Advances for future working following an online dramatherapy group for adults with intellectual disabilities and mental ill health during the COVID-19 pandemic: A service evaluation for Cumbria, Northumberland Tyne and Wear NHS Foundation Trust

Jane Bourne | Claire Brown | Debbie Corrigan | Phil Goldblatt | Simon Hackett

Abstract

**Background:** During the COVID-19 pandemic, social distancing measures were enforced and the national lockdown underlined our reliance on virtual means as a way to communicate. This new way of interacting highlighted that people with an intellectual disability were a large proportion of a digitally excluded population.

**Methods:** A service evaluation, using a mixed method design in the form of four self-reported outcome measures and qualitative feedback.

**Findings:** Clinical services need to continue when face to face sessions are not possible. Remote groups can be an alternative option not only when self-isolating due to pandemics but when living in remote locations, having physical health problems or excessive expenses and travel costs.

**Conclusions:** Online dramatherapy groups can be a beneficial alternative when face to face groups are not possible or challenging to attend due to access difficulties. Online groups can offer opportunities to meet with peers, build relationships, improve confidence and learn new skills in technology.

**Keywords**

community care, intellectual disability, mental health

**Accessible summary**

- Groups delivered online, using the internet, are an option for people with an intellectual disability when attending a group in the community is not possible.
- Online dramatherapy groups can provide people an opportunity to share stories and experiences through creative means.
- Friendships can be established through facilitated online group platforms.
- Online groups introduce people to technology and opportunities to learn digital skills that can be used outside the group.
1 | INTRODUCTION

Cumbria, Northumberland Tyne and Wear NHS Trust is one of the largest mental health and disability Trusts in England. It has over 70 sites across the north east of England, employs more than 7000 staff and serves a population of approximately 1.7 million. During the Covid-19 pandemic, there was a reduction in therapeutic provision, with face to face groups postponed for many community patients and a wide range of adaptations made to clinical practice (Zubala & Hackett, 2020). For services to have any semblance of normality and productivity integrating with advancing technologies using remote platforms was found to be the only way for people to regularly communicate. The pandemic and lockdown guidelines underlined our reliance on virtual means as a way to connect, while also highlighting digital exclusion (and digital poverty). We now understand for some sections of our society digital exclusion was, and still is, a reality; with 22% of the United Kingdom’s population described as lacking basic digital skills, having limited access to equipment, such as computers, laptops or smart devices and/or availability to the internet or a 3–5g connectivity (Glover, 2020). People who have an intellectual disability are a large portion of this digitally excluded population (Public Health England, 2020) and during the Covid-19 pandemic this already vulnerable group had reduced access to clinical services, family, carers and friendship groups.

During the height of the Covid-19 Pandemic in 2020, people with intellectual disabilities were six times more likely to die compared with the general population (Glover et al., 2020). These disproportionate deaths are indicative of wider issues relating to health inequalities for people with intellectual disabilities. As a response, the NHS Improvement Learning Disability Mortality Review (LeDeR) program was devised with an aim to improve care for this population. It led to a package of development for clinical teams working on the frontline with an aim to have a better understanding of the differing needs of people with intellectual disabilities. Despite this, and a number of different initiatives, a large health inequalities gap still exists for people with intellectual disabilities (Bourne et al., 2022; Public Health England, 2020).

There is a growing need for care and support for people with intellectual disabilities (IQ 55–85) arising from an increasingly complex society (Woittiez et al., 2019). Approximately 1.5 million people in the United Kingdom have an intellectual disability and 350,000 a severe intellectual disability (MENCAP, 2020). Patients with intellectual disabilities are understood to have greater healthcare needs with higher levels of morbidity and premature mortality than patients without an intellectual disability (Carey et al., 2016; Heslop et al., 2014). Research shows that mental health diagnoses are four–five times more common in people with intellectual disabilities than in the general population, with both primary and secondary care at times insufficient due to inadequate identification of a disability, a mental health issue, communication difficulties, atypical presentation of disorders and/or a lack of appropriate assessment tools and treatment methods (Pouls et al., 2021). As a consequence, this population is often at risk of developing more severe or chronic mental health difficulties, given more psychotropic medications and often use more services than the general population (Hassiotis et al., 2008).

