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The impact of Covid-19 on access to psychological services

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The impact of Covid-19 on access to psychological services

Abstract

Purpose

The novel coronavirus and associated mitigation efforts have produced barriers to accessing services for adults with intellectual disabilities. This paper evaluates the impact of Covid-19 on access to psychological services. The paper evaluates monthly referral rates and psychological distress scores for service users awaiting therapy.

Methodology

A quantitative service evaluation was completed in a psychology service based in the North of England which specialises in supporting adults with intellectual disabilities. A single case experimental design was employed to examine the impact of events in March 2020 on referral rates. Descriptive statistics and effect size calculations were utilised to examine the impact of prolonged waiting times on psychological distress scores.

Findings

Referral rates were examined comparing a 5-year rolling average monthly referral rate for the 12 months prior to March 2020 with the 12 months following. Findings demonstrate that events in March 2020 had a considerable impact on referral rates and rates have not recovered. Eight service users were contacted to determine the impact of prolonged waiting times with results demonstrating increases in psychological distress of a large effect size.

Originality

This is the only article the authors are aware of examining the impact of the coronavirus on access to services and psychological distress for adults with intellectual disabilities. It is hoped that these findings will be able to inform both policy and practice as services continue to navigate the pandemic.

Key words:

Psychological therapy; intellectual disability; referrals; waiting lists; PTOS-ID II; Covid-19; service development; mental health

Classification: Practice paper

Introduction

Management of the novel coronavirus (Covid-19) in the United Kingdom (UK) has required mental health services to accommodate unprecedented changes to standard practice. Social distancing guidelines (Cabinet Office, 2021) and recommendations for remote working (NHS England and NHS Improvement, 2020) have reduced the capacity for outpatient face-to-face appointments which has inadvertently created a barrier to service provision for adults with intellectual disabilities (ID) who cannot engage in remote therapy (Rawlings *et al.,* 2021). This cohort have therefore experienced a prolonged time on waiting lists during the pandemic.

Research examining the impact of therapy waiting lists highlights concern, see Cunningham *et al.* (2013), Furukawa *et al.* (2014), and Patterson *et al.* (2016). This literature suggests that waitlist patients report inferior outcomes compared to individuals in 'no treatment' conditions (Patterson *et al.,* 2016). For adults with ID who have endured prolonged wait times for psychology therapy during the pandemic, it is possible that this effect could be more profoundly experienced due to the context of the pandemic and pre-existing health care inequalities.

Literature evaluating the biopsychosocial impact of the COVID-19 pandemic on adults with ID is emerging but requires further investigation, for brief insights see Constantino *et al.* (2020) and Rawlings *et al.* (2021). Evidence preceding the pandemic suggests that individuals with ID are more vulnerable to stressful situations due to an absence of effective coping strategies (Janssen *et al.,* 2002). This has been corroborated with literature indicating a rise in behaviour that challenges during the pandemic in certain groups of people with ID (Schuengel *et al.,* 2020). Emregts *et al.* (2020a) further explored the experiences of the COVID-19 pandemic with people who have ID and reported themes of missing social interactions, difficulties adjusting to routines, and challenges understanding restrictions and mitigation efforts. Emregts *et al.* (2020b) also explored carers experiences, reporting that the pandemic has placed strain on caregivers across emotional, cognitive, practical, and professional domains. Drawing upon Janssen *et al.'s* (2002) stress-attachment model of challenging behaviours in ID, it is likely that the increase in carer-stress is causing additional difficulties for adults with ID (Heyvaert *et al.,* 2010).

A further phenomenon resulting from the adjustment to infection control guidelines has been the impact on referral rates. Data from NHS Digital (2020a; 2020b) indicates that referral rates to Improving Access to Psychological Therapies programmes and secondary mental health, learning disabilities, and autism services considerably reduced as an immediate response to the first national lockdown in March 2020. However, as these data were combined across a number of secondary care groups, the specific impact on referral rates for adults with ID remains unclear. It is therefore important to examine the significance of these changes, particularly as this represents a further barrier to mental health support services for this client group.

