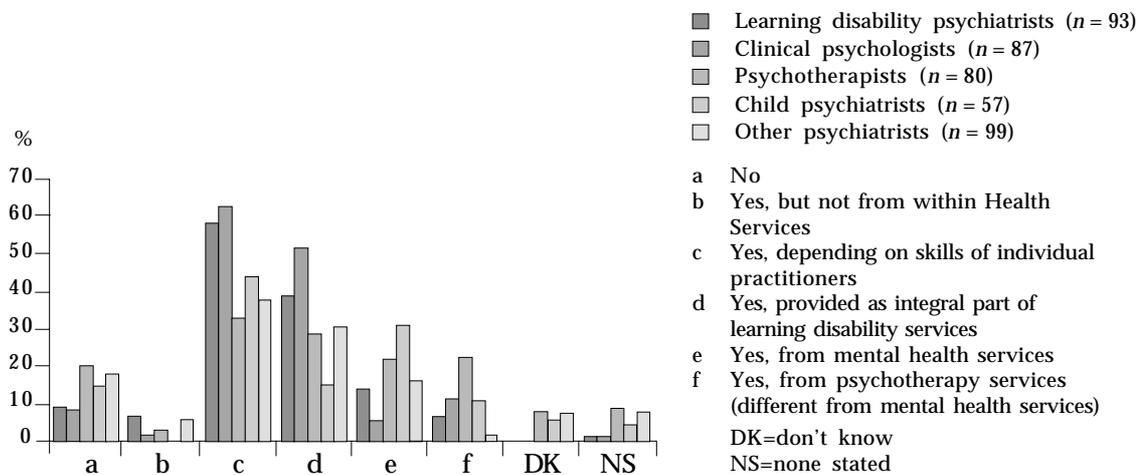


Figure 1b Do people with learning disabilities have access to psychotherapy? (Responses by professional group)

Question 2: If psychotherapy is available for people with learning disabilities, of what type is this?

Cognitive-behavioural therapy was the most frequently identified treatment modality overall; this can be attributed, however, to the frequency of this response among clinical psychologists and learning disability psychiatrists (85% and 68%, respectively). Child psychiatrists selected family therapy more frequently than other treatment types, whereas psychotherapists selected this and group therapy less than all other groups. These together with the other responses of the different professional groups suggest, unsurprisingly, that perceptions of what therapies are available are influenced by the respondent's own training or professional culture and service setting. The high response to cognitive-behavioural therapy among clinical psychologists also raises questions about the definition of psychotherapy as a specific course of therapeutic intervention as opposed to an underlying therapeutic framework for general clinical work (Type C as opposed

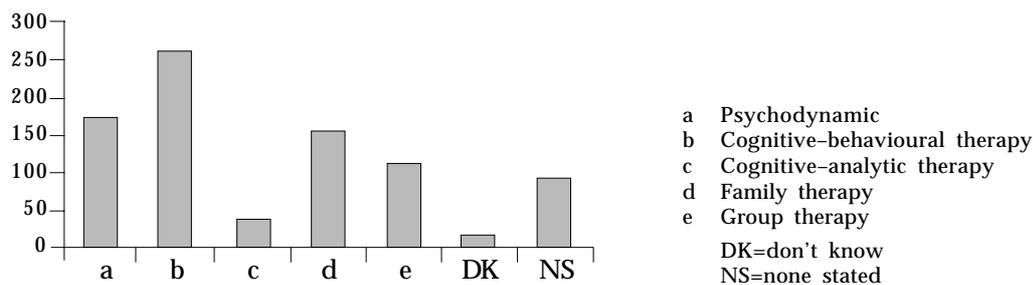


Figure 2a If psychotherapy is available for people with learning disabilities, of what type is this?

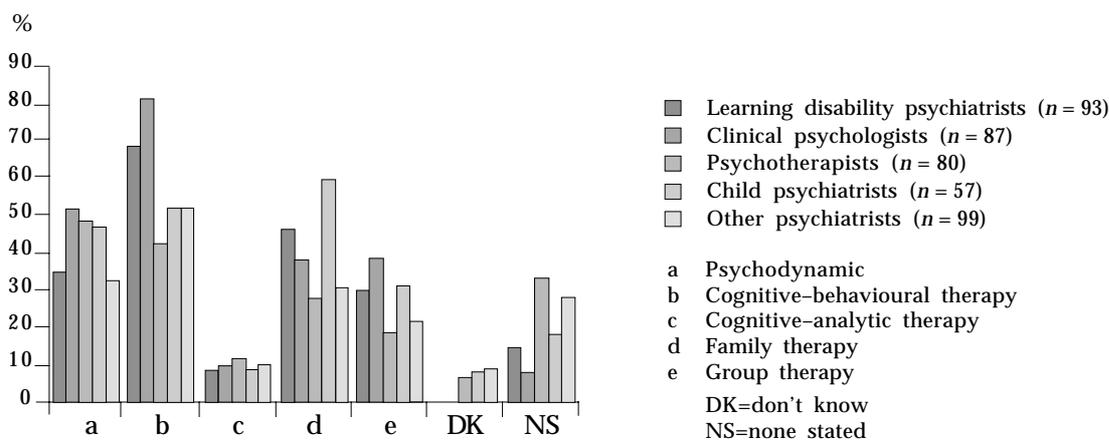


Figure 2b If psychotherapy is available for people with learning disabilities, of what type is this? (Responses by professional group)

to Type A interventions within the model proposed by Parry in the NHS review of psychological therapies).

Cognitive-analytic therapy was identified with the least frequency, though responses to other questions and comments make it unclear whether this reflects availability or lack of knowledge of this as a treatment modality. Comments contributed under this section identified a wide range of other therapeutic modalities available: counselling, bereavement work, supportive, specific work with Asperger syndrome, eclectic, brief solution-focused, psychosexual, family counselling particularly where there are siblings, vocational guidance, art and music, group work around sexuality, anger management and social skills, working through carers, play therapy, gestalt therapy, integrative, dialectical behaviour therapy, systemic, psycho-educational work, humanistic counselling, transactional analysis, sexual abuse counselling, group work with sexual offenders, and 'loosely framed counselling/objectives groups run by OT'. 'Supportive' and 'counselling' were the most common responses, and while the range of treatment approaches and their creativity are welcome, it seems likely that some interventions are being inappropriately labelled as psychotherapies. This may result from a lack of knowledge within learning disability services or may be a

reflection of the different therapeutic contexts in which psychotherapy-based interventions are being delivered as described by Parry (see above).

Question 3: What do you believe to be the demand for psychotherapy for people with learning disabilities?

The majority of responses (59%) indicated a moderate demand (a significant proportion of cases); perhaps more significantly, 83% of responses indicated either a moderate or high demand. Only 3 out of 424 responses suggested that there was no demand for psychotherapy in this client group and none of these were clinicians in the field of learning disability. Clinical psychologists were the professional group that most identified a high demand, learning disability psychiatrists a moderate demand.

Comments quite rightly distinguished between need and demand or talked of the relationship between these concepts. It was often said that need might go unrecognised owing to a lack of awareness or lack of contact with this client group. The view was also expressed that needs were not identified, or demands not acknowledged, where there was a lack of resources for providing adequate services.

The particular vulnerability of this client group to sexual abuse, loss, psychiatric disorder, consequences of institutional care and thus the need for psychotherapeutic interventions was elaborated in many responses. Reference was also made to the particular problems of people with mild learning disabilities and

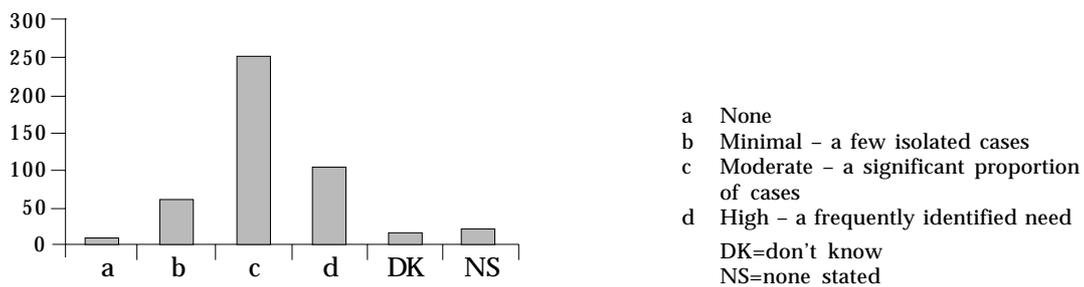


Figure 3a What do you believe to be the demand for psychotherapy for people with learning disabilities?

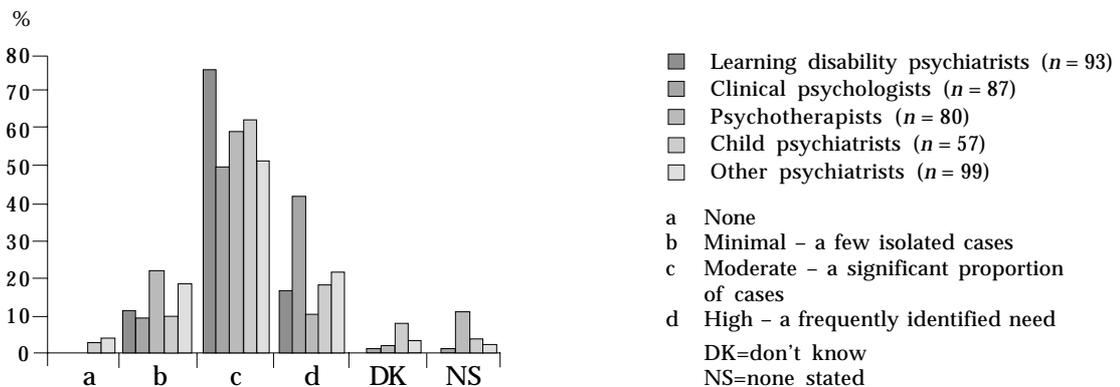


Figure 3b What do you believe to be the demand for psychotherapy for people with learning disabilities? (Responses by professional group)

personality disorders; an area where clients often fall between service eligibility criteria and do not receive appropriate treatment.

Question 4: What barriers exist that prevent people with learning disabilities receiving psychotherapy?

A minimal number of respondents felt that there were no barriers. The most frequently identified barrier was the lack of appropriately trained clinicians. Although approximately a quarter of responses identified psychotherapy services as excluding people with learning disabilities, lack of general resources and lack of available training were more often attributed as barriers to receipt of therapy. Although the responses to previous questions indicated a much more favourable and inclusive service environment for people with learning disabilities, 40% of responses suggested that psychotherapy is still not seen as appropriate for this client group.

Comments focused mainly on the lack of resources available, both specific and general. It was felt that psychotherapies were not considered adequately in the planning and commissioning of services. Psychotherapists expressed the view that their services were already under-resourced for their current work and unable to accommodate additional service demand for a ‘new’ client group. These responses imply of course that people with learning disabilities are not being considered within the current provision of these services and are viewed as a separate population.

‘Prejudice’ and unhelpful perceptions both about people with learning disabilities and about psychotherapy were cited as current barriers.

Views were also expressed about the limitations of the therapeutic process itself, ranging from a lack of research evidence, through the perceived difficulties in communicating with a person with learning disabilities, to the problems encountered in getting clients and carers to attend for therapy (transport, support, funding). It was also suggested that there may be a reluctance on behalf of therapists to engage with people with learning disabilities as they ‘don’t like to hear what comes out if clients are heard’.

