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Clinical management of individuals with Intellectual Disability: The outbreak of Covid-19 pandemic as experienced in a clinical and research center Research in Developmental Disabilities

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ABSTRACT

During the COVID-19 pandemic, the Oasi Research Institute of Troina (Italy) became an important hotbed for infection; in fact, 109 patients with different levels of Intellectual Disability (ID) tested positive for COVID-19. The procedures and interventions put in place in the Oasi Research Institute due to the COVID-19 pandemic are exhaustively reported in this paper. The description of the clinical procedures as well as remote/in person psychological support services provided to people with ID and their families are here divided into three different sections: Phase I (or Acute phase), Phase II (or Activity planning), and Phase III (or Activity consolidation). In each section, the main psycho-pathological characteristics of patients, the reactions of family members and the multidisciplinary interventions put in place are also described.

1. Introduction

The COVID-19 pandemic has brought awareness on the higher vulnerability of people with Intellectual Disability (ID), who present health problems and psycho-pathological comorbidities in a remarkably higher percentage than that of the general population (Courtenay, 2020; Courtenay & Perera, 2020; Perera, Audi, Solomou, Courtenay, & Ramsay, 2020). These patients also have shorter life expectancies, with an estimated mortality ratio of 3.18 (Glover, Williams, Heslop, Oyinlola, & Grey, 2017). Respiratory infections are among the leading causes of death in people with ID, especially in patients with Down syndrome (O’Leary, Cooper, & Hughes-McCormack, 2018). The high incidence of physical and mental disorders, together with the impaired judgment and understanding skills, represent favorable conditions for this population to experience more severe symptoms (Biswa, Vahabzadeh, Hobbs, & Healy, 2010; Perera et al., 2020).

The impaired cognitive functioning, which causes lower rational self-awareness and lower critical judgment skills on events, together with the emotional vulnerability and unavoidable physical contact with caregivers represent, indeed, an obstacle for adhering...
to proper epidemic containment measures, such as self-isolation, hand hygiene and social distancing. These “safety” measures can hardly be understood and implemented by people with severe ID, who show low levels of functioning and problem behaviors such as “spitting”, which would increase the risk of infection for their peers with ID or their family members.

Moreover, the COVID-19 outbreak has required making remarkable changes in daily routines, behaviors and procedures aimed at the containment of the infection. In addition to the stress associated with the fear of contracting the disease, social distancing and quarantine measures have shown to likely produce increased anxiety and worry levels, as well as higher obsessive thoughts concerning the compulsive search for COVID-19 information, especially in people with mild ID, or ID comorbid to Autism Spectrum Disorder (ASD). Comorbid obsessive disorders might be further aggravated by the need for scrupulous personal hygiene. Behavioral and psychological interventions, generally used to manage behavioral problems of self-regulation, can hardly be implemented, due to the significant reduction of in person support, thus significantly limiting the access to appropriate interventions, with a remarkable impact on caregivers as well. These conditions have generally also determined an increase in psycho-pharmacological interventions (Courtenay, 2020; Courtenay & Perera, 2020).

According to the UN convention on the rights of people with ID, the peculiar features of this population have to be taken into consideration in identifying key actions focused on routines and emotional aspects. In addition, the provision of rehabilitation, the support and counseling interventions from remote might be useful not only to meet the need for assistance/care, but also to deal with the psycho-physical well-being of the patients as well as the issues concerning their quality of life (Ravi, Barclay, Mukherji, Chester, & Alexander, 2020).

Several studies have documented the feasibility and potential validity of remote supportive interventions, which are provided through tele-medicine and tele-psychology practices (Lindgren et al., 2016; Simacek, Dimian, & McComas, 2017; Suess, Ruiz Pérez, Ruiz Azarola, & March Cerdà, 2014; Suess, Wacker, Schwartz, Lustig, & Detrick, 2016; Vismara, McCormick, Young, Nadhan, & Monlux, 2013; Wacker et al., 2013; Wainer & Ingersoll, 2015; Yellowlees, Hilty, Marks, Neufeld, & Bourgeois, 2008). A multidisciplinary remote support program for people with ID and their families had already been developed and implemented several years ago at the Oasi Research Institute, with a 84 % degree of satisfaction, especially with regard to the possibility of benefiting from specialist counseling, continuous support and reduction of travel costs, and to the effective increase in adaptive capabilities of their children (Buono & Città, 2007).