For many years, psychotropic medication was the only means of support offered to people with intellectual disabilities (Department of Health [DH], 2020). Public Health England (2020) states that every day around 30,000–35,000 adults with an intellectual disability are taking psychotropic medicines for a mental health condition, sometimes without a clear diagnosis. Although in 2015, NHS England’s project, STOMP (Stopping over medication of people with a learning disability) focused on improving therapeutic approaches and services for people with an intellectual disability (DH, 2015a), there still continues to be a lack of non-pharmacological interventions available for this population living in local communities (Bouvet & Coulet, 2016; Hackett & Bourne, 2014). During the recent Covid-19 pandemic, usual services were further reduced, which meant that people with intellectual disabilities and mental health problems were further isolated, which caused risks to their well-being even though Government guidance suggests adaptions are needed to clinical services to support people with intellectual disabilities when services are reduced (DH, 2021).

More than a year on from the start of the Covid-19 pandemic digital technology is present in psychotherapy practice worldwide; enabling clients and therapists to connect together regularly remotely (Zubala et al., 2021). By improving access to therapy through digital platforms people who might have previously been unable to attend face to face sessions can now benefit from the treatment. This article reports the evaluation of an adapted service, which transitioned from a face-to-face community group to an online group for people with intellectual disabilities and mental ill-health during the Covid-19 pandemic. Although there were challenges in making changes from face to face to remote working with this population, which included social distancing measures, education and training on digital engagement and the differing levels of people’s understanding in relation to using remote platforms, it was still achievable and offered real benefits. Today, those people who attended the remote group now have advanced their skills in their use of technology and are communicating with online groups regularly.

1.1 | Psychosocial group interventions

The Get Going Group online is an adaption of a community drama-therapy group and psychosocial intervention that ran successfully for over 6 years face to face before the pandemic (Bourne et al., 2020; Hackett & Bourne, 2014). Psychosocial interventions can be described as interventions that emphasise psychological, behavioural or social factors rather than biological factors such as pharmacotherapy (Bourne et al., 2021). Their benefits for the general population include interpersonal, informational activities and techniques that target biological, behavioural, cognitive, emotional, interpersonal, social or environmental factors to improve a person’s health function and wellbeing (Beail, 2016). We know that psychosocial
interventions adapted for people with intellectual disabilities are beneficial, particularly interventions that have a creative element (Bourne et al., 2021). The dramatherapy group was initiated following the implementation of the Transforming Care programme (DH, 2015b), which aimed to reduce the number of people with an intellectual disability living in hospitals. The group was successful in supporting people and demand was high with between 8 and 10 people regularly attending, so a second group was implemented. The dramatherapy groups focused on either supporting patients after their discharge from an Assessment and Treatment Unit (ATU) or when people were at risk of hospital admission (Hackett & Bourne, 2014). The groups were seen as part of a person’s discharge pathway; to support people moving back to their homes and/or needing extra support while living in their local communities. As hospital beds reduced and people began to be supported more in local communities, the groups adapted and became a contact for community patients if their mental health was declining. The benefits of these groups include: providing a creative space to share weekly challenges with learning disability professionals (Bourne et al., 2021), a space that offered people struggling with their mental or physical health so that wrap around care could be identified, in the form of community nurses or psychologists (Hackett & Bourne, 2014), a space to be able to share stories, narratives and personal experiences with peers in a mutual supporting environment (Keyes & Brandon, 2012). Evaluation of the ‘Get Going Group’ informs us that it offers a place to support a person’s wellbeing, reduce reliance on clinical service use and avoid unplanned readmissions (Hackett & Bourne, 2014).