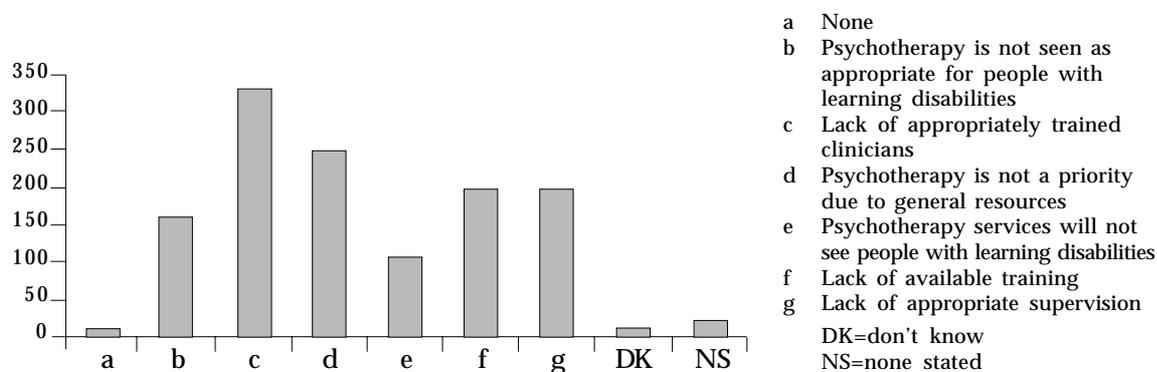


Figure 4a What barriers exist that prevent people with learning disabilities receiving psychotherapy? (All responses *n* = 424)

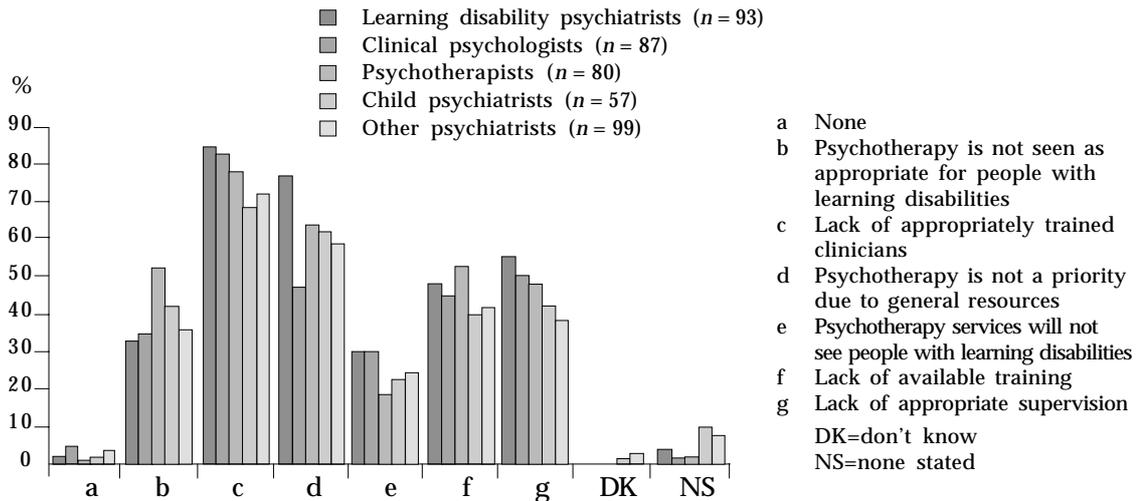


Figure 4b What barriers exist that prevent people with learning disabilities receiving psychotherapy? (Responses by professional group)

Question 5: If psychotherapy is available, how is supervision provided?

Approximately 25% of all respondents did not give an answer to this question. This may indicate that supervision is not always available or its nature and purpose is not clearly understood. Just as there are difficulties with the definition of psychotherapy, so there are with supervision. Interestingly, the professional group that most frequently gave no answer to this question was psychotherapists; those least often giving no response, clinical psychologists. This could be explained in light of responses and comments to previous questions where psychotherapists, although accepting of the need for people with learning disabilities to have access to psychotherapy, may be unaware themselves of how this is currently provided or by whom.

Within the comments received it was pointed out that supervision for clinical psychologists is an integral part of their clinical practice, though this raises questions about the demarcation, if any, between line management, clinical supervision and psychotherapy supervision. The most frequent responses for clinical psychologists were for non-learning disability clinicians with special interest or training in psychotherapy and particularly for peer group supervision, again reflecting the nature of clinical psychology training and clinical practice. In the view of child psychiatrists, supervision most often comes from psychotherapists with other training or from non-learning disability clinicians with psychotherapy training.

Psychiatrists in learning disability perceive supervision coming from a greater variety of sources, though there was a peak of responses to option d.

Comments often referred to supervision arrangements being informal or 'ad hoc' and not prioritised within services. Reference was also made to supervision being obtained through consultation either from a psychotherapist 'brought/bought in' or through seeking consultation with other services, such as family therapy teams.

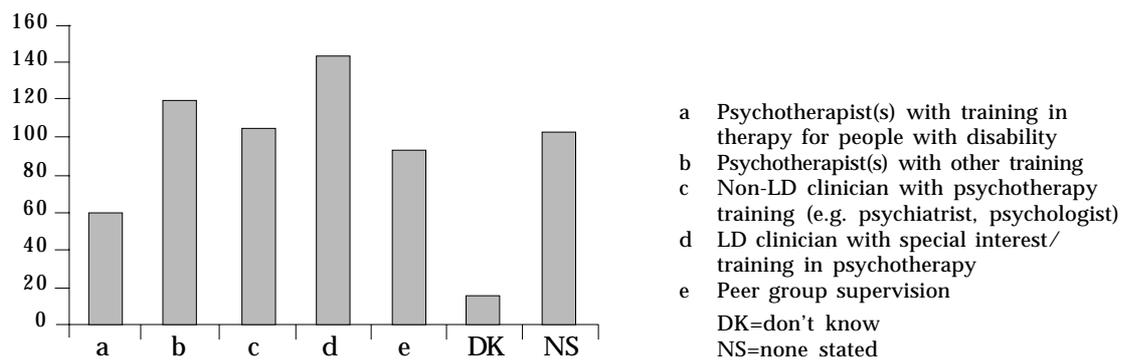


Figure 5a If psychotherapy is available, how is supervision provided? (All responses $n = 424$)

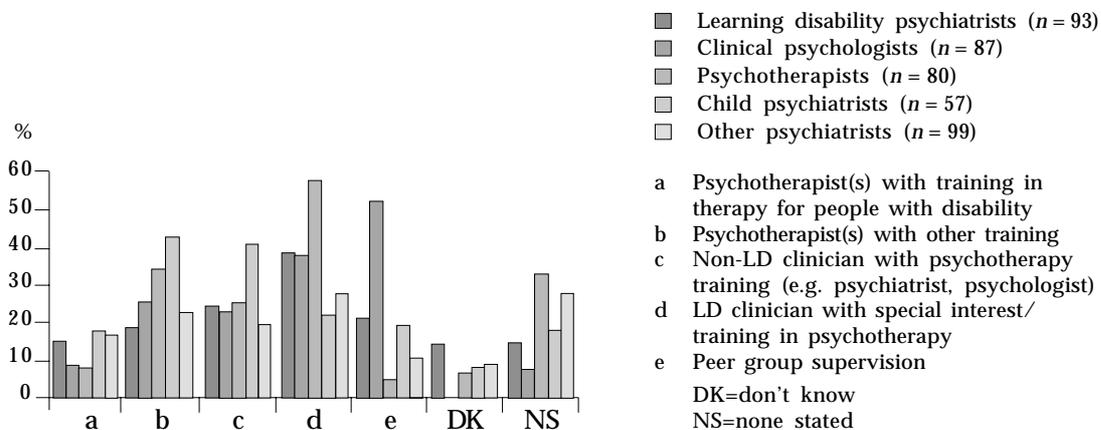


Figure 5b If psychotherapy is available, how is supervision provided? (Responses by professional group)

Question 6: What models of psychotherapy do you think may be beneficial to people with learning disabilities?

If we exclude response c (cognitive-analytic therapy – as mentioned above, it is not clear whether a low response to this is indicative of lack of support or lack of knowledge), there is a broad range of support for the different therapies, with relatively less support for psychodynamic therapies coming from psychiatrists in learning disability, child psychiatrists and other psychiatrists than from clinical psychologists or psychotherapists.

Within the comments received, although reference was made to the need for an evidence base, the responses tended to widen the field of potentially beneficial therapeutic approaches (e.g. art, music, drama and play therapies, anger management, social/language skills, integrative, humanistic, gestalt, person-centred, transactional analysis, personal construct therapy, systemic work). This suggests a wide acceptance of therapeutic possibilities and a need to adapt or modify

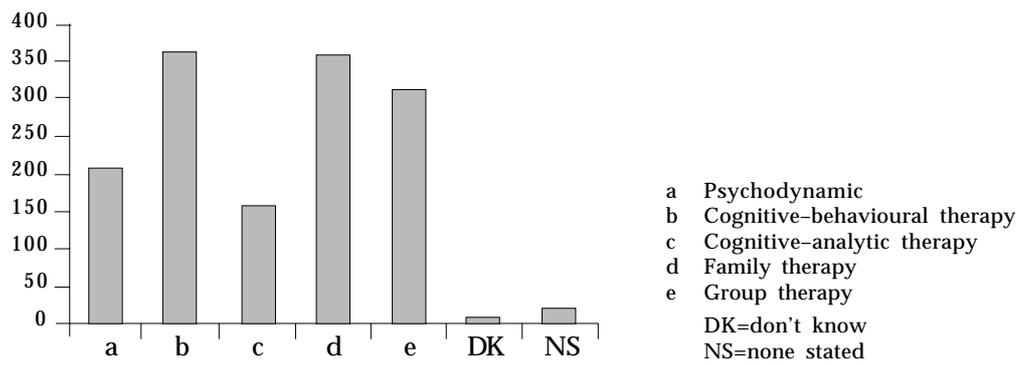


Figure 6a What models of psychotherapy do you think may be beneficial to people with learning disabilities? (All responses $n = 424$)

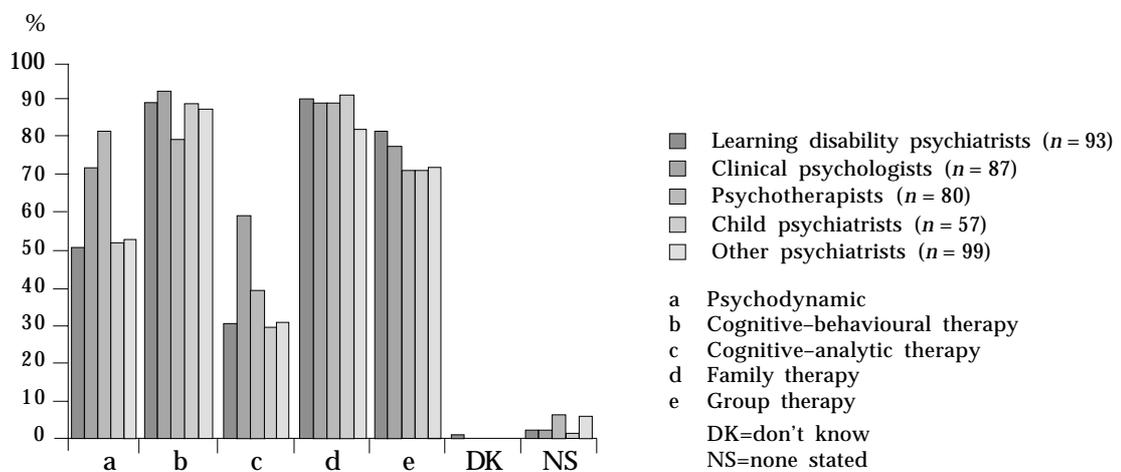


Figure 6b What models of psychotherapy do you think may be beneficial to people with learning disabilities? (Responses by professional group)

approaches to individual need. This may also reflect the issue raised in comments, of psychotherapy being both a specific therapeutic treatment and also a clinical model to inform assessment, diagnosis and general treatment interventions.