This paper reports the clinical intervention model implemented at the Oasi Research Institute following the pandemic outbreak. In the process of developing this intervention model, the WHO guidance on “COVID-19”, highlighting the importance of guaranteeing services to people with mental disorders (WHO, 2020), was taken into consideration, together with the clinical and psycho-social expertise achieved by the Oasi Research Institute staff over the years (Buono & Città, 2007; Panerai, Ferrante, & Zingale, 2002; Panerai et al., 2009; Polirstok, Dana, Buono, Mongelli, & Trubia, 2003; Zingale, Belfiore, Mongelli, Trubia, & Buono, 2008; Zingale et al., 2020).

2. Description of the service

The Oasi Research Institute is a 352-bed research and clinical hospital dealing with the prevention, diagnosis, treatment and rehabilitation of people with Neurodevelopmental and Neurocognitive Disorders. In 2019, a total number of 1923 patients was admitted to the hospital. Table 1 reports the detailed demographics of the patients, subdivided into subgroups of ID severity. Among them, the most frequent genetic syndromes were the following: Down syndrome (N = 151, 7.9 %), Prader Willi syndrome (N = 28, 1.5 %), Angelman syndrome (N = 28, 1.5 %), Fragile-X syndrome (N = 9, 0.5 %) and other syndromes (N = 18, 0.9 %). The most prevalent comorbidities were, instead: epilepsy (N = 601, 31.3 %), language disorder (N = 507, 26.4 %), ASD (N = 422, 21.9 %), child cerebral palsy (N = 199, 10.3 %), and Attention Deficit Hyperactivity Disorder (ADHD; N = 31, 1.6 %).

3. Clinical management of the COVID-19 outbreak

At the Oasi Research Institute, the comprehensive (bio-psycho-social) approach to the patient and his/her family has always been based on a multidisciplinary and interdisciplinary assessment aimed at developing a clinical management tailored to the patient’s needs. The COVID-19 infection outbreak occurred in mid-March 2020, with the identification of case 0; within the following 20 days, 109 patients tested positive for SARS-cov-2. Since the very beginning, patients who tested positive to the virus were isolated from those

Table 1
Detailed demographics of the patients admitted to the Oasi Research Institute in 2019, subdivided into subgroups of ID severity.

| ID severity | Total (f/m) | Age, years |   |   |   |
|-------------|------------|------------|---|---|---|
|             | mean | SD | range |
| Mild        | 22,27 | 16,9 | 3–85 |
| Moderate    | 25,55 | 14,02 | 5–90 |
| Severe      | 25,21 | 15,26 | 1–81 |
| Profound    | 30,84 | 15,91 | 1–93 |
| NOS         | 14,93 | 14,01 | 1–68 |
| Total       | 24,61 | 15,75 | 1–93 |

SD = standard deviation; NOS = not otherwise specified.
who tested negative. Among the latter, 12 underwent CT-scan because of respiratory symptoms and were found to present “ground glass” images ascribable to COVID-19 infection.

Out of 109 positive-testing patients, 92 were females and 17 males, with an age range of 8–65 years and different levels of ID severity, namely: mild (12.2 %); moderate (24.7 %); severe (29.3 %); profound (25.6 %); ID-Not Otherwise specified (NOS; 5.5 %) and Borderline Intellectual Functioning (BIF; 2.7 %).

The incidence of comorbidities was as follows: hypothyroidism (80 %); diabetes (1.8 %); hypertension (2.7 %); obesity (19 %); excess weight (27.2 %); autoimmune diseases (1.8 %); epilepsy (31.8 %) and other syndromes (50.9 %). Moreover, 54 out of 109 cases (49.3 %) expressed psycho-pathological comorbidities, such as: psychosis (13.7 %); ASD (14.6 %); personality disorders (6.4 %); mood disorders (9.1 %) and behavior disorders (5.5 %).

All patients were periodically monitored for full blood count, inflammation indexes (PCR, D-dimer, Beta-2-microglobuline), blood coagulation profile, serum biochemical tests (including liver and kidney function, CPK, lactic dehydrogenase and electrolytes) and CT-scan thorax examination, in order to plan a specific treatment.

The therapeutic interventions and support included supportive therapies with the monitoring of the vital parameters (body temperature, detection of \( \text{O}_2 \text{ saturation-}\text{SpO}_2 \)) at 6-h intervals. In the most severe cases, continuous monitoring and rehydration with hydro-electrolyte solutions for the physiological maintenance of acid-base balance was applied and oxygen therapy with Venturi masks was conducted in 35 patients with hypoxemia. Moreover, empirical and antithrombotic antimicrobial therapy was performed, according to national and international protocols, while no mechanical ventilation was required in any of our patients.

