What are the experiences of clinical psychologists working with people with intellectual disabilities during the COVID-19 pandemic?

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Abstract

People with intellectual disabilities are a particularly vulnerable group, at an increased risk of mortality from COVID-19 and of poor mental health. Psychologists providing mental health support to people with intellectual disabilities report poorer mental wellbeing and higher occupational stress. Moreover, they raise concerns about the ability of people with intellectual disabilities to engage with digital technologies for mental health support in the context of reduced face-to-face psychological provision. Semi-structured interviews were conducted with 11 psychologists from community intellectual disabilities services. Data was analysed using Interpretative Phenomenological Analysis. Two superordinate themes emerged. **Survive or Thrive** highlighted the challenges and successes clinical psychologists experienced while working during the pandemic. **"Left to their own Devices"** described psychologists' experiences of their clients as forgotten within society. The current study demonstrates psychologists' ability to adapt to extremely challenging circumstances, exposes the vulnerabilities of people with intellectual disabilities and highlights the gaps in service provision.

Introduction

The current COVID-19 pandemic is a global crisis. People with intellectual disabilities experience higher rates of morbidity, mortality, asthma, diabetes and obesity compared to the general population, making them more vulnerable to COVID-19 (NHSE, 2020).

The cumulative impacts of stress associated with the fear of contracting COVID-19, social distancing and quarantine measures can negatively impact mental health of some people (Pfefferbaum & North, 2020). Given that people with intellectual disabilities experience higher rates of mental ill-health (Cooper et al., 2015; Cooper et al., 2007; Emerson & Hatton, 2007), quarantine measures may trigger an escalation of problem behaviours due to a disruption of familiar routines and restriction on the physical environment (Courtenay & Perera, 2020). Furthermore, COVID-19 lockdown measures have led to service provision for people with intellectual disabilities being cut back due to staff sickness and closures of day-care and respite services, further compromising mental health of people with intellectual disabilities (Evans, 2020). The greater mental health needs of people with intellectual disabilities, however, misalign with Public Health England (2020) COVID-19 guidance for significantly reduced face-to-face clinical contact, meaning that effective delivery of behavioural and psychological interventions was reduced, delayed or not implemented. Alexander et al. (2020) published detailed guidance for the treatment and management of COVID-19 among this population. The authors identified a vital role for Clinical Psychologists (CPs) in delivering specialist psychological intervention in community settings and to mitigate any impact of the pandemic on mental health and challenging behaviour.

Langdon et al. (2021) explored the changes to job role of psychologists working in intellectual disabilities services and the impact of such changes on mental wellbeing and occupational stress as a result of the COVID-19 pandemic[a]. Almost a quarter of their sample were redeployed away from working with people with intellectual disabilities. Moreover, qualitative findings highlighted psychologists' concerns that people with intellectual disabilities may encounter more barriers to service provision, such as making use of technology to access services in the context of reduction or withdrawal of support including education and social care. Psychologists in the study stated that COVID-19 related policies and changes to usual practice did not adequately consider the individual needs of their clients (Langdon et al., 2021).

People with intellectual disabilities often rely on family and paid carers for support. The average family caring for a child or adult with intellectual disabilities is likely to live in poverty and the socio-economic position of adults with intellectual disabilities also points to high levels of poverty (Emmerson, 2007). Moreover, experiencing stressful events makes falling into poverty more likely and less likely to escape from (Emerson et al., 2010). Burgess' (2020) research investigating the use of technology during the COVID-19 lockdown highlighted a clear link between poverty and digital exclusion that is understood as the lack of access to and use of information and communication technology (ICT) resources. Household ownership of landline phones, computers, smartphones and personal internet use is less likely for people with an intellectual disabilities than non-disabled people. Moreover, nearly two in ten (18%) said their use of TVs or computers was limited due to

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[a] Hereinafter referred to as pandemic.

their condition (Ofcom, 2019). This highlights the difficulties people with intellectual disabilities may have in accessing psychological provision using digital technologies.