4. The developing picture

(a) Service provision

The Working Group's survey has given a superficial overview of therapeutic work currently being carried out and highlighted the idiosyncratic nature of service provision throughout the country. Within this, there are examples of discrete and specific service provision that provide useful insights and pointers towards future development.

The *Review of Strategic Policy on NHS Psychotherapy Services in England* (Department of Health, 1996) is the first national report to strongly endorse the role of psychological therapies in the treatment of mental health problems (Temple, 1998). In addition, it gives helpful indications of what constitutes a good service. The aim should be to achieve psychotherapy services that are comprehensive, coordinated, user friendly, safe, clinically effective and cost-effective. This is difficult to achieve. The review's consultation process suggested that there was a failure to provide comprehensive services for many groups of people, and that people with a learning disability and several other groups (older people, people from Black and ethnic minorities, gay or lesbian people, people with chronic illness and people from socially disadvantaged backgrounds) are underrepresented in the population receiving psychological therapies. It seems that mainstream psychotherapy provision is not sufficiently accessible, and that significant barriers need to be removed or alternatives to be provided for several minority groups.

The document describes three types of provision in NHS mental health services (see Chapter 1) and states that all three levels of treatment need to be available, that there should be coordination between them and they should each be considered strategically to obtain the maximum benefits to NHS patients.

'Specialist' v. 'mainstream' psychotherapy services

On the basis that having a learning disability should not be a bar to receiving the same treatment for a mental health disorder available to the general population, it is useful to think about whether these individuals should be treated within the ordinary psychotherapy provision or whether they require specialist services, adapted to their needs but within the recommendations of the psychotherapy review. People with a learning disability experience a wide range of psychological problems. Their ability to deal with these is influenced by their considerable variation in ability to communicate verbally or otherwise, intellectual ability, level of maturity, physical and sensory disability and dependence on carers. In addition, this is a group who may have experienced the trauma of institutionalisation, social exclusion and high levels of physical, sexual and

emotional abuse. Though specialist skills may be required for effective work in these circumstances, some people should be able to benefit from mainstream psychotherapy services, providing the services have an understanding of their special needs. There are often, however, particular difficulties and considerations, such as issues of consent, difficulties in understanding and communication, need for support to attend sessions, and systemic issues in staff teams and services, which, without significant adaptation, make it difficult for many individuals with learning disabilities to derive benefit from generic services.

Conversely, to provide a comprehensive, coordinated, user-friendly, safe, clinically effective and cost-effective service for a relatively small group also poses great problems, as we have found in the process of looking into examples of the current services, described below, all of which are quite specialised. We begin by reflecting on practice in the most commonly available resource to people with learning disabilities, and that to which problems are most likely to be referred, that is the community team.

Generic learning disability services: pathways to care

We carried out a small survey of pathways to care by presenting clinical vignettes to a selection of community teams for people with learning disabilities who were asked how they would respond to such referrals. The vignettes gave descriptions of people with differing degrees of learning disability who had psychological problems that might benefit from a psychotherapeutic approach. These included eating disorder, sexual disorder, post-traumatic stress disorder after a sexual attack, anxiety/depression and abnormal grief reaction; severe mental illness was excluded. In analysing responses, we were particularly interested to determine how people discriminated between the levels of psychotherapeutic skills required (A, B, or C, see pp. 16–17) and their capacity to provide such treatment options.

The responses received demonstrated clearly the idiosyncrasies of mental health provision for people with a learning disability.

Examples of responses

In this section, we give examples of the responses received from three community teams (in England, Scotland and Ireland).

Team 1:

Consultant psychiatrists and community nurses are expected to respond to all the referrals initially, with the possibility of CBT as a treatment option from the psychologist. The possibility of referral to tertiary services is considered but in practice this does not happen. Team members said that they do not have expertise with the particular problems but ‘would do their best anyway’.

Team 2:

The community nurses and occupational therapists feel able to offer all forms of psychological interventions despite an acknowledged lack of training. The psychiatrists in this team have experience and training in individual psychodynamic work, group work, family therapy and dealing with sexual problems, but it would appear that they cannot always ensure particular treatment interventions because of resource limitations and the approach can appear uncoordinated. Psychologists undertake most psychological interventions, usually CBT or behaviour therapy. Some referrals are made to outside specialist agencies such as Relate or Bereavement Care.

Team 3:

This team had a more coordinated approach to clinical problems, with more members of the multi-disciplinary team contributing to the assessment and management of the patients. Staff had some training in the areas required and also were more likely to send people to specialist outside services.

General:

- Responsibility for assessment and treatment tends to lie with the psychiatrist, who indeed may well have the broadest experience of dealing with these disorders.
- Teams have in common, significant degrees of uncertainty in responding to individuals with learning disabilities who have psychological needs that require comprehensive plans of assessment and treatment that include psychotherapeutic models.
- In attempting to meet the complex needs of their patients, professionals working with people with a learning disability sometimes appear to undertake psychological treatments for which they have not had adequate training or supervision. This is much less likely to happen in services for the general population, where adequate and appropriate training and support is available.
- While some people may pursue specific psychotherapeutic interventions (level B or C), there is also a surprising lack of application of the general psychological skills (level A) that are frequently required in working with people with learning disabilities, e.g. helping a person with a bereavement or a sexual difficulty.

Examples of innovative service models in learning disability services

The Working Group identified from the working knowledge of its members, a number of innovative providers of specialist psychotherapy for people with learning disabilities. Some services were recognised as having made particular progress in addressing the need for psychotherapy resources within their own

services and have developed what appear to be high quality, local services with good networks, opportunistically deriving resources from resettlement programmes, vacant posts, etc. Others specialise in particular areas of difficulty such as loss and bereavement, sexual abuse and sexual offending. Some operate in a particular therapy modality including psychoanalytic psychotherapy and cognitive–analytic therapy; others take a more eclectic approach. These services have in general organised their practice along sound therapeutic principles including formal assessment and structured supervision. They have also developed creative and flexible approaches to dealing with the special difficulties of the client group.

A: Community learning disability team

This service was established in response to local need, with money designated to clinical psychology but used to employ psychotherapists to work as part of the community team. There are three part-time therapists who offer gestalt therapy, integrative and attachment-based analytic therapies and systemic work. Psychotherapists discuss the assessments and work closely with the psychologists, giving careful consideration to issues of consent, motivation and whether it is an individual or systemic intervention that is required. Supervision and support groups to staff are provided. Psychotherapists are now considered to be essential members of the team. This service illustrates one of the most integrated forms of delivery of psychotherapies for people with learning disabilities within a specialist learning disability service.

B: Specialist psychodynamic service with links to intensive outreach service and community teams

This service was developed by a consultant in the psychiatry of learning disability experienced in psychodynamic psychotherapy and a psychoanalyst with particular expertise in working with people with disabilities. People are referred from within the catchment area of two local authorities through the local community teams or intensive outreach service and from probation services. Referrals also come from parents outside the catchment area and to whom it has been recommended. The two specialists carry out assessments and supervise a team of therapists who have allocated time for this work within their general responsibilities; many of them are clinical staff in training. Trainee art therapists are part of the team and tend to work with people who are more severely disabled, or with poor verbal communication. Individual and group therapies are provided.

C: Two large supra-district services

These were both set up and led by clinical psychologists in response to perceived need and using money from unfilled posts. Both services are reported as being highly valued by service users and their carers; this promotes referrals and supports the therapeutic process once this has been offered. Serving a large catchment area, they are able to offer a variety of therapies, including brief,

cognitive work and longer-term individual and group work with a psychodynamic focus; one service has found CAT particularly helpful with this group. Supervision for all therapeutic modalities is provided. Both services ensure that there is a thorough process of assessment, often lasting several sessions. The assessments address in particular the patient's understanding and motivation, consent to treatment and the importance of communication with the referring multi-disciplinary teams in any areas of ambiguity.

D: Specialist bereavement counselling

This service covers a whole county and was established as part of a hospital resettlement programme. Initially the remit was to act as a training organisation for staff, but following much demand for work on bereavement progressed to offering formal bereavement counselling to clients. Integral to the work of the service is the training, support and supervision of direct care workers, social workers and other staff to be able to help an individual work through their loss; this is based on an acknowledgement that staff often lack experience, training or confidence in addressing these issues as part of their day-to-day work with a client. In more complicated cases of bereavement, the service may offer direct individual or group therapy. The treatment has a psychodynamic perspective and may last for 1 to 2 years. Although issues of loss may be common to the general practice of psychotherapies, this is a particularly specialised service that addresses a well-established area of psychological vulnerability in people with learning disabilities.

E: Voluntary sector psychodynamic psychotherapy service

This service was set up in the early 1990s in response to a recognised need for treatment for people with all degrees of learning disability who had been sexually abused. The work of the organisation expanded in the mid-90s to take referrals of a forensic nature. There is now a fairly even division between its work with victims and its work with victims who are also perpetrators of abuse. Psychotherapy is its main activity, alongside assessments of risk and dangerousness, and investigations of alleged abuse. There is a team of highly trained and supervised therapists who work within a psychoanalytic model. The organisation is based in the voluntary sector, and generates income through charging for its treatment and assessment services. These services are subsidised from income generated through training, fund-raising and some statutory funding from the Department of Health. All cases referred are highly complex and often high risk. A national helpline and website are provided for people with learning disabilities who have been abused or who are at risk of abusing, and for staff and carers who are seeking advice or support. This is a clear model of a type C service.

F: Specialist learning disability psychotherapy service in a specialist psychotherapy institute

This institute pioneered much of the early psychodynamic work with people with learning disabilities in the 1980s and established the first training courses

and some of the first formal research in the field. All aspects continue to be developed, and they presently offer assessment, individual therapy and a consultation service as well as training to Masters level. Supportive work is offered to parents and carers. In contrast to other services, the age range catered for includes children and adolescents. This tertiary service is aimed at people with a range of emotional, relationship and mental health problems, including complex cases with associated trauma, abuse or brain injury. This is one of a very few services to provide psychotherapy for people with a dual diagnosis of autism or Asperger syndrome. The team is multi-disciplinary and includes psychotherapists, psychologists, social workers and a psychiatrist, all highly trained and involved in training. There is a website for professionals. This is a good example of a type C service, within the NHS.

(b) Therapeutic approaches

Until 10 years ago we just did behaviour therapy, but there has been an attitudinal shift, now we are being asked to help with emotional problems.