Patients presented with the following clinical signs: fever, gastro-intestinal manifestations (loss of appetite, nausea, vomiting, diarrhea), respiratory symptoms (cough, rhinitis, desaturation, dyspnea), asthenia. In addition, CT-scan “ground glass” images, indicating interstitial pneumonia with different severity levels, was reported for all 109 patients; moreover, 1 patient had pneumothorax, 31 patients developed acute respiratory distress syndrome and 12 were transferred to the Intensive care unit, 6 of which passed away.

Clinical recovery (absence of symptoms and normalization of inflammation indexes) was observed around 4–5 weeks after the onset of infection in about 90 % of patients. A significant reduction of symptoms, such as compulsive or aggressive behaviors, was observed in all patients with psycho-pathological diagnoses; in some cases, a decreased dose of neuroleptic therapy was required. At the end of May, virological recovery was observed and confirmed in all 103 patients by two consecutive rhino-pharyngeal swabs performed at 48–72 h from each other.

4. Psychological management

4.1. Procedure used to build the model

The intervention procedures were progressively defined in relation to the emergencies and psychological needs that people with ID and their families presented during the pandemic, also taking into account the guidelines issued by the Italian Ministry of Health. The operators of the multidisciplinary team working within the structure participated in all three phases of the experience. The basic team was made up of: doctors, psychologists, pedagogues, social workers and assistance and re-habilitation workers.

To define the phases, strategies and actions to be implemented for the psychological support during the emergency, we relied on the expertise acquired over time by the operators of the Oasis Research Institute concerning the clinical management of people with ID and, more specifically, their experience in remote assistance, called OasiNet (Buono & Città, 2007). The director of the Psychology Unit carried out the proposal and validation of the different psychological phases and procedures of tele-assistance.

Considering the emergency nature and the progressive readjustment of the actions taken, frequent meetings were held between the psychologists of the Psychology Unit involved in the tele-assistance. The meetings were aimed at comparing and monitoring the experience. No external contacts were involved.

The multi-stage intervention model was aimed at guaranteeing the broadest level of assistance, including the support to psychological development, interpersonal relationships, social inclusion, rights, and emotional well-being of people with ID since we strongly believe that supporting and serving vulnerable people is an ethical and moral commitment, in the same way as guaranteeing them the right to health, especially in the SARS-CoV-2 emergency phase (Luckasson & Schalock, 2020).

The process of developing the multidisciplinary model was oriented to ensuring the continuity of treatment and care through a re-modulation of clinical activities and the use of technological aids, which helped to remotely support people with disabilities and their families during this particular phase of the epidemic that required home confinement, dramatic reduction of displacements and activation of remote psychological aids (Zingale et al., 2020).

People with ID and their families were supported by the same psychologists who had dealt with their clinical management in the period preceding the onset of the pandemic. This was beneficial during the pandemic, as people with ID and their families maintained relationships with the same staff. The methods and strategies of intervention were previously discussed and agreed with the top management of the Institute and periodically checked.

In order to implement the intervention program, the following activities were carried out:

- use of IT devices, provided by the Institute, to ensure remote contacts and use of specific Apps and telematic platforms;
- remote and smart working interventions, in line with the social restrictions imposed by the regulations issued within the Institute, provided by the 16 psychologists involved;
- meetings of the multidisciplinary team;
- frequent meetings between the staff involved in tele-psychology activities and the director of the Psychology Unit;
- personalized interventions in line with the program defined for each user prior to the pandemic and adapted to the new psychological and clinical conditions of the person with ID and COVID-19;
- identification of specific staff in the various departments to optimize the use of devices by people with ID.

4.2. Acute phase (15 days)

4.2.1. Psychological and behavioral characteristics

a Patients – During the acute phase of the COVID-19 outbreak, the vast majority of patients who tested negative for infection was temporarily discharged. The remaining inpatients showed, in general, a reduction of their problem behaviors, which were typically manifested before the onset of the pandemic, probably because of their COVID-19 symptoms (fatigue and physical asthenia). Furthermore, a reduction of self-stimulating behaviors, hyperactivity, self/other sexual aggression and oppositional behavior was observed in many patients with severe ID and associated psychotic disorders. Patients with mild or moderate ID, in general, showed skills in managing the emergency condition and a collaborative attitude towards the healthcare staff. The most relevant reactions were: decreased appetite and increased sleep disturbances, often related to breathing difficulties caused by COVID-19.

b Families – The reactions of families could be grouped into two main categories: parents of the hospitalized patients showed anxiety, concern and need to be constantly informed, while parents of patients discharged requested support for managing behavior and daily routines of their children with ID at home.