An overview of empirical literature has highlighted people with intellectual disabilities as a particularly vulnerable group, at an increased risk of mortality from COVID-19 and at increased risk of poor mental health due to COVID-19 associated restrictions. Furthermore, psychological provision for people with intellectual disabilities in community settings has decreased due to redeployment of staff into other areas. Additionally, psychologists who provide mental health support to people with intellectual disabilities in community settings also report suffering poorer mental wellbeing and higher occupational stress. Moreover, they raise concerns about people with intellectual disabilities engaging with digital technologies to access mental health support. Understanding psychologists' experiences of working with people with intellectual disabilities during the pandemic will help to identify more effective ways of tailoring service provision to the needs of people with Intellectual disabilities, and consider how to support clinicians in the delivery of care. Therefore, the current study attempted to answer the following research question: "What are the lived experiences of clinical psychologists working with people with intellectual disabilities during the COVID-19 pandemic?"

Methods

Ethical approval was obtained from Coventry University Ethics Committee (project code P117341). The epistemological position of this research was interpretivist. In accordance

with the epistemological position, this study employed Interpretative Phenomenological Analysis (IPA) to interpret and make sense of participants' responses. A sample of CPs working in community services for people with intellectual disabilities, in England, was recruited using purposive sampling method. This sampling method is particularly helpful in identifying and selecting individuals or groups of people who are particularly knowledgeable about a particular subject or have experience in the phenomenon of interest (Cresswell & Plano-Clark, 2011).

The inclusion and exclusion criteria of participants are presented in Table 1.

INSERT TABLE 1 HERE

The sample was recruited via clinical psychologists' professional networks by disseminating a research poster and the participant information sheet advising participants to express interest in the study by contacting the researcher via email.

Participants were assigned pseudonyms to preserve their anonymity. Of the 11 participants, majority were female (n = 10; 91%), with an age range of 32-54 years (M = 41). All except one identified as belonging to white ethnic group (n = 10; 91%), with one participant belonging to mixed/multiple ethnic groups: White and Asian. The sample consisted of psychologists of all grades from CP to Consultant. Time spent in intellectual disabilities service they were employed at, at the time of interview ranged from 14 month to 27 years (M = 10 years).

Data was collected using semi-structured interviews between the 1st and 12th of March 2021, during the third Coronavirus lockdown in England. The interviews lasted between 43 and 62 minutes, with an average of 52 minutes. Due to COVID-19 Public Health restrictions,

interviews were conducted remotely, via MS Teams. Audio data was transcribed verbatim and analysed using IPA (Table 2).

INSERT TABLE 2 HERE

Coding, interpretation and analyses conducted by the researcher were reviewed by the supervisory team to triangulate perspectives and ensure validity. The researcher, a trainee CP, aimed to remain mindful of biases and preconceptions that may have influenced study design, development and data collection to capture a true representation of the participant experience. The bracketing interview was conducted to identify any prior biases or preconceptions about the research topic. The identified position of the researcher and its impact on the research process was mitigated via the use of reflective journal, discussion with the supervisory team and inclusion of prompt questions in the interview guide to elicit impact of feelings from participants.

Results

Analysis elicited two superordinate themes and five subordinate themes (Table 3). See supplementary materials for additional quotes reflecting the themes.

INSERT TABLE 3 HERE

Survive or Thrive

The superordinate theme **Survive or Thrive** highlighted the challenges and successes CPs experienced while working during the pandemic. CPs within intellectual disability services endured an emotional onslaught throughout the pandemic, impacting their practice. The surreptitious blurring of boundaries between work and home hindered their ability to

navigate challenges, insidiously encroaching on psychologists' personal lives. However, despite this some psychologists flourished working in new ways. Working through the pandemic brought about unanticipated benefits. This superordinate theme includes three subordinate themes of *"I feel like a speck in the base of a tsunami"*, *"My head space is filled up"* and *"When the rule book gets thrown out the window",* described below.

"I feel like a speck in the base of a tsunami"

The stresses and uncertainties of working during the pandemic took a significant emotional toll on psychologists' wellbeing:

> *"I've sort of said that kind of anxiety, I noticed, sort of, before going into work each week, the day before feeling that, that sense of real anxiety and almost like panic within me of not, not really knowing what we're doing and when is this going to end"* (Pat, 190-193).