Literature examining the barriers and enablers to accessing mental health services for adults with ID has been consolidated in Whittle *et al.'s* (2018) scoping review. A critical enabler identified across research was interagency collaboration. The practice of close collaboration between support services ensures that the needs of adults with ID can be efficiently matched with appropriate resources (Trollor, 2014). A critical barrier was reported as a lack of help-seeking, with evidence suggesting that adults with ID are less likely to voice a desire for support compared to other societal cohorts (Whittle *et al.,* 2018). The 'work from home' governmental guidance during lockdowns one, two, and three reduced the capacity and efficiency of interagency collaboration throughout 2020 and into 2021. Considering this, alongside the evidence that adults with ID are less likely to voice their need for support, it is probable that reductions in referral rates has been exacerbated in this cohort.

Therefore, a service evaluation was conducted to examine rates of referrals prior to and following the first national lockdown in the UK on 23rd March 2020 and the impact of the pandemic on psychological distress scores for patients on the waitlist for psychological therapy.

Method

The service

The service is based in a community health team specialising in supporting adults with ID within a Metropolitan Borough with a population over 245,000 in the North of England. The psychology team (two clinical psychologists, two trainee clinical psychologists, and an assistant psychologist) oversees a range of pathways including diagnostic assessments, direct therapeutic work, and behavioural consultations. For a detailed overview of the service see Jackson and Beail (2016).

Since March 2020, the service has responded to infection prevention and control guidelines and appropriately adjusted routine practice. From November 2020 to the time of writing, the service has been engaging in a significantly reduced amount of outpatient face-to-face appointments across all pathways. The reduction in daily contacts ensures that clinic rooms which facilitate appropriate social distancing can be accessed for all sessions, that these rooms can be thoroughly sanitised between sessions, and that foot-flow is controlled throughout the clinic minimising encounters in the waiting room and corridors. This has resulted in longer waiting times for patients referred for psychological services. The maximum wait time prior to the pandemic was 18-weeks (a key performance indicator which was consistently met by the service). Following the pandemic, the average wait time has been 35.7 weeks.

Data collection

To examine the impact of Covid-19 on referrals, in February and March 2021 the first author reviewed minutes from the service's allocation meetings between January 2015 and February 2021, collating a history of monthly referral rates. Months with missing meeting minutes were removed from analysis.

To examine the impact of prolonged wait times for therapy, a review of pre-therapy triage assessments identified eight service users (5 men, 3 women; age 23 to 29 years) who had completed the Psychological Therapy Outcome Scale for Intellectual Disabilities – 2nd Edition (PTOS-ID II; Jackson *et al.,* 2017; Vlissides *et al.,* 2017) during their pre-therapy appointment. The PTOS-ID II is a 32-item self-report questionnaire which requires patients to report "*over the past week"* how frequently they have experienced certain phenomena across a four-point scale ranging from: "*Not at all*" to "*A lot"*. The measure includes 16-items which provide a psychological distress score ranging from 0-48, 11-items which provide a positive wellbeing score from 0-33, and 5-items which calculate a risk score from 0-15. Greater scores on the psychological distress and risk scales signify increased difficulties, whereas greater scores on the positive wellbeing scale signify increased wellness. Vlissides *et al.*'s (2017) component analysis of the PTOS-ID II revealed good internal consistency for the psychological distress ($\alpha = 0.85$) and positive wellbeing indexes ($\alpha = 0.81$). The psychological distress index is also well correlated with the Brief Symptom Inventory's (Derogatis and Melisaratos, 1983) Global Severity Index ($r = 0.85$). Finally, the psychological distress scale has a clinical threshold of 16, scores greater than this suggest individuals would benefit from receiving professional support.All service users had a diagnosis of ID, had been on the waiting list for longer than 92 days, and completed their triage appointment prior to, or during, the covid-19 pandemic. Pre-therapy triage appointments took place between 22nd November 2019 and 26th November 2020. The average time waiting between pre-therapy triage appointment and follow up was 250 days, ranging from 98 days to 392 days. These service users were contacted again between November 2020 and March 2021 either via telephone by the first author or in clinic with a therapist prior to the commencement of their therapeutic package. Service users were provided information about the service evaluation project and verbally consented to take part. During these contacts a PTOS-ID II was completed.