4.2.2. Management strategies and actions implemented

a Identification, activation and revision of safe clinical practices. This phase mainly involved physicians, nurses and health carers. Clinical practices were revised as follows: 1) reorganization of the environment to facilitate distancing and limit the spreading of the infection, and arrangement of exclusive COVID-19 wards; 2) “cohortization” of patients; 3) identification of a COVID-team; 4) definition of therapeutic and health care pathways for the treatment of patients affected by COVID-19; 4) rearrangement of cleaning and sanitation procedures for the environments and contact surfaces like handles, push-button panels and other contact surfaces; 5) staff training courses on prevention and containment measures, as well as the proper use of personal protective equipment.

b Ongoing remote psychological support and counseling activities addressed to patients and their families through telephone and/or online platforms provided by psychologists and social workers.

4.3. Activity planning (about 30 days)

4.3.1. Psychological and behavioral characteristics

a Patients – In this second phase, the improved health conditions of the patients affected facilitated the application of psycho-educational protocols, differentiated by ID levels, which were aimed at improving the patients’ quality of life. The proposed IT activities were welcomed with particular enthusiasm and interest; some of the high-functioning patients proved to be even excellent tutors for the low-functioning peers in the use of IT devices. Problem behaviors were under control in this phase too, irrespective of the patients’ ID level. As for patients that had temporarily returned at home, almost all parents of children and adolescents with ASD reported during teleconference sessions with the staff to have experienced difficulties with their children, with differences due to the ID and levels of language impairment. Specifically, increased problem behaviors seemed to be relating to the lack of daily routines and outdoor activities. The most frequently reported problem behaviors (regardless of patients chronological age, ID levels and syndromes) were the following: altered sleep-wake cycles and eating habits, increased stereotypes and self/other-injurious behaviors. Those with higher cognitive skills showed an increased difficulty in tolerating frustrations and a longer duration and frequency of rituals (e.g., cleaning and/or handwashing). It was noted that social distancing had substantially little effect in people with ASD, whereas it appeared to have a negative impact on people with mild and moderate ID without ASD. In the latter, in fact, social isolation led to anxiety, mood deflection and increased eating disorders (bulimia). Furthermore, based on family reports, social relationships were sometimes replaced by inappropriate and excessive use of social media, leading, in some cases, to on-line relationships with strangers. In a very few cases escape behaviors from the family environment and aggressive and destructive acting-out behaviors emerged, which thus required the hospitalization in health facilities.

b Families – Decreased levels of anxiety and concern were reported by parents of hospitalized children, while those having their children at home reported an improved management of their children’s daily behavior following the psychological tele-assistance activities.

4.3.2. Management strategies and actions implemented

a Development and administration of questionnaires for the collection of information on the quality of life, mental health conditions and psycho-pathological risk factors of people with ID and their families, with the aim of detecting priority needs and consequently plan patient-tailored interventions.
b Planning and implementing appropriate procedures and daily activities to support patients and their families, by increasing the number of psychological, rehabilitation and educational intervention protocols provided via tele-assistance, in order to limit the psychological consequences of the quarantine as well as to improve the challenging staff conditions at work during the emergency. All this implied the redefinition of the rehabilitation intervention protocols and the agenda of recreational and occupational activities to be implemented during the emergency, with the support of psychological tele-assistance (see Table 2). Specifically, the activities planned for people with mild and moderate IDs concerned:

- daily routine activities relating to personal hygiene, clothing and eating to guarantee adequate safety measures for both healthcare staff and patients (use of personal protective equipment; distancing even during meals; proper sanitation of cutlery, plates and glasses, clothing and linen);
- psycho-educational interventions aimed to improve the ability to understand the current situation, the infection, the way to avoid contagion and the procedures adopted to cope with the consequences of the pandemic (use of protection equipment, adaptation to the setting, social distancing, etc). Information and instruction were provided with the help of visual aids as well as verbal repetitions in a clear and accessible language, appropriate to the functioning levels of patients, whenever necessary;