Clinical psychologist

The therapeutic context

- People with learning disability have impairments in intellect, cognition and reasoning which can lead to difficulties in taking in complex information, in 'thinking' and therefore understanding. This results in a diminished capacity to adjust psychologically and process internal experiences (in this context feelings) and external experiences (including relationships with others).
- The underlying intellectual deficits and resultant learning difficulties, together with an individual's experiences during development, can result in marked impairment of communication, particularly the communication to others of internal mental states.
- People with learning disabilities are likely to be more dependent on others to maintain their well-being. This is likely to limit choice and freedom and makes them potentially vulnerable in relationships.
- Families of people with learning disabilities can experience considerable stress and emotional disturbance that affects the functioning both of the individual and of the family as a whole.
- Many therapists think that there has, in the past, been a denial that people with a learning disability have problems with feelings and with adjustment. It is now recognised that these problems often underlie disturbed behaviours.
- Advances in therapeutic thinking have led to an increased recognition of the importance of non-verbal processes and communication. Therefore, lack of verbal ability need not preclude engagement in therapy.

Particular issues in the treatment of people with learning disabilities

Referral

Self-referral for treatment is very unusual. In a previous database of 160 adults referred to a therapist at the Tavistock Clinic, none was a self-referral. Only 2 of the 160 had semi-initiated the referral by asking a parent directly for 'someone to talk to' and the individuals, when assessed, were judged as being in need and could make use of a psychoanalytically orientated treatment. The majority showed their need for treatment through mood or behaviour rather than feeling able to ask for help for themselves.

In a separate service, a number of adults referred had personally asked a key worker to arrange for a talking treatment.

While individual ability to verbally communicate need is a significant factor in the mode of referral, it may be that a culture of empowerment in community services or even the existence of a high-profile local service may result in more self-referrals.

Consent to referral and treatment

Referral letters requesting psychotherapy as a treatment for the ordinary adult population would normally include an account of the patient's wishes. Referrals of learning disabled adults are more likely to reflect the views and needs of the referrer and possibly may not have been discussed with the individual. The initial assessment therefore has to be used for clarifying consent and explaining the meaning of therapy.

If the referral comes, as is usual, in the form of a letter, it is unlikely that the client will know what is in this letter, how he/she is perceived or what the referral problem is or means. It is important to consider with the client the meaning of the written information provided.

Even in the best circumstances a person coming to treatment is less likely to have made a considered decision, to have weighed up the advantages and disadvantages and to have recognised that psychotherapy may not be easy. Decisions therefore may depend more on feelings and the person's perception of the assessor than on thinking things through. This is an area of significant vulnerability, particularly to inappropriate or poor-quality therapy, and therefore therapists must be properly trained and supervised.

Some therapists may take several weeks to make an assessment, being concerned about the need for the patient to make an informed choice on whether to continue in therapy. Others do not have this prolonged assessment, but bear in mind constantly the issue about whether the person wants to be there having the therapy.

The issue of consent and continuation of therapy may need to be considered in a systemic way. Not only can carers impede the progress of therapy but they may also be demanding therapy for an individual when the difficulty may lie more in the needs of those carers or in the environment than in the designated patient.

Transport and escorts

People with learning disabilities may have considerable difficulties in both independent and supported travel. Without support for travel, psychotherapy may be ruled out or fail, regardless of their ability to make use of it. Some people can become more independent during a period of treatment but others will always need regular support.

This is not an easy or straightforward task for care workers or indeed for families to undertake. Staffing shortages and inconsistencies and financial restraints can impede regular attendance at sessions.

Attendance for therapy may give rise to a complexity of feelings in the carers such as envy or impatience with the time taken.

Those escorting the client may be curious about what they are doing with the therapist and find it difficult not to question them. Paid carers may well have their own difficulties that drew them into this field and it can be painful to see those they care for receiving the professional help that they may want for themselves. This may lead to envious attacks on the therapy process and emphasises the need to address the whole process and support system around the client.

Forming a treatment alliance

Warmth and friendliness, actively working to form a positive relationship with the patients, is emphasised by many therapists. Forming a treatment alliance may be more problematic as a result of an individual's adverse experience in early relationships. Grief-stricken parents may have difficulty relating to a child with a learning disability and the child may well have impairments that render their ability to make relationships difficult. These early problems may lead to long-term difficulties in attunement and affect the ability to form trusting relationships with others, with feelings of rejection or being disliked.

Analytic neutrality was never meant to be a poker face. It means not becoming the archaic transference object of the patient. If the patient has met discomforting, unhearing responses then a distant analytic tone will not be neutral, it will mean a painful re-enactment. At the same time as I became aware of the need for an empathic response with facial expression and voice tone with learning disabled and traumatised patients, Anne Alvarez at the Tavistock Clinic became aware of the same need with autistic patients.

Valerie Sinason

Psychoanalytic therapists have identified that difficulties in the area of basic trust can lead to the formation of a psychotic or non-reality-based relationship with the therapist which requires considerable skill to address.

Others have expressed the view that this group of people benefit from slightly looser boundaries in therapy, emphasising issues such as talking to the patient in a more friendly, familiar way, extended sessions at times of distress and the appropriateness of physical touch. In psychodynamic therapies, this warm and empathic stance may be seen to foster a more positive transference or relationship to the therapist, though at a deeper level may lead to a situation in which it is then difficult to explore negative feelings in the relationship.

Communication

Particular attention is paid to non-verbal communication, and some therapists actively use alternative methods, e.g. art, drama and music therapies. The use of drawings may assist the understanding of the client and enable them to express their feelings with more immediacy. Several titles in the 'Books beyond Words' series of picture books for adults, published by St George's Hospital Medical School and Gaskell, address emotional issues that commonly present in therapy. Topics covered include bereavement, abuse, being mugged, making relationships, being depressed, moving home and one about being in therapy. Many therapists use pictures from these books in assessment and treatment sessions with people with learning disabilities.

Treatments tend to be very much face to face, with therapists being vigilant for all aspects of non-verbal communication and being attentive and encouraging to everything that is communicated in the sessions.

Establishing therapeutic communication can take a considerable time, with the early part of the therapeutic process being concerned with therapist and client attuning to each other's means of expression. For some clients this may mean that sessions may be held in verbal silence and yet remain therapeutically meaningful.

Confidentiality

Respect for confidentiality is fundamental to the process of therapy, but difficult decisions have to be made about how much to share with others when a client is highly dependent, where there are issues of abuse or in order to maintain the therapeutic process.

It is essential that the therapist's particular approach to confidentiality be made explicit with the client and carers at the outset.

Some therapists believe that confidentiality should be absolute, but to deal with issues impinging from outside the therapeutic relationship will make phone calls or write letters with the patient present during the therapy sessions. The patient is enabled to understand what communication is taking place about them.

Others meet regularly with carers and explain in a general sense how therapy is progressing and how they can continue to support and maintain the individual's attendance for sessions.

Clearly there are no absolutes with regard to confidentiality and each case has to be decided on the basis of the individual's understanding, their circumstances and the nature and focus of therapy; such issues should be an essential component of the therapist's supervision.

User views

The challenges posed by communication difficulties, their traditionally dependent status and a less-sophisticated understanding of process need to be overcome if

the consumer voice is to be heard in a meaningful way. Early efforts are being made by a small number of specialist services to introduce ways of consulting with users. For example, Respond have been developing a User Consultation Group which is supported by staff, initially focusing on issues of access and presentation of information via telephone helpline and their website. More recently the group has been involved in drawing up an information leaflet describing services, and they intend to describe the process of psychotherapy in an accessible way.

The onus is increasingly on organisations to involve people with learning disabilities in their work, and the experience of Respond's consultation group indicates that meaningful progress can be made towards this goal provided it is backed up by sensitive and thoughtful support.

Cultural issues

Therapists need to be aware that people from different cultures have different beliefs about learning disability, which affect the attitude of the family to the person, the person to themselves and may be relevant to the process of therapy. These include issues about looking directly at them and concerns about male/female relationships. Sometimes the individual with a learning disability from a different culture appears to be more integrated into society than their family and this can cause inter-generational problems. The changes that therapy can bring may challenge the individual's relationship with their family and cultural group.

The application of different psychotherapeutic modalities

Cognitive-behavioural therapy

This was the most frequently identified treatment modality in the nationwide survey (see Chapter 3), reflecting in particular the current nature of type B and type A interventions by clinical psychologists. There is in addition, however, a growing body of experience of and evidence for the applicability and effectiveness of cognitive-behavioural interventions delivered in a more focused individual or group therapeutic framework. This has generally stemmed from studies of anger management carried out in groups. Together with approaches derived from work with adults who do not have a learning disability, this has been developed over recent years into methods aimed at helping people with learning disabilities to acquire understanding and skills aimed at self-control of anger. Cognitive-behavioural theory has provided a model for understanding how people with learning disabilities may have difficulty in perceiving and correctly identifying emotional states in themselves and/or others. Through adaptation of mainstream cognitive-behavioural interventions, including non-verbal materials, visual aids and simple cue words, it has been possible to demonstrate change, even in people with severe learning disabilities.

Adaptations include drawings, symbols, photographs, dolls and role-play. Stories or other narrative approaches (written or pictorial life histories, picture

storybooks) can be used to illustrate a number of life situations that people with learning disabilities have to face, such as bereavement or abuse. They can provide a means of enhancing the therapeutic dialogue and introducing a narrative style that enables the individual to 'piece together' their personal history and the history of significant events.

People with learning disabilities may have difficulty generalising from the therapy setting to the situations of everyday life and are more likely to require much repetition, practice and support between sessions and after therapy has finished. Workers in this field have demonstrated that the quality of the individual's environment and the level of support available from carers influence effectiveness.

Other applications of cognitive-behavioural and related therapies have included work with people with autism, sex offenders, relaxation training in people with severe learning disabilities, work in groups and the use of 'cognitive-behavioural support programmes' in residential treatment or secure settings.

Psychodynamic therapies

Past adherence to strictly traditional approaches to psychoanalytic and psychodynamic therapies made it hard for people with learning disabilities to have access to and make use of these types of therapy. This has often then been used as justification for the view that people with learning disabilities 'cannot benefit' from these approaches, displacing the responsibility for the failures of therapists and therapeutic contexts onto the individual. Through the perseverance of a few individuals and a flexibility of approach, also drawing on experiences of working in a variety of contexts, including children, it has been possible to reach a situation where the psychotherapeutic models most written about with specific regard to people with learning disabilities have been the psychodynamic/psychoanalytic.

Most of the adaptations to the therapeutic approach have already been elaborated at the beginning of this chapter. In addition, there are particular perspectives that have come from these treatment models:

People with learning disabilities may be rather passive and find it difficult to express negative feelings towards people on whom they depend. The verbalisation of these feelings is a linchpin in the psychodynamic treatment of people who have adopted an 'appeasement' posture of smiling, pseudo-compliance to defend against the trauma of being different or fears of the therapist's hatred of them.

Valerie Sinason (Sinason, 1992) describes three stages of therapy in analytic work, which may have broader application. The first stage involves the reduction of secondary handicap. This is the psychological defence of exaggerating handicap to cover up the traumatic hurt of being 'different' and may be seen as the 'handicapped smile', inappropriate clothing, and ways of walking or talking. The reduction or elimination of secondary handicap can lead to a second stage in which the patient is extremely vulnerable. This is the period where the depression

of having a learning disability is faced together with all the feelings of loss, including the wasted years hidden behind secondary handicap. If successfully worked through, this may move on to a stage of improvement in internal and external functioning.

Valerie Sinason and Sheila Hollins have described specific areas that commonly arise with this client group and need to be addressed for therapy to progress satisfactorily (Hollins & Sinason, 2001). These are: the impairment itself, death, dependency needs, sexuality and fear of annihilation. These are presumed to be too painful to talk about with friends and family and have become taboo subjects or 'secrets'.