Psychologists' commitment to provide adequate psychological services to their clients via telephone or digital videoconferencing platforms left them feeling like their *"formulations are missing a big piece of the puzzle"* (Ashley, 341) often experiencing feelings of guilt and inadequacy:

> *"That kind of makes me think you know, I'm not doing my job right because like, you know, I don't think I'm actually able to sort of provide the service I want to provide to people"* (Max, 251-252).

CPs experienced feelings of disconnection from colleagues and clients which arose due to barriers remote working presented. Alex *"found remote working to feel quite isolating"*

(Alex, 66). Moreover, social distancing restrictions and use of PPE provided additional barriers to connection:

> "*The experience of going into any of the bases but all being very separate and in separate rooms and the screens between you and the service users*" (Jamie, 160-161).

Witnessing the impact of the pandemic on their clients, "*risk increasing and a lot of people hitting crisis*" (Ashley, 111), coupled with the protracted impact of pandemic, led to feelings of burnout "*like you're walking through treacle*" (Chris, 92-93) which "*wasn't at all sustainable*" (Max, 295-296). This resulted in some psychologists having to "*take some emergency annual leave*" (Jamie, 289). Surviving the emotional onslaught of the pandemic was evident in the language psychologists used when recalling their experiences: "*we have made our way around that*" (Jules, 258), "*we've ridden the storm*" (Andy, 365-366), and "*muddle through it*" (Billie, 103).

Psychologists discussed overcoming these obstacles by actively establishing means to connect with one another: "*there's all these kind of things that we've put in place to sort of be able to support each other*" (Max 219-220).

"My headspace is filled up"

Enduring the pandemic was hindered by psychologists reporting a merging between their work and personal identities due to blurring of boundaries between work and home life which remote working perpetuated. Shifting boundaries and the demands of juggling home and work life often left psychologists feeling exposed and unsafe, inevitably encroaching on their personal lives.

Remote working left CPs in a perilous state, feeling exposed an unsafe as they struggled to "*separate work from home*" (Ashley, 226). The lack of a physical boundary between work and home left no space to decompress after work:

> "*When you're kind of working on your kitchen table, and all you're doing at the end of the day is closing your laptop and taking a few steps to the sofa. It's, it's a bit, um, it feels a bit trickier to have that kind of work/ home separation*" (Alex, 150-152).

Furthermore, the increased demands of juggling looking after children, home schooling and remote working further impaired capacity to maintain professional boundaries:

> "*At first children were still in school. And so you could kind of maintain a little bit of work life balance. But then when I've got three young boys and dogs, and [pets] and all that stuff in the background, actually maintaining that professionalism and keeping that kind of barrier, that boundary between home and work life balance became a little bit more challenging*" (Jules, 130-133).

Work was insidiously invading psychologists' personal lives:

> "*Because you're not leaving the office anymore in closing the door. That's difficult because it infiltrates into your house*" (Chris, 336).

Work intrusions such as carrying out therapeutic work in the home with children present was felt to be "*a real invasion of my privacy*" (Sam, 150). Moreover, psychologists encountered feeling vulnerable as the grip on professional boundaries appeared to slip "*I have shared with one, one particular carer, perhaps more than I feel happy with having shared*" (Max, 432).

"When the rule book gets thrown out the window"

The experience of surviving the pandemic was contradicted by some psychologists, for whom the pandemic "*opened doors*" (Jules, 187) allowing them to thrive in new ways of working:

> "*It's just expanded our repertoire really in a way that we can engage with people differently which, across Intellectual Disabilities, we get to be creative anyway, but it's just an area that we haven't really played around with. It's forced us to step out of our comfort zones and get used to this technology and see who it might work for"* (Ashley, 374-377).

Some clinicians flourished during the pandemic because working from home better suited their lifestyle:

> "*I've been given a flexibility that I never would have been afforded before this pandemic hit*" (Andy 277-278).

The change to usual practice brought about "*silver linings*" (Andy, 301) which helped psychologists to navigate the challenges they encountered and, in some cases, conferred significant benefits. Clients with Intellectual disabilities were empowered by remote technology "*it's given them a real sense of accomplishment and an independence*" (Sam, 290-291). Another unanticipated benefit of remote technology was how "*clients (with ASD) engaged above and beyond any level they've previously engaged with [using remote technology]*" (Jules, 53-54). When commenting on this many psychologists said they were "*surprised*" (Jamie, 312), indicating that they underestimated their clients' abilities of working in new ways.