Table 2
Example of a multidisciplinary psycho-social program for persons with mild and moderate ID implemented at the Oasi Research Institute during the COVID-19 emergency.

| General purposes | Instruments |
|------------------|-------------|
| - Consolidate and enhance adaptive skills | Activities were carried out with the help of electronic devices, such as tablets and smartphones. |
| - Reduce the negative effects of COVID-19 on patients’ emotional well-being and quality of life | Each patient was required to use a series of tool kits, either disposable or reusable (the latter was continuously sanitized in order to avoid contagion). |

Methodology
The program and methodology used were adapted and tailored to the characteristics and levels of disability of each patient. In addition to the provision of 24h medical assistance, multidisciplinary psycho-social activities (30–45 min) were carried out both individually and in small groups, consisting of 2–3 people, in large and airy spaces.

General objectives planned for patients, divided by intervention area:

**Personal care/independence**
- taking care of personal hygiene, with particular attention to hand washing
- changing garments, with particular attention to underwear

**Environment management**
- cleaning and sanitizing all surfaces used
- disinfecting the surfaces after eating a meal
- using disposable items during the meal (cutlery, glasses, plates, napkins) and personal linen (towels)
- tidying up one’s room
- airing out rooms frequently

**Functional activities**
- improving the recognition of new signals within the hospital wards
- enhancing the use of electronic devices

**Social skills**
- learning and applying the rules relating to COVID-19 containment measures
- keeping safe distances
- using face masks
- recognizing and respecting the visual indicators of social distancing
- avoiding exchange and sharing of food while eating a meal
- maintaining social relationships through the use of electronic devices, such as smartphones, tablets, computers, to facilitate contact with parents, carers, other patients located in other settings to ensure social distancing
- taking part in recreational activities in compliance with current safety regulations

**Emotion management**
- recognizing and being aware of the “Coronavirus” event
- expressing and verbalizing the fears and emotions experienced during the emergency period

**Physical activity**
- performing motor paths, through the use of visual aids
- performing total body workouts through the use of video-tutorials
- improving eye-manual coordination: coloring activity; creation of objects through the use of paper material

**Cognitive skills**
- performing activities aimed at cognitive enhancement, presented through the use of electronic devices (tablets, PCs, smartphones)
4.4.2. Management strategies and actions implemented

- specific training, through the use of modeling or other behavioral procedures, on the use of face masks, hand washing and distancing;
- small-group activities to promote psycho-physical well-being; all activities were re-settled according to appropriate hygiene measures against COVID-19 and carried out in large and airy spaces, thus facilitating safe social distancing according to the current regulations;
- psychological interventions for the management of emotional and behavioral problems deriving from a forced quarantine, isolation and social distancing, as well as for the enhancement of behavioral self-regulation skills;
- individual psychological support and treatment;
- structured individual training every two-three weeks in which the following were addressed: attention, executive, memory and learning functions, communication skills, emotional skills, social skills, independence skills, theory of mind, cognitive enhancement, metacognitive stimulation;
- small-group interventions concerning mindfulness meditation.

c Provision of enhanced psychological support, counseling and psycho-educational training activities to families, more specifically addressed to the observation of their children’s behavior at home to improve social, independence and communication skills and to better manage any problem behaviors.

4.4. Activity consolidation (about 60 days)

4.4.1. Psychological and behavioral characteristics

a Patients – In this phase, further improvements in the health conditions of patients led to the reappearance, in some cases, of problem behaviors typically present before the pandemic, such as disorders in the eating and sleep-wake rhythm, self/other-injurious behaviors, oppositional disorders, motor restlessness and relational problems. From an emotional perspective, mood alterations/deflection and short temper were commonly observed. People with moderate-severe ID showed an excessive fear and refused to leave the “prosthetic” environment in which they had spent the quarantine period, in other words, they refused to return to their daily routines.

b Families – Significant reductions in anxiety and concern levels were reported by parents of both hospitalized and non-hospitalized patients.

4.4.2. Management strategies and actions implemented

a Enhanced psychological activities for the clinical management and emotional support to patients and their families (to reduce and manage the stress associated with a longer hospitalization period);

b Restoration of in person rehabilitation activities in dedicated settings;

c Planning and implementing adequate procedures for remote diagnoses with the definition of specific protocols consistent with the type of neurodevelopmental disorder.