A number of authors have described group analytic work with people with learning disabilities, and where there has been a persistence of this approach, lasting benefits have been observed. Just as with individual work, adaptations to the traditional functioning of group therapies may need to be made and account taken of particular contextual issues such as mode of referral, how voluntary an individual's presence may or may not be, the expectations of carers and other professionals, transport and communication with others about individual or group issues. Group work can have a specific focus such as sexual offending or bereavement and may use varied techniques, including pictures, stories and mime.

Those who have experience of conducting group therapies have emphasised the need for higher standards of training, experience and supervision than have been applied in the past to working with groups of people with learning disabilities.

Cognitive analytic therapy (CAT)

Cognitive analytic therapy is a time-limited psychotherapy that has been developed particularly for use within the NHS. It integrates insights from psychodynamic and cognitive-behavioural models. The aim of CAT is to provide an accurate shared understanding and description of current difficulties and to make the link between these and earlier experiences. The structure of CAT includes a clear time limit, reformulation letter, personal diagram of damaging patterns of thinking, feeling and behaving, and a goodbye letter. This provides a containing and grounded approach to emotional and personality difficulties in which the therapeutic relationship can be developed and explored. Within this structure there is also scope for incorporating techniques from other models and for creative innovation.

With modification, CAT can be used effectively with people with mild to moderate learning disabilities, for example simplifying, the wording of the CAT paperwork according to the needs of the individual, using tapes for the reformulation and goodbye letters, and having concrete visual representation of the time limit. It is usually necessary to complement the verbal aspects of therapy with non-verbal techniques such as symbolisation, drawing, colour or buttons, depending on the individual talents and inclinations. The Vygotskian concept of the zone of proximal development, which is important to the theory and practice of CAT, is particularly relevant to this work.

The CAT theory of the development and mutual re-enactment of reciprocal roles in relationships informs the therapeutic relationship. It allows therapists to have a balanced and rounded view of the relationship difficulties and to avoid being drawn into the common responses of trying to be the powerful caregiver or magical rescuer, which leave clients powerless and dependant, awaiting rescue or perfect care.

Actively engaging with the client, the explicitly collaborative approach and the use of narrative are powerful ways of helping individuals to find their voice, for that voice to be witnessed and for the development of self-reflection.

Art therapy

Art therapy offers a psychodynamic approach to assessing the psychological and emotional needs of the client with learning disabilities both in individual and in group settings. Clients can develop, over time, a trusting psychotherapeutic relationship with the therapist, and, using whatever art processes are most comfortable to them, feelings, relationship difficulties and experiences, which might otherwise be difficult to express, can be externalised and explored.

The emphasis is on unconscious processes and the exploitation of transference phenomena as a basis of the therapeutic change. These are played out in the tripartite area between client, therapist and image. Owing to the fundamental nature of art making and its role in symbol formation it is possible for clients to establish a profound relationship with themselves through the art work, giving greater flexibility in the way they choose to use the relationship with the therapist.

Art therapy can operate at a number of cognitive and emotional levels. At one end of the continuum the physicality of the medium can mean that art therapy may concentrate almost entirely on the experience of holding, which can be achieved on a very concrete and non-verbal level with clients who have no spoken or signed language and limited development of broader symbolic functioning. At the opposite end of the spectrum, the client is engaged in art processes that both client and therapist subsequently reflect on together. Art therapy can make an important contribution to clients who exhibit autistic features. Through developing a therapeutic relationship within a tangible potential space, the clients have the opportunity to renegotiate or negotiate very early developmental stages. Through the symbolic use of art materials they can develop an understanding of symbols that parallels the development of their ability to conceptualise and have successful meaningful relationships with the world as developing adults. Art therapy is a treatment that is led by clients' needs and encourages the active involvement of individuals in their own therapy. The client's method of communication is respected and enhanced, supporting a feeling of self-worth and confidence which can enable them to make more independent and creative actions or changes in their life.

Drama therapy

Drama therapy is used extensively with this client group across the full range of ability and disability for both individual and group therapy. Key principles of the work are play, expression and empowerment.

The underlying theoretical models vary between practitioners, psychodynamic and social constructionist thinking being strongly represented. Drama therapists use a variety of media, including puppets, cloth, music, movement and dance, interactive games, story-telling and enactment. In fact, any of the media to be found in the theatre, drama and play can be used within the therapy.

Drama therapists structure their sessions to include a warm up and closure around a central activity. In group drama therapy, activities are chosen to enhance awareness of self and other. Sessions are structured with sensitivity to the level of risk involved: familiar activities are used to frame the session, while activities demanding a sense of creative risk-taking are held within the central body of the session. So a name game or song may be used to frame the session at the point of greeting and closing. Games tailored to the level and interests of the group are used to establish a known repertoire of communication and a shared language for group members. At the heart of the session there may be the possibility of working in depth with a personal or fictional/metaphorical story and role. Whenever the imaginative world of the 'as if' has been used, drama therapists place importance on the process of 'de-roling' and returning to the shared here-and-now reality of the group.

In one-to-one sessions, activities may focus on working through particular life events, often through metaphor and story. In the case of profound and multiple disabilities the focus may be on building a one-to-one relationship via the media of sensory activities and play.

Music therapy

Music therapy in Britain has been used within the field of learning disabilities for many years. It has been defined as 'a systematic process of intervention wherein the therapist helps the client to achieve health, using musical experiences and the relationships that develop through them as dynamic forces of change' (Bruscia, 1998). The underlying theoretical perspective may vary, though the work of developmental psychologists such as Trevarthen and Stern and aspects of psychodynamic theory are frequently drawn on in understanding the music therapy process.

Sessions normally take place weekly over a period of time, and in common with other therapies, consistency and security of the environment is important. Although the emphasis in Britain is on playing or listening to live music as a means of developing the relationship, it is not necessary for the client to have any musical training or apparent ability. The elements of music are part of our earliest communications; the affective content of a communication, in particular, is carried by the musical elements of intensity, duration, rhythm, pitch and timbre.

The music therapist will provide a selection from a wide range of instruments, such as tuned and untuned percussion and keyboard. The client is offered the opportunity to play any of these, or they may choose to vocalise, move around or simply sit and listen. The therapist pays attention to the quality of the client's

music or actions and responds with improvised music. This can support, contain and challenge in a similar way to spoken language, but it also reaches and engages people at a different level. This is of benefit for those for whom words are not readily accessible but is also valuable to others. The use of improvised music brings unconscious areas into awareness. This can apply to emotional and relational aspects, including counter-transference issues that can surface in the therapist's own music. Where appropriate, the therapist may also make a verbal response.

Music therapy has been used at all developmental stages and with people who are autistic. It allows for choice and the growth of self-esteem and the fostering of an awareness of self and other.

Family/systemic therapies

In addition to those individuals who live with their biological or 'nuclear' family, most people with learning disabilities live in 'family' groups such as group homes or institutional settings, or are supported by staff teams. Working with families may be the most appropriate focus for therapeutic work or can enhance the therapeutic process with an individual. Families, whatever the nature, often (but not always) want to be involved and can benefit individually and collectively from the experience. The survey in this document demonstrates professional desire for family therapy. Themes such as loss, isolation, ambivalence, anxieties about sexuality and concerns about failure can be explored with the family members helping each other. The roles of various family members, including the individual themselves, can be helpfully explored, particularly where the individual has been assigned a role of being 'special' or even being 'the stupid one'. The person with a learning disability may be serving a function of maintaining a family or parental relationship or may be the focus of expression of parental relationship difficulties. Siblings may also find themselves trying to fulfil a role of being special or particularly successful.

Staff or carer groups form part of a complex and dynamic system around an individual. In the presentation of behaviour problems, psychological difficulties or mental illness, the interactions of this system together with its environment can be significant in terms of predisposing, precipitating or maintaining factors. This is particularly marked in those of individuals with disturbances of personality development and/or a history of abuse. The system (or 'family') may need specialist expertise in reflecting on and developing an understanding of issues such as powerful counter-transference, strong dynamics such as splitting or envy evoked by this group or oscillation between different psychological states and patterns of interaction. These insights may illuminate the client's psychological conflicts and their effect on others, including the people, professional teams and institutions involved in their care.

Techniques of behavioural family therapy are particularly useful because of the potential of role-play practice and role substitution in people with limited

verbal ability. The evidence currently supports the application in conditions such as schizophrenia and there are no evaluations of behavioural family therapy in the field of learning difficulties. However, clinicians who have used it report good results that justify further evaluation of this therapeutic tool, especially of role play substitution, which can be seen as utilising the principles of advocacy in a therapeutic context.

While the provision of therapy can be achieved through the inclusion of people with learning disability in generic family services, some specialist family clinics for families with a learning disabled member have been set up and are becoming expert in the particular issues that arise. Others provide specialist consultation to groups or organisations from a systemic or analytic perspective.

(c) Professional training and development

Awareness and prevention of emotional and mental health problems in people with learning disabilities

Because of the special characteristics of the client group and their vulnerabilities, both awareness and prevention of emotional and mental health problems require all staff in direct contact with them to have some understanding and education in this area. At present, non-professional staff who have most face-to-face contact rarely receive any educational input. Likewise, the training of professional staff, including teachers, social workers, nurses, speech therapists, occupational therapists, physiotherapists, general practitioners and others, should encompass these issues in order that they contribute to healthy emotional environments and provide appropriate responses and referrals where necessary. Examples of good training resources already developed for this purpose include Guys Hospital 'Mental Health in Learning Disabilities' (training pack) and the PAS-ADD Checklist specifically for the detection of mental health symptoms.

Providing a therapeutic response

Following the identification and assessment of an emotional or mental health problem, different levels of specialisation/sophistication in training are required to provide appropriate responses. These responses may include a psychotherapy-based intervention:

Type A service responses involving basic counselling and personal support, with perhaps an element of psycho-educational work, require staff in learning disability services to have training that includes a basic educational element on the emotional development of people with learning disabilities and skills such as communication and counselling. Nursing and social work staff who work with people with learning disabilities may already have had some aspects of this in their professional training, but its importance is generally not recognised and applied systematically.

Type B service responses involve the provision of specific, and usually brief, psychological therapies or counselling (specially adapted for people with learning disabilities) either within learning disability services or through referral to other agencies.

In learning disability services, nurses, social workers, psychologists or junior doctors in training may possess sufficient skills and experience to deliver these interventions. There is no structured post-qualification training in psychotherapies for nurses and social workers who have to seek this opportunistically through special courses, for example the Diploma in Psychotherapy. Organisational and financial support for training is inconsistent; those who do succeed in obtaining training may not always be enabled to exercise their skills in different work settings. There is no career pathway for psychotherapy in these disciplines. Training for psychologists and psychiatrists is described below. Graduate mental health workers are being trained to work within primary care to deliver short, evidence-based psychological therapies. It is not yet known if learning disabilities will be included within their training.

Outside of learning disability services, most staff in organisations providing counselling or therapies (such as Cruse and Relate) do not have specific training in working with people with learning disabilities but may access special Diploma courses where these are available. There are some encouraging developments beginning in this area.

Type C service responses constitute formal psychotherapies. There is no specific recognised training in psychotherapy and disability. Apart from a very few specialist centres like the Tavistock Clinic and St George's Hospital Medical School, which now offer opportunities for Diploma and Masters level courses with a psychodynamic orientation, there is a marked lack of connection and integration between available training in psychotherapy and learning disability. Psychotherapy trainings are many and varied, being dependent on the particular therapeutic model and the context in which the therapist is intending to practice.