"Left to their own Devices"

This superordinate theme described psychologists' experiences of people with intellectual Disabilities as insignificant and forgotten within society and the systems around them during the pandemic. Psychologists felt abandoned in their battle with services in advocating for their clients, feeling powerless to help. This superordinate theme contained two subordinate themes, "*God only knows what's going on behind the closed doors*" and "*Lots of red tape to get around*", described below.

"*God only knows what's going on behind the closed doors*"

Psychologists discussed their experiences of people with intellectual disabilities "*left just to try and make sense of this with no support*" (Pat, 318-319) and their needs being completely disregarded:

> "*They 've [clients with intellectual disabilities] been very much overlooked in this pandemic, you know, once again, in societies they have been subjugated, and so many of the guys we're supporting, just don't, just don't have those other support networks out there*" (Pat, 86-88).

Feelings of abandonment and loss were particularly poignant when clients' lives were lost due to COVID-19:

> "*And there's times when, when we are going into seeing people who are at the end of life, or we've got people we've known for many years, who were in hospital, and we*

know they're going to die. And previously, we, team members, would have gone, seen

them and we haven't been able to, or we've known of clients of ours, who've died

alone" (Charlie, 336-336).

Vehemently advocating for their clients, psychologists highlighted their vulnerabilities and emphasised that they "*are more in need than ever*" (Pat, 152) during the pandemic. Some commented on inadequacies of government communication of COVID-19 guidance, in meeting the needs of people with intellectual disabilities "*many of our guys, they don't, sort of follow what's going on in, in the media*" (Pat, 287-288) leaving them cut off and unable to look after themselves:

> "*They're not following government guidelines. They've had one mask the whole pandemic, and they've never changed it or washed it. They don't get it*" (Chris, 350-351).

CPs appeared resentful of the indifference their client group were subjected to. Government COVID-19 management strategies were inconsiderate of the needs of their clients and presented a multitude of obstacles with one psychologist describing masks as "*definitely a hindrance and a barrier to relationship forming*" (Andy, 549-550). Another clinician reflected that "*service users have really struggled to understand this concept [social distancing], or have worried about it excessively*" (Jules, 345-346), again highlighting government guidance as insufficient to adequately meet the needs of people with intellectual disabilities. Another psychologist pointed out that COVID-19 management strategies could in themselves be traumatising to clients:

> *"And for one lady, particularly, PPE was such a trigger, she had a trauma around a hospital admission, not COVID related, but any kind of medical equipment, gloves, masks, aprons, was quite a trigger to her trauma"* (Ashley, 322-324).

Similar to government directives, CPs were disappointed with the local, service guidance for remote working which "*hasn't necessarily attended to kind of what it might be like in intellectual disability settings*" (Alex, 29-30). Moreover, NHS Trusts' response to stop face-to-face visits and the "*abandonment that elicits [in clients with complex trauma] has often sent people off into crisis positions*" (Pat, 444), highlighting not only the lack of consideration of clients' needs but the disastrous impacts of poor service decisions.

In addition to the inequity of government and service COVID-19 response, the pandemic exposed the social inequalities people with intellectual disabilities experienced, as reflected by Ashley:

> *"A lot of our folks don't have access to laptops and smart phones and if they do have access even through their own means or family or carers they're not very used to using them and it can be really hard with intellectual disabilities to learn new stuff"* (Ashley, 38-40).

Reliance on staff or family to facilitate remote assess added extra complexity, exposing "*issues around confidentiality and safety and security*" (Charlie, 75) that presented an additional challenge to therapeutic work. Whereas, telephone contact, due to lack of visual cues, presented additional "*issues around risk and monitoring risk*" (Jamie, 48).