1.2 | The ‘Get Going Group’ goes online

During the Pandemic as community face to face groups ceased and people’s wellbeing declined; measures taken to suppress the virus-affected people, with longer term consequences to their mental health (Suleman et al., 2021). The aim of setting up an online group was to move the face-to-face group to an online platform so as to support people who were isolated in the community. The process was not easy to implement due to a lack of access to reliable technology, smart devices and broadband connectivity, which again highlighted digital poverty and barriers to adapting services for people with intellectual disabilities and mental ill health (Glover et al., 2020). To allow the pilot online group to run an inclusion criteria for referrals needed to be implemented which related to group members needing some form of access to technology and Wi-Fi, which consequently excluded some individuals.

1.3 | Service evaluation aims

Our aim was to evaluate the acceptability of the online psychosocial intervention for this population and to understand if this kind of group could still offer clinical benefits even though people were not meeting face to face. We focused on understanding if the online group could:

- Reduce excessive service use in terms of contact with general practitioners and the crisis teams.
- Support friendship building.
- Help skill development in terms of using technology to meet people.
- Improve people’s emotional wellbeing through increased confidence and self-esteem.
- Lower people’s anxiety and lift their mood through engagement.

Questions for this service evaluation included:

- What are the challenges of setting up online groups for people with intellectual disabilities and mental ill health?
- Does having weekly sessions with clinicians still offer a space to share difficulties or concerns?
- Can meeting people online offer a place to build friendships and communicate their experiences?

1.4 | The participants

Participants were recruited from a Community Learning Disability Community Team within the Trust, n = 8, with a specific inclusion criterion:

- Adults with an intellectual disability diagnosis.
- Suffering from mental ill health.
- Living in the community.
- 18 years or above.

All participants lived either at home with parents/carers or in a supported living setting in the community. There were two males and six females recruited to the group with an average age of 35 years. Half of the group had previously been admitted to the hospital for their mental health, which included diagnoses of anxiety, depression and psychosis. Ethics was not applied for by an appropriate local research committee, as this was a service evaluation, but consent was given from all participants to share the evaluation’s findings.

2 | METHOD

The group was held weekly online, for 10 sessions. Before the group started outcome measures were taken in the form of questionnaires via the telephone with the help of support staff (Table 1). The same questionnaires were also completed postgroup. All measures were specific to this population. The questionnaires were posted to the referred person before the completion so that these could be looked over with support from a carer before the scheduled telephone call by the Trainee Clinical Psychologist or Assistant Practitioner.
providing an action to go with their name. The group were then invited to mirror back this action while repeating the person’s name. The game was fun and offered continuity to the start of the group with a reminder of everyone’s name.

The second warm-up game, involved a facilitator choosing a colour (which changed weekly), and participants finding something of that colour in their home environment to bring and share remotely with other members. This process allowed people to bring both something of themselves and something from their environment into the group online space. The process was both playful and intriguing, as participants brought items, such as pets, cushions, ornaments and clothing, while adding short stories about what and why they were bringing that item that day and what it meant to them. The activity added engagement and group bonding, with a function to bring people’s locality into the group. This allowed people to feel connected with each other on screen as well as learning something new about each group member and their environment.

Story making was the main group activity. There is a human need to share stories to make sense of the world (Vettiraino, 2015). We used the 6-Part-Story-Method (or 6PSM), which is a drama therapeutic approach that enables stories that are created to be embodied by both the teller and the listener (Lahad & Ayalon, 1993). Its process allows for story making, telling and reflection. The six-part-story contains component parts of: a character, a place or land, a goal, an obstacle, some help to overcome the obstacle and an outcome or ending (Hackett & Bourne, 2014). The origin of the six-part story is rooted in identifying coping strategies and resilience in people experiencing ongoing stress (Lahad & Ayalon, 1993; Lahad, 2013).
so was seen as an ideal approach for the online group during the pandemic.