Data Analysis

Monthly referrals rates were analysed in accordance with Lenz (2013) and Parker *et al.'s* (2011) single case experimental design (SCED) analysis. A SCED was utilised as the introduction of the national lockdown provided a natural separation between Phase A (monthly referrals pre-first national lockdown) and Phase B (monthly referrals post-first national lockdown). The baseline phase could then become a natural control measure which increased the transparency of the impact of COVID-19 on referral rates as comparisons could be made across phases (McMillan and Morley, 2010; Smith, 2012). To account for the increased risk of procedural sensitivity due to the number of Pre-March 2020 datapoints, a five-year rolling monthly average was taken for the 12 months preceding March 2020 to compare with the 12 months following March 2020. Descriptive statistics, nonoverlapping data analysis, and Mann-Whitney U tests were then performed and examined. PTOS-ID II scores were analysed utilising Minami *et al.'s* (2008) effect size calculations alongside descriptive statistics.

The service evaluation was commissioned by the service lead and registered with and approved by the trusts Quality Improvement and Assurance Team.

Results

Referral Data Pre-March 2020

The five-year rolling average monthly referral data for the 12 months immediately preceding March 2020 is presented as the first 12 data points in figures 1-3. Visual inspection suggests that total, therapy, and diagnostic referral rates remain relatively stable. Scores are high and gradually increase.

Pre-March 2020 Trends & Autocorrelations

A Kendall's tau-b (Kendall, 1938) was calculated for each dataset to establish trends in data prior to March 2020. Tarlow's baseline corrected tau calculator was utilised (Tarlow, 2016). Results indicated that the pre-March 2020 baselines demonstrated insignificant mild positive trends (total referrals τb=–.394, p=.086; therapy referrals τb=–.351, p=.130; diagnostic referrals τb=–.394, p=.086). These mild-positive trendlines indicate that significant negative changes following March 2020 can largely be attributed to the coronavirus pandemic and subsequent mitigation efforts.

Autocorrelations for Pre-March 2020 datasets were performed in SPSS (Ljung and Box, 1978). Lag 1 results for all datasets were insignificant, total referrals autocorrelation .247 (SE=.256) Box-Ljung .931 (*p*=.335), therapy referrals autocorrelation .287 (SE=.256) Box-Ljung 1.258 (*p*=.262), diagnostic referrals autocorrelation .346 (SE=.256) Box-Ljung 1.823 (*p*=.177). These results suggest no coherent developments or progression is present in referral rates prior to March 2020 which is to be expected.

Autocorrelations for the complete pre and post-March 2020 datasets were also completed. Lag 1 results were significant for the total referrals measure (autocorrelation .459, SE=.192, Box-Ljung 5.718, *p*=.017) and the diagnostic referrals measures (autocorrelation .568, SE=.192, Box-Ljung 8.766, *p*=.003). The lag 1 result for the therapy referrals measure was insignificant (autocorrelation .334, SE=.192, Box-Ljung 3.024, *p*=.082). The significant results within the total and diagnostic referrals measures indicate serial-dependency which suggests the impact of the covid-19 pandemic has had an incremental impact across the year.

Visual Inspection of Complete Dataset

Figure 1 presents the complete dataset for total referrals. Visual examination indicates a considerable deterioration of referral rates following March 2020. The trendlines for each phase are on a similar gradient which suggests that recovery towards pre-March 2020 referral levels will be gradual. There is also an increase in variability of scores from a variation of 8.3 referrals (low 12, high 20.3) in the rolling averages prior to March 2020 to a variation of 11 referrals (low 3, high 14) post-March 2020.