"Lots of red tape to get around"

Psychologists felt they were left on their own, to navigate the challenges of the COVID-19 crisis in a system ill equipped to meet the needs of its clients, often having to fight the bureaucracy of the system. Feelings of abandonment were evident in psychologists' narratives: "*doesn't feel like they've [senior management] been particularly present in any of this*" (Pat, 163) with Chris vividly describing being forsaken:

> "*I remember being in the office at the start and it was just like, I was there on the first day. None of…. the... higher, our manager wasn't there. I think I was the only senior member in the in the office, and there were just loads of us there all going: 'what are we meant to do'? (laughs) So, because all of the, my Trust's, like directors, everyone were in a meeting all day trying to plan what to do, they've forgotten to tell the people on the ground: 'hey, go home, like or at least some of you go home'*" (Chris, 143-148).

Moreover, psychologists described how the lack of "*clear guidance*" (Charlie, 140) elicited feeling directionless, underscored by a sense of "*who is kind of steering this ship, really?*" (Billie 119), leaving clinicians to manage alone.

Advocating for their clients' access to digital technology to access support, one psychologist described as "*having to almost fight with social care to get them to give some funding*" (Chris, 49). Having to "*have to justify why we want to see people face to face*" (Billie, 95-96) and battling with care providers to meet clients' needs was recounted as "*coming up against brick walls*" (Chris, 58).

The needs of people with intellectual disabilities amplified significantly during the pandemic: "*our referral rates to psychology have rocketed, and the level of complexity, the level of need is just dreadful*" (Charlie, 252-253). Furthermore, CPs feared for their clients' safety due to

their increased vulnerability to COVID-19 and clients "*dying disproportionately, compared to the general population*" (Ashley, 63-64).

To help those in distress clinicians resorted to subverting referral criteria and accepting clients whom they knew were not eligible to access intellectual services because of the level of need and no other support available:

> "*So, I know that over the summer, between myself and my colleagues, we've probably each had at least one to two clients who we knew didn't have a intellectual disabilities. But because we couldn't establish that very clearly at the beginning, we've ended up picking those pieces of work up. Um… because there's a distressed person at heart of it. And, they've been quite complex and quite involved. And, we're now in the position of probably having a caseload that is much bigger than we should have because of it*" (Jules, 379-384).

Navigating the bureaucracies of the system, some psychologists appeared utterly powerlessness to help clients, as implied by feeling unable to "*do anything about that*" (Billie, 372) and experiencing being called upon to intervene and feeling somehow responsible at not being able to help, powerfully described by Chris:

> "*What it is, is at the crux of all of this, I think is… that you don't have a magic wand, you can't take COVID away, you can't allow your service users to go back to day services and their activities, but people are still looking at you to come to come fix this problem*" (Chris, 282-284).

Feeling powerless was amplified by processes within the system such as possible redeployment: "*a looming threat of you might be pulled out of this job any minute*" (Ashley, 217) and Pat describing feeling unsupported by the service and senior management:

> "*And I think, particularly when you feel like you've not got the, maybe the backing of management, when there's these other pressures coming down on you, I think that's been really, really hard and really frustrating, really, and not always feeling that understood or valued by the service, I think, particularly at management level when there's more pressures being put on at a time when we're already struggling so much. I think that's quite hard*" (Pat, 425-429).

Discussion

The current study aimed to explore CPs' experiences of working with people with intellectual disabilities during COVID-19 pandemic. Two superordinate themes emerged: **Survive or Thrive** and **"Left to Their Own Devices"**.

The prolonged exposure to stress and uncertainty of working during the pandemic had a deleterious effect on CPs mental wellbeing, leading to burnout. This in consistent with findings of Langdon et al.'s (2021), and McMahon et al.'s (2020) surveys of psychologist and healthcare workers, respectively, working in intellectual disabilities settings and numerous other studies reporting burnout in healthcare providers (Sharifi et al., 2021). It is unsurprising given the multitude of challenges CPs experienced in their role, as a direct impact of COVID-19 related changes to usual practice.