There are three main routes by which practitioners may currently obtain training:

- Training in psychotherapy (including arts therapies) followed by development of interest in its application for people with learning disabilities.
- Professional training in the field of learning disability followed by development of an interest in psychotherapy together with appropriate training.
- Psychotherapy training offering placement in learning disability services or accepting training cases of people with learning disabilities.

The main professionals working at this level are psychiatrists, psychologists and psychotherapists. We have examined the training pathways for each in turn:

Training for psychiatrists

In medical undergraduate training, students undertake a psychiatry module, which may provide some limited experience in learning disability and in psychotherapy. The minimal time available makes it highly unlikely that students would gain any practical experience of psychotherapy unless undertaken as a special interest.

Basic specialist training

Postgraduate basic specialist training in psychiatry is detailed in the Curriculum of the MRCPsych examination of the Royal College of Psychiatrists. Some theoretical knowledge and experience of psychotherapy is mandatory and the requirements are rising very significantly. However, most experience at this stage is likely to be with adults without learning disability and usually of working age. The psychotherapy curriculum details a requirement for trainees to have a knowledge of the 'basic use of psychotherapeutic techniques with special groups', which include people with learning disabilities. It stipulates that this should be in terms of *suitability for dynamic therapy, modification of technique, creative use of art, music, drama, etc. and family and group intervention.*

While all psychiatrists in training will have experience in psychotherapy, not all will have guaranteed exposure to learning disability. However, since 2000 it has been mandatory to have experience of developmental psychiatry with 6 months in either child and adolescent psychiatry or learning disability, and a common curriculum has been developed.

Basic specialist training in the psychiatry of learning disability requires that trainees should be able to describe the concepts of treatment of psychiatric and behavioural disorders in people with learning disabilities and that this would include knowledge of 'psychological treatments'. Psychotherapy is not specified as a psychological treatment nor is it included as one of the clinical competencies that trainees are expected to acquire.

Higher specialist training

Until recently it was possible for a trainee psychiatrist to reach the stage of higher professional training and have had no experience of the psychiatry of learning disability.

Since May 2000, entry to higher training requires a minimum of 6 months' experience in developmental psychiatry.

Higher psychiatric training as a specialist registrar (SpR), lasts a minimum of 3 years and leads to the award of a CCST (Certificate of Completion Specialist Training). Possession of a CCST confers eligibility to be entered on the Specialist Register of the General Medical Council and is the basic requirement for a consultant post. Higher psychiatric training is usually undertaken in one of a range of psychiatric specialties, including the psychiatry of learning disability and psychotherapy. It is possible, however, to undertake dual training, that is

training in two specialties, and the length of time required for completion in this combination is five years.

Single CCST in the psychiatry of learning disability

Specialist registrars' training for a CCST in the psychiatry of learning disability may have access to psychotherapy experience. This has tended to be ad hoc and dependent on locally available interest/expertise. The Faculty of Psychotherapy is developing guidelines for recommended psychotherapy experience for SpR's in the various specialties. The Working Group has contributed to these guidelines for learning disability, and these can be found in Appendix 1. They describe the range of knowledge and skills thought to be important as a minimum and require specific training experiences that would be difficult to access in totality and indeed even in part in many areas of the country for a number of years to come. In particular, many of the present consultants who provide training and supervision have had no such training themselves. A similar dilemma exists for a higher trainee in psychotherapy having limited access to supervisors who have training and experience with issues of disability and the particular problems of the client group.

Training programme directors and trainees in learning disability have been utilising a variety of methods to try to overcome the present vacuum in joint, integrated training. In some schemes, good use is made of the two special interest sessions per week. These have been used to access mainstream psychotherapy and family therapy courses and case supervision. Diploma and Masters courses in psychotherapy have been undertaken and a special study made of learning disability applications.

Single CCST in psychotherapy

This training lasts for three years and there are very stringent requirements for 'the development of knowledge and skills in at least one branch of psychotherapy and sufficient knowledge about other branches to know the indications and contra-indications in order to match therapy to patient need'. This could include patients with a learning disability, but this is relatively infrequent at present. Another requirement of relevance is 'ability to contribute as an expert in psychotherapy to care in mental health and general medical services through consultation and/or joint care of patients'. Psychotherapists who have not had experience or exposure to patients with learning disability during their training may be reluctant to act as expert or supervisor.

Dual-training joint CCST in psychotherapy and psychiatry of learning disability

To train in either learning disability or psychotherapy the junior doctor must hold an MRCPsych and apply for and obtain an SpR post in that discipline in open competition. It would be theoretically possible, therefore, for an SpR to undertake dual training in the psychiatry of learning disability and in psychotherapy, but there are significant obstacles to doing so:

- The training is lengthy and there are not posts established to provide career opportunities.
- The two faculties, psychotherapy and learning disability must agree on the training, the length, the content and the arrangement of placements throughout training years (location, sequence, and synchronicity with other SpR training schemes). Neither of the specialty training requirements at present demands experience of the other and cross-specialty opportunities would have to be created to apply the psychotherapy training to learning disability.

The Royal College of Psychiatrists will be developing competencies for Specialist Registrars along the same lines as the National Occupational Standards. These will form the criteria for accreditation and membership of the Specialist Register prior to becoming a consultant. Psychotherapy is one of the proposed areas but does not specify learning disability. The guidelines for psychotherapy experience in learning disability referred to in the previous paragraph could be incorporated into the learning disability or psychotherapy competencies.

Training for psychologists

Clinical and counselling psychologists all receive some introduction to psychotherapy and many psychologists have become involved, to varying degrees, in psychotherapeutic practice and training. The degree to which this is developed is very much an individual choice. During training, clinical psychologists can elect to do a long placement in their third year and some choose disability psychotherapy. The result is that some newly qualified psychologists may have quite a lot of training, but no formal recognition of their competence.

The British Psychological Society, in a report prepared by its Psychotherapy Implementation Group (approved by BPS Council October 2001) has set out a framework for the development of training and practice for psychologists specialising in psychotherapy as well as addressing the considerable overlap in theory and practice between psychotherapy and psychology. The main focus of development will be the creation of a Register of Psychologists Specialising in Psychotherapy; the document, however, aims to broadly describe a psychological perspective on training and practice in psychotherapy through:

- the spelling out of basic principles that will have implications for the continued development of both disciplines and in particular for psychologists specialising in psychotherapy;
- the sketching of a broad approach to psychotherapy training practice that seems particularly appropriate for psychologists specialising in psychotherapy;
- the outlining of general grounds for evaluation that will be used for acceptance onto the Society's Register of Psychologists Specialising in Psychotherapy;

- the clarification, in relation to the basic principles and the broad approach, of the major aims in training and the competencies that should be achieved by those seeking to register as psychologists specialising in psychotherapy;
- the articulation of requirements for acceptance onto the Register of Psychologists Specialising in Psychotherapy as foundation members and regular members, for pre-registration, and for the later recognition of psychologists as advanced practitioners in psychotherapy;
- regulatory notes for guidance for training courses, for psychologists seeking to specialise in psychotherapy and for the Registration Committee for Psychologists Specialising in Psychotherapy (RCPP) and its working groups.

However, in an ongoing process of development and refinement, the proposals in the document aim to be inclusive of a wide range of practitioners and relevant to all psychologists working with individuals at any stage of life and in any therapeutic context (individuals, couples, families or groups).

The aim is to achieve a wide representation of practice and experience and thus generate a process of constructive debate, sharing of ideas and ‘imaginative inquiry’.

Inclusion in the Register is only open to chartered psychologists, and constitutes recognition of a basic level of competence in psychotherapy (a competence that is not based simply on attendance at courses); it does not address special distinction or long-term experience. Membership of the Register will also require ongoing maintenance and development of skills through continuing professional and personal development. For those who already have, or are developing, a high degree of specialist expertise and experience in psychotherapy, membership is a first step to gaining recognition as an ‘advanced practitioner’.

As stated above, inclusion on the Register would be in the category of either Foundation Member or Regular Member, the former being someone with a greater degree of established training, experience and supervision. A process of re-registration will be expected and initially after 8 years from first admission to the Register; the timing of subsequent re-registrations are to be determined by the RCPP.

Although there will be a single Register of Psychologists Specialising in Psychotherapy, it will be possible for those who have made distinctive contributions to the theory, practice, training or other aspects of psychotherapy to be considered for recognition as ‘advanced practitioners’. Eligible candidates will have made a significant contribution to the field over at least 10 years since qualification and will be judged through combinations of innovative teaching, training, consultation, supervision, psychological inquiry, publications or other creative ways.

It can be readily seen that the above proposals are not primarily concerned with discriminating between client groups or therapeutic approaches. Therefore, while psychotherapy for people with learning disabilities is not specifically addressed, in this regard it is no different from any other specialist area in

psychotherapy. The proposals should therefore allow, promote and develop, a level of recognition and validation of psychologists who have been working in this field or who wish to develop their expertise further. The inclusion of such individuals within the register should promote a constructive debate on the development of psychotherapies for people with learning disabilities.

Training for generic psychotherapists

Psychotherapists do not constitute a single discipline whose training is prescribed in the same way as that for psychiatrists and psychologists. They come from a wide range of backgrounds and as qualified practitioners their training differs depending on the tradition, school or modality used. There are two organisations in the United Kingdom that are established to approve training and promote high standards of practice: the United Kingdom Council for Psychotherapy (UKCP) and the British Confederation of Psychotherapists (BCP). Both organisations maintain and publish a voluntary Register of appropriately qualified practitioners who meet training requirements and ethical standards. There is no legal requirement to be registered as a therapist but there have been significant moves towards this, primarily with a view to the protection of those seeking therapy.

The UKCP has eight autonomous Sections representing all the main traditions in practice. The Council sets training requirements which apply to all sections; the sections apply training standards in accordance with these to the organisations represented within them. For example, accreditation through the British Association for Behavioural and Cognitive Psychotherapies currently provides the only means of registration within the Behavioural and Cognitive Psychotherapy Section for this modality. In all there are 80 organisations involved in training or in approving training; the Royal College of Psychiatrists and the British Psychological Society are Special Members on the UKCP Council.

Accredited training courses are aimed at postgraduate level and are not normally shorter than 4 years part time (or equivalent). The training covers a minimum curriculum and focuses on modality rather than client group needs, though there is, for example, recognised separate training for child psychotherapists. Trainees can work with individuals, couples, families or groups. At present there is no specific recognition of training experiences required to work with people with learning disabilities in any of the Sections. However, the recent establishment of the Institute of Psychotherapy and Disability, which is a member organisation of the UKCP, will move towards the establishment of such training and its recognition and regulation (vi).

The British Confederation of Psychotherapists (BCP) is the umbrella organisation for most of the psychoanalytic and psychoanalytic psychotherapy-based training including child psychotherapy, all of which has very exacting training requirements from the Member Societies. Training time is a minimum of 4 years and includes personal analysis or therapy.

Both these organisations, the UKCP and the BCP have useful websites.

Postgraduate diploma training

Examples most frequently encountered in work with people with learning disabilities are art, music and drama therapists. The postgraduate diploma course and qualifications result in State Registration with the Arts Therapists Board of the Council for Professions Supplementary to Medicine. Following the diploma course it is possible to register for an MA or PhD in which the student is able to follow his or her own special interest. The diploma training is understandably varied but focuses on relevant psychological and psychotherapeutic principles and practices and in particular on psychoanalytic, humanistic and systemic theories. Personal therapy is now a requirement.