5. Concluding remarks

The experience reported in this paper has brought awareness of the higher vulnerability of people with ID than the general population during the COVID-19 pandemic. There is no doubt that the challenging daily management of these patients is even more complex during an emergency such as that, which occurred due to the COVID-19 outbreak.

This work was intended to describe the clinical practices and psychological interventions that were put in place for the management of an elevated number of patients (109) with ID in a 352-bed research and clinical center, where one of the largest infection outbreaks of the last decades took place. Multidisciplinary interventions, as implemented via tele-conferencing, were addressed to people with ID, their families and their carers. The successful outcome of these interventions might represent a model to be applied and generalized in other rehabilitation and residential centers for people with intellectual disability.

The experience, as reported in this paper, covers a period of time ranging from mid-March to the end of May 2020. During the infection outbreak, a series of actions were undertaken consistently covering each of the three time ranges (phases). In the initial most challenging phase all the efforts of the professional staff were addressed to the containment of the infection and the management of the health conditions and behavioral manifestations of people with ID, who suddenly found themselves as confined in an unfamiliar environment and in the absence of customary daily routines. During the intermediate phase, the collection of clinical and psychological data facilitated a better understanding of the general situation and the application of multidisciplinary intervention protocols addressing all bio-psycho-social domains of the patients. Finally, the third phase consisted in the stabilization of the interventions as well as the progressive return to normalization of the patients’ customary activities.

During the overall outbreak period, the shift from one intervention phase to the other was driven by the general health conditions to be dealt with, as well as the needs expressed by the patients with ID and their families. Indeed, following the initial emergency phase that was almost entirely dedicated to the management of anxiety, interventions started to be progressively structured and the improved health conditions made it possible to implement more tailored psychological and educational treatments as well as more targeted training sessions.

The intervention protocol, as developed by the specialists of the Oasi Research Institute, was aimed, on the one hand, at
guaranteeing the highest level of clinical and psychological assistance during the three phases, and, on the other, at ensuring the respect of the rights of people with ID as well as supporting their personal well-being.

The staff turned out to be highly qualified, professional, and humane in coping with the challenging management of such a large number of people with ID affected by COVID-19, even succeeding in avoiding the worse to happen. In other words, the Oasi Research Institute staff played a decisive role in coping with this invisible enemy, demonstrating professionalism, self-denial, tenacity and courage. Moreover, our experience has highlighted that immediate, modular and flexible multidisciplinary approaches are required, in compliance with safety regulations, capable of dealing with the multiple dimensions that ID management entails in emergency conditions. Appropriate synergies between staff members (physicians, nurses, psychologists, social workers, carers etc.) are strongly recommended to promptly cope with new health and behavioral emergency needs, within certain settings that inevitably need to be re-arranged and activities that have to be specifically re-shaped, with the help of technology for remote interventions as well.

In terms of human costs, all interventions of psychological support were provided by the same staff in force at the Oasi Research Institute, by reorganizing their working shifts and activities, while in terms of financial efforts, the only extra costs borne by the Institute were for the purchase of materials and technological devices to facilitate the provision of psychological interventions during the pandemic. It should be emphasized that the experience presented here was carried out in a publicly-funded healthcare facility under the Italian National Health Service (NHS), which has always guaranteed all citizens the right to access healthcare services. Unlike many other healthcare providers, the Oasi Research Institute ensures people with ID a quick and effective access to highly-specialized appropriate care and treatment services (both medical and psycho-pathological interventions), as differentiated by ID levels and comorbidities.

The COVID-19 outbreak in Italy has represented a real challenge, especially for hospital health services. Our experience might hopefully offer useful insights in the management of vulnerable people: timely and appropriate health interventions, precautionary isolation of infected people, remote/in person psychological support for patients, their families and their carers are the key elements to be taken into consideration in any healthcare context dealing with frail people.

6. Limitations

Given the emergency context in which this experience took place, no social validation procedures were sought by the professionals involved, nor by people with ID or their families, nor by external personnel.

CRediT authorship contribution statement

Serafino Buono: Conceptualization, Writing - review & editing. Marinella Zingale: Conceptualization, Writing - review & editing. Santina Città: Conceptualization, Writing - review & editing. Vita Mongelli: Data curation. Grazia Trubia: Data curation. Giovanna Mascali: Data curation. Paola Occhipinti: Data curation. Enrica Pettinato: Data curation. Raffaele Ferri: Supervision. Catalda Gagliano: Data curation. Donatella Greco: Data curation.

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