Figure 1

Total Referral Rates Five Year Rolling Average Pre-March 2020 vs Post-March 2020

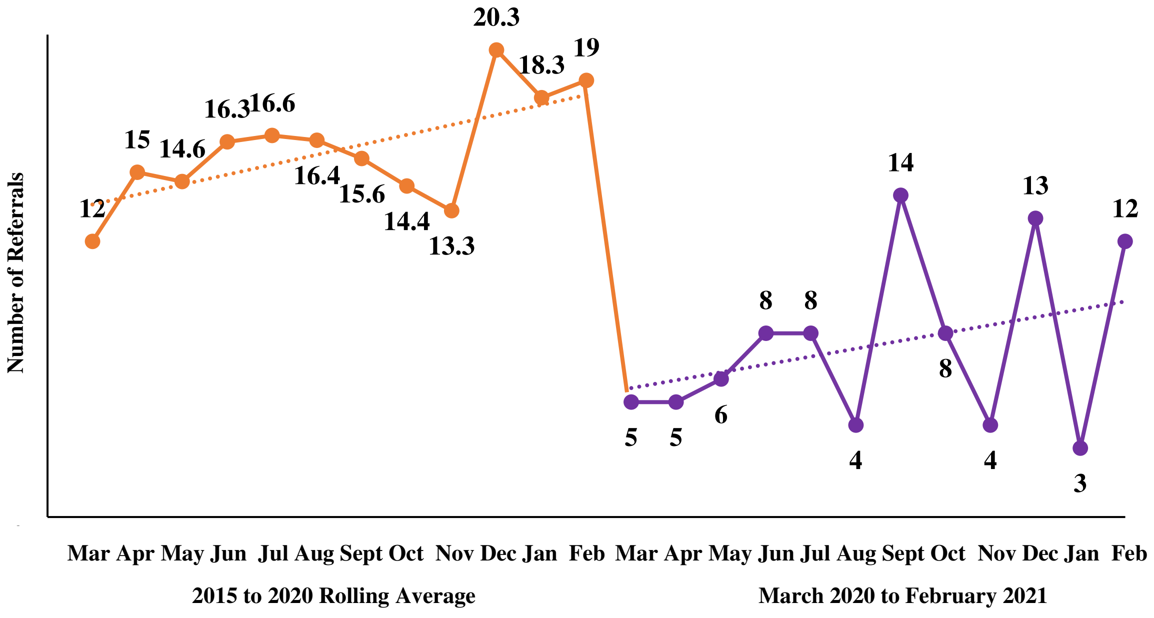


Figure 2 presents the complete dataset for therapy referrals. Visual inspection suggests that therapy referral rates have deteriorated to a lesser extent. There is an increase in variability of referrals from 4.6 (low 4.7, high 9.3) pre-March 2020 to 7 (low 0, high 7) post-March 2020. Additionally, the post-March 2020 trendline demonstrates a gradual regression in referral rates compared to the previous 12 months. This suggests that steps of recovery towards pre-March 2020 levels are not yet being made.

Figure 2

Therapy Referral Rates Five Year Rolling Average Pre-March 2020 vs Post-March 2020

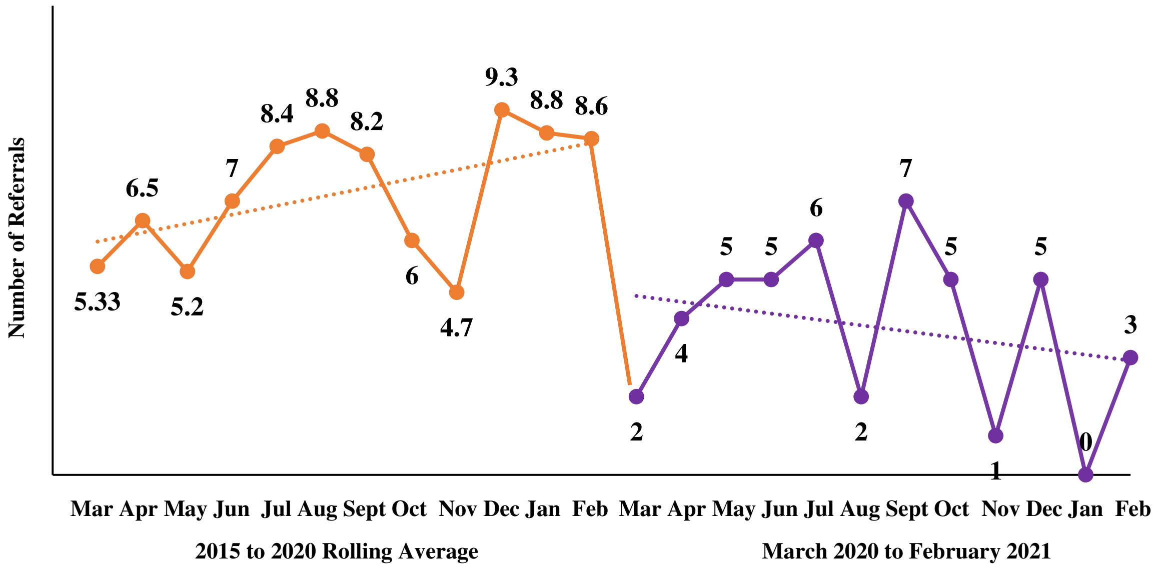
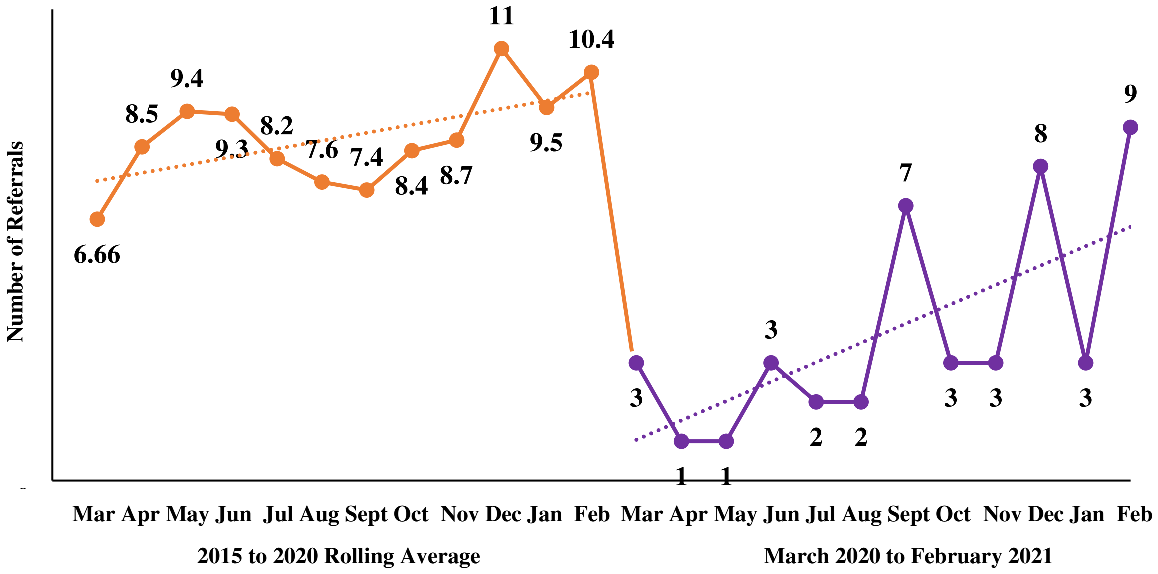