It appears that state-registered practitioners take up posts in learning disability because of their own interest in the people and the subject generally and adapt their practice as appropriate. Some, not all, will find supervisors working as psychotherapists with people with learning disabilities; others form peer groups, though available funding for supervision is variable.

Certificate, diploma and other training for all professionals and other staff

The Tavistock Institute in London has developed a Postgraduate Certificate awarded after a 1-year part-time course and a Postgraduate Diploma after 2 years part time in Psychotherapeutic Approaches to Working with People with Learning Disabilities. This is open to professional staff of all disciplines and from all sectors who have 2 years of experience.

Respond also run a variety of 1- and 2-day courses on working with people with learning disability with particular issues such as sexual abuse, sexual offending, parenting, etc. Both Respond and the Centre for Attachment Based Psychoanalytic Psychotherapy (CAPP) run courses for psychotherapists who wish to develop their work with people with learning disabilities.

Elsewhere, training is being developed to apply other modalities such as cognitive-behavioural specifically to work with people with learning disabilities, but much of this is at an early stage. Only examples that are known can be mentioned. There is a need for information to be collated and centralised as opportunities are made available.

Regulation and 'quality control'

While the regulatory bodies that approve the trainings described above can take responsibility for those elements of training that they specify, there remains a major gap in specifying and regulating the application of these methods for use with people with learning disabilities as well as the more general promotion of development of the whole specialism of psychotherapy and disability. These specialist aspects have been described in 'Therapeutic approaches' (p. 38) and apply to all modalities.

At the present time, the only specific development for the promotion, advance and regulation of psychotherapy for people with learning disabilities is that of:

The Institute of Psychotherapy and Disability

The recent launch of the Institute of Psychotherapy and Disability provides a regulatory body and a home for those individuals who have been promoting psychodynamic approaches for many years. The Institute is accepting members who have experience in psychotherapy with people with learning disabilities; currently these are mainly psychotherapists who have worked with adults with learning disabilities or learning disability professionals who have provided psychotherapy with a qualified supervisor. Inevitably some people within this new field have managed with peer supervision to develop their skills and expertise. It is expected that progress will be made towards securing funding of research, promotion of appropriate posts for therapists and proper regulation of those in practice. The Institute has a Training Committee and is working towards the development of a set of accreditation standards for courses that would lead to qualification. This process will take several years.

In a more generalised context, regulation of standards of competence and practice for all professionals may in future be addressed by:

National Occupational Standards

The Department for Education and Skills is directing all professions towards competence-based training and accreditation. National Occupational Standards are being developed for the National Service Framework for Mental Health (England). It is a complex area and the levels of skill require careful consideration according to the context in which a practitioner is practising or training. The Government appears to be committed to having a competent and externally evaluated workforce. It is vital that any new training and qualifications lead to registration within this context but also that such a drive does not marginalise and devalue the considerable range of experience and expertise that has been built up over decades.

Future training initiatives – an example

A bereavement intervention study was carried out in Bognor Regis, Liverpool, Edinburgh, Inverness and South London between 1999 and 2002. The full results of this study have been submitted for publication (further details available upon request from Professor Sheila Hollins, St George's Hospital Medical School, Cranmer Terrace, London SW17 0RE). One of the interventions involved providing additional training for experienced volunteer bereavement counsellors to equip them for counselling bereaved people with learning disabilities. Standardised outcome measures demonstrated significant improvements in the mental health of those who completed between 8 and 30 counselling sessions. The majority of the counsellors reported a willingness to include people with learning disabilities amongst their client group in the future. Funding is being sought to develop a top-up training package for bereavement counsellors. Could such top-up training be appropriate for other counsellors/psychotherapists to improve access to mainstream psychotherapy services?

5. Conclusions and recommendations

Conclusions

This report demonstrates that there is neither inclusion nor equity for this needy client group in accessing psychotherapy services from which evidence shows they can benefit. Present strategy, in England in particular, appears to value 'inclusion' to the detriment of equity. If these values are to be equally respected, ordinary psychological services need to be willing, resourced and trained to meet the needs of those people with learning disability for whom they could provide. Learning disability services must be enabled to provide a mentally healthy emotional environment. Therapists must be trained to deliver specialist therapy to those with the special needs described. No single professional group or statutory or voluntary/independent agency can plan or deliver these services in isolation. Collaborative joint planning and implementation is required. Likewise, there are implications for the development of education and training which apply to many disciplines at different levels of specialism.

Recommendations

1. Strategy, service planning and delivery

This must be based on the same principles as those for non-disabled people with the acknowledgement that special training and specialist service provision will be required to eliminate health inequalities.

1.1. Needs based

All people with learning disabilities require services that are psychologically informed in order to promote their good mental health. Specialist psychotherapeutic services require therapists who have experience in learning disabilities in order to respond to their special needs.

1.2. Focused on service users/carers

Users and carers should be involved in advising on all aspects of services and support should be provided to enable them to do so.

1.3. Evidence based

Research criteria should acknowledge the constraints of working with this client group. Funding needs to be made available for research, specifically with this client group if the principle of inclusion of people with learning disabilities is to be respected.

1.4. Coordinated

Coordination is required at all levels, between service planners in Mental Health and Learning Disability Services, between all agencies providing psychological services, and between the various disciplines working in community learning disability teams.

1.5. Accessible

Education for all staff in contact with people with learning disabilities is required to encourage appropriate referrals. Transport and escorts are essential and should be accounted for in the budgetary planning of therapeutic services

1.6. User friendly

Local services should actively seek the opinions and experience of people with learning disabilities and carers on the accessibility, attitudes, comfort, convenience etc. of the services provided.

1.7. Safe

Rigorous organisational and professional standards should be applied in all aspects of individual work for the protection of this vulnerable client group, with a particular emphasis on skilled supervision.

1.8. Confidential

Protocols should be established to respect the right to confidentiality and should balance this with necessary sharing of information.

2. Service delivery in practice

Successful service models should be able to demonstrate the following characteristics, that they:

- consult users and carers about all aspects of service development and delivery;
- target clearly defined need and offer appropriate treatment at an appropriate service level;
- offer a range of therapies;
- be evidence based;
- be multi-disciplinary;
- have a clear training strategy;
- have a single point of entry with clear referral and assessment procedures;
- undertake audit;
- be well integrated into mainstream mental health services and contribute to the development of psychologically aware learning disabilities services;
- apply rigorous professional standards in all aspects of work with this vulnerable patient group.

3. Education and training

There should be appropriate training at all levels to deliver a psychologically informed service which will have the dual effect of fostering good mental health and supporting early detection of problems and appropriate and timely referrals. There is a requirement for trained professionals with competence in the provision of psychotherapy in various modalities with this client group.

3.1. Psychologically informed service delivery

- 3.1.1. The education of all professional and non-professional staff in contact with the client group should include aspects of psychotherapeutic theory and practice.
- 3.1.2. This report should be made available to training organisations and professional registration organisations in all the jurisdictions in order that they may consider how to incorporate the information into their basic curricula.

3.2. Training needs of those who deliver therapy

For those in training

- 3.2.1. All organisations training psychotherapists should examine how the training they provide equips therapists to provide services to people with learning disabilities, and consider including a core module on working with people with learning disabilities.
- 3.2.2. Registration bodies such as the BCP and the UKCP should request each Member Society or Section to describe how their training will be adapted to be inclusive of people with learning disabilities.
- 3.2.3. The Royal College of Psychiatrists should establish a joint training forum between the Faculty Specialty Advisory Committees to establish dual training in psychotherapy and learning disability.
- 3.2.4. Training programmes for psychiatrists in psychotherapy should include a requirement for inclusion of a person with learning disabilities as a training case and in Higher Training at Specialist Registrar level all trainees should be expected to acquire competence in applying their skills with people with varying degrees of learning disability.
- 3.2.5. The guidelines for psychotherapy training of specialist registrars in psychiatry of learning disability (Appendix 1) should be adopted and a date set for implementation.

Top-up skills for trained professionals

- 3.2.6. Psychotherapists working in the NHS should accept patients with learning disabilities for treatment, seeking supervision from disability psychotherapists as appropriate.

- 3.2.7. Courses should be developed that can help apply the skill and expertise of mainstream services to people with learning disabilities.
- 3.2.8. Courses for staff in learning disability services on psychotherapeutic approaches in general and for particular issues such as sexual abuse and bereavement should be further developed and made widely available (Respond, Tavistock and CAPP all provide examples).
- 3.2.9. Certificate and Diploma courses in psychotherapeutic approaches to working with people with learning disabilities should be replicated for wider access.

Training as a disability psychotherapist

- 3.2.10. The Institute of Psychotherapy and Disability is developing a course for UKCP/BCP trained therapists to apply their skills to people with learning disability and the intention to develop specialist training with accreditation should be supported.

4. Priorities for action

- 4.1. The contents and implications of this document should be widely publicised in each of the jurisdictions: England, Wales, Scotland, Northern Ireland and the Republic of Ireland.
- 4.2. Service commissioners should be asked to ensure that local services are shaped and developed to meet the needs identified here. (The care pathways in Appendix 3 may be useful.)
- 4.3. Training commissioners for all disciplines working with people with learning disability, and psychotherapy training and accreditation bodies should be requested to take action on these recommendations.
- 4.4. A multi-disciplinary group should be established to develop evidence-based practice guidelines for treatment choice in psychological therapies for people with learning disabilities, to further develop this work and to make its applicability more widely known.
- 4.5. The Royal College of Psychiatrists' Public Education Committee should consider how the broader implications of this report, especially the issues of stigma, might be addressed.

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Appendix 1: Guidelines for psychotherapy training for specialist registrars in psychiatry of learning disability

(a) Knowledge objectives

1. To expand basic knowledge in developmental theories and the practice of psychotherapy. To be able to apply this knowledge to inform case formulation and management.
2. To acquire expert knowledge of all forms of psychopathology as they present in people with learning disability.
3. To develop an understanding of how psychological, social and environmental factors may interact with biological factors to shape personality and behaviour in people with an identified cause for their learning disability.
4. To acquire knowledge of how psychological and emotional factors influence the development and course of illness or emotional disturbance in people with all levels of disability, particularly in the case of severe physical and intellectual disability.
5. To understand and describe the dynamics of various settings with their differing models of care and sociocultural backgrounds.
6. To understand how disability affects both the individual and family members and may affect family or marital functioning.
7. To understand personal, social and institutional factors that may lead to abuse of persons with disabilities.
8. To understand the psychological impact of long-term dependency, stigma, loss and abuse experiences upon people with learning disability and with those people responsible for supporting them.
9. To understand the issues involved in maintaining and supporting appropriate interpersonal, social and therapeutic boundaries.

(b) General skills objectives

By the end of SpR training the trainee will be able to:

1. Communicate appropriately and effectively with people of all degrees of learning disability.
2. Identify psychological and emotional factors relevant to the development or maintenance of disturbed behaviour.
3. Assess indications, motivation and capacity for psychological intervention in persons with learning disability who present with psychiatric, behavioural or emotional disorders.