CPs reported reduced visual cues and incomplete assessment and formulation when conducting psychological interventions remotely. These concerns were noted by Langdon et al. (2021) and are consistent with findings of a survey of 335 psychotherapists who also reported reduced visual cues affected their confidence in remote work (McBeath et al., 2020). Similarly, CPs in the current study reported finding remote interventions inferior to delivering therapy in person, leading to feelings of inadequacy and guilt. These feelings may be conceptualised as arising from lack of familiarity with remote delivery of psychological interventions and may be reflective of the broader issues of NHS digitisation, such as, the National Programme for IT, with persistent use of outdated systems and chronic underinvestment (Controller and Auditor General, 2020). This suggests that NHS may have lacked the infrastructure to respond swiftly to the demand for remote technology.

Despite the challenges of delivering remote interventions CPs unequivocally found that this mode of therapy was preferable to some client groups, such as people with autism. Similarly, a recent survey of frontline staff working with people with intellectual disabilities and/or autism found staff widely endorsing remote delivery of services (Sheehan, et al., 2021). Moreover, CPs experienced remote consultation as fostering a sense of empowerment for their clients as they succeeded in mastering remote technologies. This offered clients, who may not have been offered interventions remotely, a choice and ensures parity of mental health interventions for all. Interestingly, many CPs were surprised by their clients' ability to adapt to new ways of working. This may highlight a broader issue where abilities and resilience of people with intellectual disabilities is often underestimated.

Current findings suggest that the abrupt shift to remote working presented unforeseen challenges to maintaining a work/life balance. The absence of a physical boundary between work and home negatively impacted CPs, leaving them feeling unsafe, exposed, and intruded upon. Similar concerns were noted by Butler et al. (2021) and Langdon et al. (2021). This is of concern, as work/life balance represents an overall appraisal of personal satisfaction with work and home roles (Greenhaus & Allen, 2011). As remote and blended approaches become the norm in healthcare the British Psychological Society (BPS) has produced guidance for sustainable working from home, emphasising the need to set boundaries and how this can be achieved (BPS, 2020).

Findings of the current study exposed the loneliness and disconnection CPs felt because of remote working. Clinicians instinctively coped by seeking out connection with their colleagues, setting up peer support groups and informal supports. The BPS recognises that working from home can be isolating and that loneliness can lead to stress, anxiety and depression and recommends seeking out and maintaining social connection at work (BPS, 2020).

The pandemic has significantly disrupted CPs' work environments and practices. While some clinicians felt galvanised by this disruption, making connections and developing new ways of working, others felt demotivated and alienated from their colleagues. The British Psychological Society (BPS, 2020) conducted a survey of over 200 academic, practitioner psychologists, and trainee psychologists working across various disciplines, and from diverse backgrounds. The "Survive or Thrive" theme supports the findings of the BPS (2020) survey.   Similar dichotomies in responses of healthcare staff have been reported by Butler et al. (2021). The current study, however,

offers no indication on what internal or external factors contributed to CPs' ability to flourish

or struggle during the pandemic. Literature suggests that in responding to complex and

unpredictable disruptions to clinical practice a team-based approach can be beneficial.

However, established team working processes were significantly impaired by staffing

shortages due to redeployment, clinicians shielding and move to remote working.

Moreover, CPs experienced confusing communication and lack of direction from senior

management, and felt abandoned, unvalued and unsupported. Extreme stress has been

shown to negatively impact leadership style (Sandler, 2012) which can impair the quality of

support provided by leaders. Moreover, supportive managers foster better mental health in

their teams (Brooks et al., 2018), and their absence might have been a contributing factor to

burn out reported by CPs.

This study highlighted the vulnerable position of people with intellectual disabilities, during

this pandemic. CPs highlighted that governmental policy and subsequent changes to mental

health service provision, did not take into account the needs of people with intellectual

disabilities thus emphasised their digital poverty and exclusion. These issues have been well

documented in recent literature (Alexander et al., 2020; Burgess, 2020; Courtenay, 2020;

Embregts et al., 2020) and suggest that people with intellectual disabilities may require

additional adaptations to support their access to remote mental health provision.

Additionally, CPs in the current study often felt powerless whilst struggling to navigate the

bureaucracy of systems not fit to meet the needs of people with intellectual disabilities.

Willner at al. (2020) and Patel et al. (2021) highlighted carers of people with intellectual

disabilities expressed similar feelings of powerlessness , during the pandemic. This suggests

the need for robust policy and service processes to ensure adequate mental health support for clinicians, carers and people with intellectual disabilities.