Figure 3 presents the complete dataset for diagnostic referrals. Visual analysis reveals that diagnostic referral rates have also faced a considerable deterioration following March 2020. Despite this the trendline suggests a rapid recovery has begun. Variability also increased from 4.4 (low 6.6, high 11) prior to March 2020 to 8 (low 1, high 9) post-March 2020.

Figure 3

Diagnostic Referral Rates Five Year Rolling Average Pre-March 2020 vs Post-March 2020



Referral Data Descriptive Statistics

Table I presents the mean average, median average, and standard deviations for each referral measurement during the pre-March 2020 phase and the post-March 2020 phase. The sum of total referrals are also calculated. Table I demonstrates that for all three idiographic measurements both the mean and median average scores decreased following March 2020, that standard deviations increased, and that the sum of total referrals are considerably below what would be expected.

Table I

Monthly Referral Rates Descriptive Statistics

	Pre-March 2020 (March 2015-February 2020: 5-Year Rolling Average)				Post-March 2020 (March 2020-February 2021)			
	Monthly Mean	Monthly Median	Monthly Standard Deviation	Average 12-Month Total Referrals	Monthly Mean	Monthly Median	Monthly Standard Deviation	12-Month Total Referrals
Total Referrals	16.0	16.0	2.28	191.85	7.5	7	3.57	90
Triage Referrals	7.2	7.6	1.58	86.78	3.75	4.5	2.04	45
Diagnostic Referrals	8.8	8.6	1.19	105.06	3.75	3	2.59	45

Independent samples Mann-Whitney U tests were utilised to determine the significance of change between pre-March 2020 referral rates and post-March 2020 levels, total referrals U=3.500 (SE=17.294, *p*=.000), therapy referrals U=13.000 (SE=17.268, *p*=.000), diagnostic referrals U=11.000 (SE=17.237, *p*=.000). Significant results across all three datasets indicates that events in and proceeding March 2020 have caused referral rates to significantly deter from the 5-year rolling average. However, as autocorrelation results highlighted serial dependency within the total and diagnostic datasets, the assumption of independence has been violated here. Therefore, Mann-Whitney U results for these datasets should be interpreted with caution.