4. Adapt psychological treatments to the needs and abilities of persons with learning disabilities regardless of causation.
5. Recognise how the various residential settings, and particular dynamics thereof, may affect the implementation of psychotherapy and the need for a supportive framework to facilitate the delivery of treatment.
6. Recognise the constraints upon psychological interventions when abuse procedures are in progress.
7. Recognise how experiences of dependency, disempowerment and exclusion can influence a person's emotional capacity for exercising choice.
8. Formulate problems from a systemic and organisational viewpoint. This requires an understanding of the impact of various events, such as abuse, death and violence upon particular settings.
9. Facilitate multi-disciplinary case reviews and management plans that encompass the dynamic issues involved between self, staff and clients.
10. Conduct a family interview in which the referred patient is one with learning disabilities, and assess the family dynamics and the appropriateness and nature of further family-based interventions.
11. Recognise and manage the personal impact of working with chronic disability.

(c) How will these skills be developed in psychiatry of learning disability?

1. Experience of assessment of patients for psychological intervention, for example: abuse experiences, self-injury, bereavement.
2. Treatment of at least one patient (child/adult) presenting with behavioural problems using one major psychotherapeutic model.
3. Treatment of at least one patient (child/adult) presenting with psychological problems or mental illness using one major psychotherapeutic model.
4. Experience of Group Work with people with learning disabilities.
5. Experience of a family assessment and treatment of at least one patient using a family therapy approach.
6. Experience of using leadership and interpersonal skills in understanding one's own team processes and in consulting to homes and other institutions.

(d) Who supervises?

1. The educational supervisor will provide general supervision of many aspects of the knowledge and skills objectives dependent upon their particular training and competence.
2. Supervision in particular treatment modalities may be provided by consultants in psychiatry of learning disability who have specialist

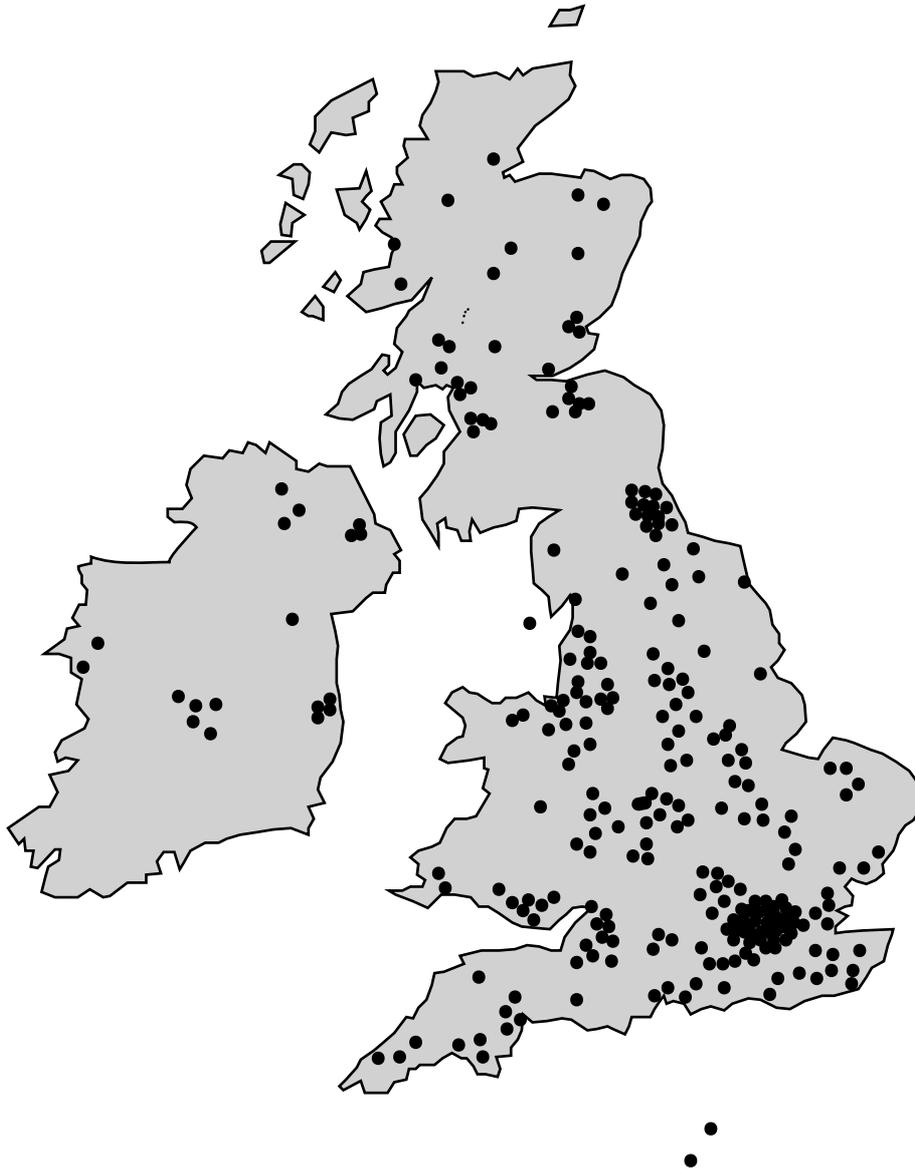
training or by supervision with specialist psychotherapists (of any discipline) experienced in the assessment and practice of particular treatment models with people with learning disabilities.

3. Peer supervision with trainees of other disciplines utilising psychotherapy as a treatment model.

(e) How to assess

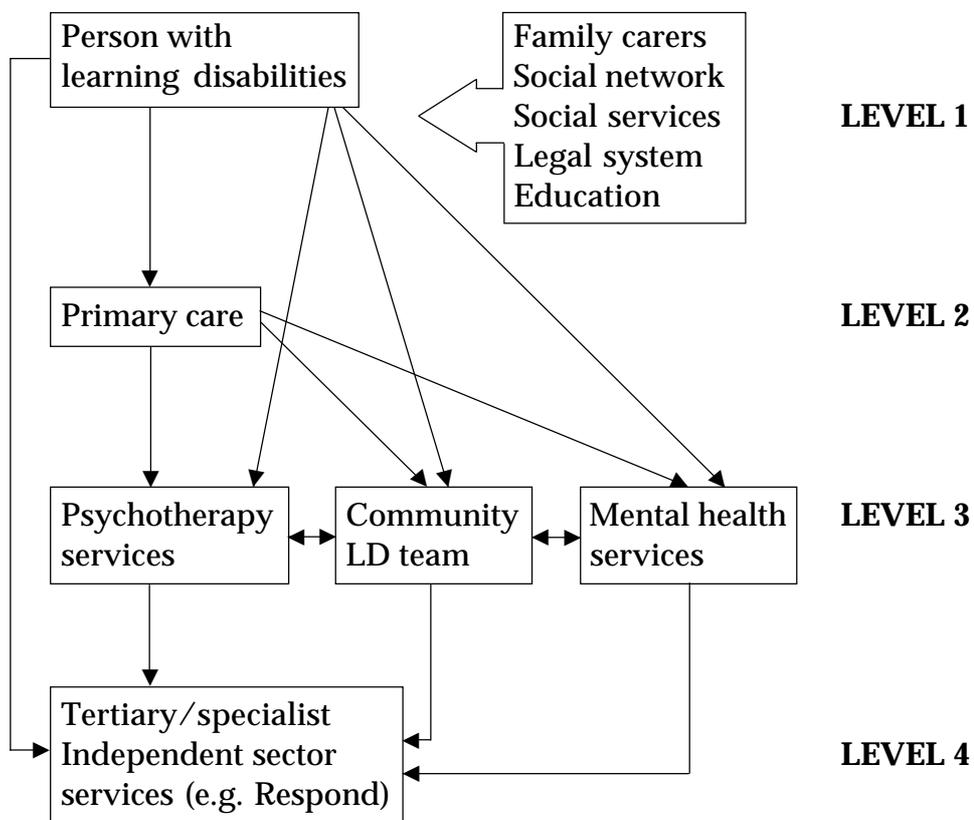
1. Trainees should formally write up a piece of individual, group or family therapy that they have completed for the relevant supervisor. Audio/visual taped interviews for psychological assessment and family interviews may be useful.
2. Each trainee should write a report that demonstrates an understanding of the institutions involved in learning disability from old, long-stay hospitals to educational day centres or community teams. The report should emphasise how the dynamics of the institution impact upon the care that a patient receives. This report may be assessed by the supervising specialist psychotherapist and the assessment communicated to the training programme director for inclusion in the specialist registrar appraisal system.

Appendix 2: Responses to questionnaire from the United Kingdom and Ireland



Appendix 3: Levels of access to psychotherapeutic skills and resources

Through the medium of a rudimentary ‘care pathway’, we have illustrated the network of processes in which the place of psychotherapies can be considered. The diagram can also be seen as illustrating points at which access to psychotherapy can be facilitated and in the subsequent tables we have elaborated on the skills and resources required and have referenced this to relevant parts of this document to act as a quick reference and information guide:



LEVEL 1

	Requirements	Report ref.
Identification	Awareness of emotional needs, particularly at times of stress or change, and of services that can address these needs. Awareness that emotional distress can cause challenging behaviour, e.g. angry outbursts	Page 19 Page 48 Page 59
Assessment	Ability to listen to and talk with individual. Non-verbal communication awareness necessary	Page 55 Page 59
Intervention	Taking notice of signs of difficulty in client or their family and making appropriate referral, with their agreement	Pages 39–41
Training and supervision	Development of listening skills and skills in attending to peoples' emotional needs	Page 48 Page 59
Resources	Knowledge of particular precipitants of distress, e.g. bereavement. Trained workforce	Page 22 Page 59

LEVEL 2

	Requirements	Report ref.
Identification	Awareness of and attunement to clients emotional need that may appear to lie behind behavioural problem or client may be cut off from their feelings	Page 22 Page 48 Page 59
Assessment	Willingness to talk about potentially upsetting personal issues with client	Page 23 Page 48
Intervention	Decision about whether clients should be referred for treatment. May need to be discussed with carers and with commissioners	Page 39 Page 57
Training and supervision	More awareness of vulnerability of client group to environmental changes	Page 22 Page 48
Resources	Time and interest. Listening skills. Trained workforce in both learning disability and psychotherapy services	Page 59

LEVEL 3

	Requirements	Report ref.
Identification	Referrals from primary care and other sources. Awareness of emotional needs and therapeutic possibilities	Page 22 Page 48 Page 59
Assessment	Assessment procedures and protocols that specifically address psychotherapeutic approaches. Joint assessment protocols – between psychotherapy and LD services. Consultation to teams	Pages 35–38 Pages 57–58
Intervention	Continued experience, widening of evidence base. Integrated care pathways for specific problems, e.g. bereavement, abuse, assault, relationships	Page 22 Page 57
Training and supervision	Increased awareness in community teams (LD and Mental Health) and psychotherapy services of appropriateness of therapy. Reciprocal supervision arrangements. Shared CPD (LD, Mental Health, Psychotherapy).	Page 55 Page 59 Page 47
Resources	People with training/ knowledge at all professional levels. Help for client to access therapy. Support to carers	Pages 59–60 Page 39 Pages 41–42

LEVEL 4

	Requirements	Report ref.
Identification	Referrals from secondary and tertiary care. Awareness of research findings.	Pages 20–22
Assessment	Assessment for psychotherapy. Consultation with carers re: support to person, for access, etc. Supervision of therapists with either no learning disability experience or no psychotherapy experience	Page 39–42
Intervention	Provision of specialist psychotherapy	Pages 42–48
Training and supervision	Specialist psychotherapy skills, and experience in learning disabilities and appropriate supervision	Pages 59–60
Resources	Highly trained disability psychotherapists to provide therapy. Patient transport and support to them and to carers essential	Pages 59–60 Page 40