Strengths and Limitations

The current study adds to the literature in two areas. Firstly, it highlights CPs' ability to adapt to extremely challenging circumstances. Secondly, it exposes the vulnerabilities of people with intellectual disabilities, and the gaps in service provision to meet their needs adequately. However, this study is not without limitations. The sample consisted of majority White British, female participants. These demographics are representative of the field, however, may not adequately capture experiences of CPs who are male and those of other ethnic groups. Further, the small sample size, appropriate for IPA methodology, limits generalisability of findings to the broader experiences of CPs.

Implications: Policy and Practice

Given that going forward the NHS is likely to adopt a blended style of healthcare delivery, offering both in person and remote intervention options, there is a great need for policy to address the digital exclusion of people with intellectual disabilities. To ensure equity of access to technology policy should improve the digital literacy of clients and their carers. Provision of financial support to access appropriate equipment for this population is also a necessity.

Additionally, intellectual disabilities services may benefit from investing in leadership training to enhance support processes for managers.

CPs may benefit from continued support and supervision in use of digital technology to conduct remote interventions safely. Similarly, CPs may need robust protocols in place for assessing and monitoring risk during telephone consultations.

There is a clear need for improved access to mental health support for clinicians. This need has been acknowledged by NHS England, who in collaboration with NHS Improvement have pledged to invest an extra £15 million to strengthen mental health support for nurses, paramedics, therapists, pharmacists, and support staff. The implementation of staff mental health support hubs by NHS Trusts has commenced.

Suggestions for Future Research

This research provides a perspective on how people with intellectual disabilities engaged with remote delivery of services through the CPs' lens. However, research into experiences of people with intellectual disabilities and their carers is needed to truly understand their views of accessing mental health care remotely.

Given the variability of CPs' response to the challenges presented by COVID-19, it may be pertinent to examine factors affecting individuals' stress and resilience to develop more effective strategies to support clinicians in crisis situations.

Conclusion

The pandemic has significantly disrupted CPs capacity to provide mental health care to people with intellectual disabilities, whose needs have been forgotten during the pandemic.

Going forward, this presents an opportunity to adapt mental health service provision for the

digital age, to support CPs to meet the needs of this client group adequately.

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Table 1.

Inclusion and Exclusion criteria

Criteria	Inclusion	Exclusion
Job role	Clinical Psychologist	Any other job role
	HCPC registered	Trainee psychologists
Setting	NHS service	Private providers
	England	Any other country of the UK
	Community	Primary or tertiary care, inpatient settings
Patient group	ID and/or autism	Any other patient group
	Adults	Children

Table 2.

Stages of IPA Analysis and Description of Process (after Smith, 2007).

Stage of analysis	Procedure	Description
1	Reading and re-reading	The first stage involved the researcher immersing themselves in the data by reading and re-reading the transcript. The researcher noted what thoughts and perceptions the interviewee invoked in them.
2	Initial noting	Exploratory phase, where the researcher examined language, connections and contradictions in the transcript and noted down interviewee's descriptions and implicit meanings.
3	Developing emergent themes	The researcher looked for emerging theme titles within each transcript, resulting from analysis, reviewing and collating responses that supported these themes.
4	Searching for connections across emergent themes	The emerging themes were merged into clusters producing a table of themes where clusters were given names and formed several subordinate and superordinate themes.
5	Moving to the next case	The researcher underwent the same process for each transcript however, some transcripts offered richer content and therefore more interpretation or themes. In moving from one transcript to another the researcher attempted to bracket ideas from previous transcript in an effort to be idiographic.
6	Looking for patterns across cases	The final stage of the process was to organise themes and identify patterns across all transcripts by identifying what themes were more prominent and consistent across participants which led to the development of superordinate themes.

Table 3.

Superordinate and Subordinate Themes

Superordinate Themes	Subordinate Themes
Survive or Thrive	"I feel like a speck in the base of a tsunami"
	"My headspace is filled up"
	"When the rule book gets thrown out the window"
"Left to their own devices"	"God only knows what's going on behind the doors"
	"Lots of red tape to get around"