Non-Overlap Analysis

Table II details the results following non-overlap analysis which was performed in line with Parker et al.'s (2011) principles and strategies for non-overlapping data analysis in SCED.

Table II

Non-overlap analysis

	Percentage of Non-Overlapping Data (PND)	Percentage Exceeding the Median (PEM)	Percentage of All Non-Overlapping Data (PAND)
Total Referrals	75%*	100%**	87.5%*
Triage Referrals	50%	100%**	75%*
Diagnostic Referrals	75%*	91.66%**	87.55%*

*scores between 70-89% represent change of moderate effectiveness.

**scores greater than 90% are indicative of large effectiveness.

(Scruggs and Mastropieri, 1998).

The PND calculation analyses the number of post-March 2020 data points which are lower than the lowest score in the pre-March 2020 phase (Scruggs *et al.,* 1987). Utilising Scruggs and Mastropieri's (1998) efficacious change scoring mechanism the impact of the Covid-19 pandemic can be calculated. The PND scores suggest that the Covid-19 pandemic has had a moderate effect on the number of total and diagnostic referrals, whereas no impact of therapy referrals.

The PEM calculation examines the number of post-March 2020 data points which are lower than the pre-March 2020 median score (Ma, 2006). PEM can be seen as a robust reflection of the impact of the coronavirus on referral rates, as if the virus had no impact on referral rates it would be expected that post-March scores would oscillate around the pre-March median with 50% falling above and 50% falling below (Ma, 2006). The PEM scores suggest that the Covid-19 pandemic has had a large impact on total, therapy, and diagnostic referrals rates with well over 50% of data points falling below the median on each measure.

The PAND calculation computes the sum of post-March data points which would require removal to ensure that no post-March data points overlap with the pre-March data points (Lenz, 2013; Parker *et al.,* 2011). PAND calculations are more closely aligned with effect size calculations like *R* (Lenz, 2013; Parker *et al.,* 2011), whilst also correlating with PND scores (Parker *et al.,* 2007). The PAND scores suggest that the Covid-19 pandemic has had a moderate impact on all total, therapy, and diagnostic referrals.

Waiting List Data

Five of the eight service users reported deteriorations in score on both the distress and wellbeing subscales, one service user reported a decrease in both scores, one participant reported an increase in both scores, and one service user reported improvements of both distress and wellbeing. The mean average, median average, and standard deviations for each timepoint are displayed in table III. The mean average results suggest that PTOS-ID II distress scores deteriorated by 5.75 points whereas PTOS-ID II wellbeing scores improved by 0.63 points.

Table III

PTOS-ID Descriptive Statistics

	Initial Pre-Therapy PTOS-ID			Follow-Up Pre-Therapy PTOS-ID		
	Mean	Median	Standard Deviation	Mean	Median	Standard Deviation
PTOS-ID Distress Score	20.25	17.50	6.16	26	24.50	6.56
PTOS-ID Wellbeing Score	19.50	20	8.05	20.13	20	7.94

Effect Size Calculations

Following the mean average wait time of 250 days service users (n = 8) reported greater distress scores in the Follow-Up Pre-Therapy PTOS-ID II assessment (M = 26, SD = 6.56) compared to the Initial Pre-Therapy PTOS-ID II (M = 20.25, SD 6.16), d = .83, 95% CI [1.72, -.06]. Service users also reported greater wellbeing scores at follow up (M = 20.13, SD 7.94) compared to initial scores (M = 19.50, SD 8.05), d = .07, 95% CI [.56, -.38].

The effect size for the change in PTOS-ID II distress scores surpasses Cohen's (1988) standard principle for a large effect size (d = .80) whereas the wellbeing score indicates insignificant change.

Discussion

This service evaluation explored the impact of Covid-19 on access to services for adults with ID. The impact on monthly referral rates was examined alongside the impact of prolonged therapeutic wait times. Key findings identified that referral rates considerably diminished following March 2020 and have not yet recovered. Further, client's psychological distress scores increased for those awaiting therapy throughout the pandemic.

Referral Rates

The non-overlap analysis results PND, PEM, and PAND each report varying scores of varying strengths. It is important to evaluate which calculation provides the most accurate reflection of the impact of Covid-19 for the dataset collated. For example, Lenz (2013) suggests PEM calculations provide greater utility when datapoints are collected over inconsistent time points and/or when outliers are present within the baseline dataset. This is not the case for the data collated in this project and therefore the PEM results should be interpreted with caution. Additionally, Lenz (2013) highlights that PND calculations can be unduly influenced by outliers which increases the chance of type 2 errors. This effect can be seen in the triage referrals PND result of 50%. If the outlying score of 4.7 was removed from the Pre-March 2020 stage the PND effect size would jump to an effect size of 83.3%. However, PAND scores can prove particularly robust when over 20 data points have been collected across consistent time points (Lenz, 2013). Therefore, Parker *et al.* (2009) would suggest utilising PAND as the most accurate calculation of the impact of Covid-19 on referral rates for this service evaluation.

The PAND calculation suggests that events taking place in March 2020 and beyond have had a moderate negative effect on total, therapy, and diagnostic referral rates for the service. These findings support prior research into the facilitators and barriers to support services for individuals with ID (Whittle *et al.,* 2018). Troller (2014) identified that key component of accessible mental health support for adults with ID is effective interagency collaboration between services. A reduction in the efficiency of this due to working from home transitions and staff absences relating to isolation or sickness is likely to have contributed to this reduction in referrals.

Additionally, the increased risk of death or serious health complication from Covid-19 for adults with ID (Office for National Statistics, 2020) could be interfering with help-seeking behaviours. Carers and individuals with ID may be delaying help-seeking through fear of having to attend regular outpatient appointments and increasing their risk of infection. This may have been exacerbated due to physical and logistic issues which can also form additional barriers to service access for adults with ID (Arcury *et al.,* 2005). In the early stages of the pandemic, world passenger demand on public transport reduced by between 80%-95% (Vickerman, 2021). The perception of increased risk of transmission on public transport may have prompted carers and adults with ID who require such transport to further conceal their need for support. Thus, contributing to reductions in referrals.

The trendlines provide additional insight into the impact and potential recovery of referral rates. The Post-March 2020 therapy referral rate trendline is on a downward trajectory which suggests referrals within this pathway are not yet showing signs of recovery. This could be due to the second and third lockdowns in the UK across November 2020 and January-March 2021. Conversely, the Post-March 2020 diagnostic referral rate trendline demonstrates a steep upward trajectory. This suggests that referrals to the diagnostic pathway may soon recover and are likely to exceed the Pre-March 2020 mean average. The sum of diagnostic referrals demonstrates that Post-March 2020 reported 60 fewer diagnostic referrals compared to the 5-year rolling average during this period. Therefore, if referral rates are to recover following the Covid-19 pandemic, it could be possible for diagnostic referrals to exceed the average expect referrals (105) by more than 60 in the coming year.

The clinical implications of the period of reduced referral rates are also significant. Foremost, if total referral rates continue to increase it will be imperative for services to allocate the appropriate resources to facilitate the adjustment in working intensity for staff members. A focus on workplace wellbeing should be taken as perceptions of unsurmountable increases in workload can lead to staff member burnout (Finkelstein *et al.,* 2018). Moreover, as referral rates recover it is likely that waiting times will be maintained or lengthened. This could increase the risk of experiences known as ‘moral injury’ for staff members (Williams *et al.,* 2020). Moral injury occurs when an individual’s behaviours contradict their moral code (Hossain and Clatty, 2021; Williams *et al.,* 2020). A desire to provide swift access to therapy for service users on the waiting list may contradict with what is practical and possible in coming months and years. Services should emphasise a culture of self-stewardship (Hossain and Clatty, 2021), in which staff members are encouraged to regularly monitor their levels of stress and are encouraged to seek support where necessary.

Awaiting Therapy During Covid-19

Prior to the lockdown in March 2020, the maximum wait time for access to the psychology service was 126 days. For the service users included within this study, this increased to an average wait of 250 days (maximum 392). The absence of a comparator limits the conclusions that can be drawn from the PTOS-ID II data. However, increases in distress due to the pandemic have been corroborated by current literature examining changes in psychological distress levels in general population samples in Japan (Kikuchi *et al.,* 2020), Israel (Lahav, 2020), and the UK (Shevlin *et al.,* 2020). The impact of Covid-19 on adults with ID is likely to be exacerbated for several reasons. Primarily, having an ID places an individual at an excess risk of death or serious health complication (Office for National Statistics, 2020). Consequentially, adults with ID are living in environments of fluctuating levels of risk and fear (Constantino *et al.,* 2020). Those awaiting therapy for anxiety related distress are being asked to tolerate increasing amount of uncertainty (Constantino *et al.,* 2020) and those awaiting therapy for depression related distress are being asked to stay at home tolerating reduced agency, changes in routines, and increased loneliness (Emregts *et al.,* 2020a). Within this context, it is therefore understandable that PTOS-ID II distress scores would regress following a mean average therapy wait time of 250 days during the pandemic.

Additional mitigation efforts such as physical distancing and mask wearing are also likely to be contributing to increased distress in adults with ID (Constantino *et al.,* 2020; Emregts *et al.,* 2020a). For many adults within the ID population, non-verbal communication such as lip reading, facial expressions, and physical proximity are necessary to maintain rich, full, and meaningful interactions with others (Constantino *et al.,* 2020; Martin *et al.,* 2012). It is therefore likely that these mitigation efforts have contributed to an increased difficulty in understanding, connection, and affect regulation. Thus, contributing to worsening PTOS-ID II distress scores.

A final consideration on the impact of the Covid-19 pandemic for adults with ID is caregiver stress (Emregts *et al.,* 2020b; Willner *et al.* 2020). The pandemic has undoubtedly caused an increase in caregiving strain (Emregts *et al.,* 2020b), with caregivers reporting increased experiences of anxiety and depression alongside reductions in social support (Willner *et al.,* 2020). In response to this, preliminary research has highlighted that adults with ID have been providing support to others (Navas *et al.,* 2020). The practice of providing support to others may be bestowing unfamiliar emotional demands onto adults with ID. This could be a further justification for the worsening PTOS-ID II distress scores reported.

The clinical implications of the impact of prolonged waiting times are considerable. Foremost, services should seek to alleviate this issue and engage in waitlist management. Services could trial the impact of regular telephone check-ins for those awaiting therapy and explore the provision of self-help resources (Scottish Commission for People with learning Disabilities, 2020). Regarding therapeutic work, if service users continue to access therapy with more complex needs, services will need to be prepared to adjust therapeutic provision accordingly. Meta-analyses have shown longer term psychodynamic therapeutic packages to be efficacious for complex presentations (Leichsenring and Rabung, 2008; Leichsenring and Rabung, 2011). Therefore, on a case-by-case basis services should consider whether a greater number of sessions is required to accommodate for this level of increased distress. Additionally, Covid-19-syncratic issues for adults with ID should be held in mind throughout the therapy. Disability is often a mutative theme in therapy for people who have ID (Hollins and Sinason, 2000), it is therefore possible that the relationship adults with ID have with the Covid-19 pandemic could remain mutative in therapy. Therapists should be prepared to hold issues of risk to life, loneliness, dysregulation, and role transitions in their working hypothesis and formulations for each service user. Moreover, the long-term impact of Covid-19 remains unclear, therefore the issue of maintaining therapeutic gains within a pandemic and post-pandemic world should be considered. Finally, services should consider the impact of increased distress and more complex therapy sessions on staff wellbeing and the risk of burnout. Evidence suggests that professionals working with individuals with ID are more likely to burnout if there is increased role ambiguity, a perception of excessive workload, and an excess in job involvement (Finkelstein *et al.,* 2018). These organisational variables should be considered and appropriately navigated by services.

Conclusions

Practice-based evidence resulting from service evaluations can provide rich and detailed insights into how certain phenomena are being experienced in day-to-day settings. This evidence can prompt the development and inform the design of research in more experimental and controlled environments. Although practice-based research demonstrates common limitations such as reduced sample sizes and low environmental control, it is hoped that the findings presented will remain useful to other services navigating the impact of the Covid-19 pandemic. To increase utility, the clinical implications have been synthesised from the available evidence base, bridging the gap between practice-based evidence and evidence-based practice.

Research is now necessary to produce predictive modelling that can forecast referral rates over the next few years to allow services to appropriately prepare for changes in workload. The impact of a range of waitlist management approaches should also be empirically evaluated so efficacious systems can be implemented by services. Facilitators and barriers to maintaining therapeutic change within the context and aftermath of Covid-19 also needs to be researched to ensure therapeutic approaches maximise the outcomes of therapeutic provision. Finally, it would be valuable to explore the experiences of psychological practitioners in relation to stress, burnout, and potential moral injury.

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Conflict of Interests

No conflict of interest to report.

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