At the first session, the six-part-story was completed collectively using google paint, (TM © Version 3.2) on Teams, which can be seen in 'Image 1'. Collectively, the group decided that the main character should be a rabbit whom wanted to find a friend, and to achieve this it was thought having a meal together would help to develop a friendship. However, not being able to meet people due to the Covid-19 restrictions (at that time) made this goal a difficult one to achieve.

The ending of the story, as can be seen in box 6 (Image 1) and shows the two rabbits meeting for a meal but modelling social distancing. As was demonstrated by the group’s story, the national lockdown restrictions during this period were on people’s minds and loneliness was prevalent among group members. The story allowed discussions around loneliness, having friends and Covid restrictions to be openly reflected upon.

Over the following weeks, all participants were invited to make their own six-part-story, to build props and to role-play their story with the support of the facilitators, support staff, and/or other participants. To help with this process, once stories had been devised on paper, participants were invited into remote breakout rooms. Breakout rooms are sessions that are split off from the main meeting space and allow people to meet in smaller groups, completely secluded in terms of video and audio from the main session. Having break out rooms allowed participants to work through their stories closely with a facilitator and one or two other participants so as to decide how they wanted to perform their story. They also allowed participants an opportunity to closely reflect on their story, alter their story or ending, as well as build their characters, obstacles or identified help within their story in a small group before sharing it with the rest of the group.

Once the stories were finalised, a list of people’s performances was produced so that everyone got their turn to share their story and knew when this was happening. The whole process offered participants a chance to direct their story, negotiate and cooperate as a team and support one another. We also found using this approach offered an accessible and engaging activity that increased a person’s confidence through playing and role play, improved communication and participation in online group platforms as well as identified difficulties a person might be experiencing.

3 | EVALUATION RESULTS

3.1 | Group attendance

Attendance and retention was good overall, the number of people who were referred to the online group was similar to the numbers who attended the face to face groups. Unfortunately, three members had to stop attending the group due to health problems and admissions to acute physical health hospitals. None of these admissions was related to Covid-19. Three of the eight participants who attended the sessions had previously attended face to face drama therapy groups.

3.2 | Self-reported outcome measures

Quantitative data in the form of outcome measures (Table 1) were taken pre- and post-group from all the participants (n = 5) who completed the group. Results were found to be positive in the main
TABLE 3 The Get Going Group's scores showing mean pre- and postgroup scores

| Participants | GAS-ID | GDS-ID | CORE-LD | Rosenberg S-ES |
|--------------|--------|--------|---------|----------------|
|              | Pre-   | Post-  | Pre-    | Post-          | Pre-  | Post-  |
| 1            | 33     | 28     | 24      | 25             | 11    | 11     |
| 2            | 35     | 29     | 25      | 24             | 16    | 13     |
| 3            | 17     | 20     | 11      | 13             | 7     | 5      |
| 4            | 19     | 19     | 8       | 0              | 0     | 4      |
| 5            | 24     | 22     | 26      | 14             | 10    | 7      |
| Mean scores  | 25.6 v 23.6 | 18.8 v 15.2 | 8.8 v 8.0 | 19.4 v 18.8 |

Abbreviation: v, versus.

with a mean increase in people's self-esteem, anxiety and/or mood postgroup.

Significant changes in people's anxiety and depression (Table 3) were found from the adapted ‘Glasgow Anxiety Scale’ (GAS-ID) (Mindham & Espie, 2003). The GAS-ID is a 27-item self-rating scale of anxiety symptoms for people who have a mild intellectual disability. Higher scores indicate higher levels of anxiety with a maximum score of 54, with subtotals: ‘worries’, ‘fears’ and ‘physiological symptoms’. All scores pre- and postintervention were in a clinical range of above 15, but 4 out of 5 people's scores reduced postintervention. A paired T-test was completed using SPSS software (version 27) to identify changes between the pre- and postscores; a T-test is a statistical procedure where one set of sample scores are paired with observations from another set of sample scores from the same participant. The paired T-test showed 'significant changes' in participants' anxiety scores post-intervention with a value of p = .02 post-group. p values tell us if an outcome is a result of a change or if the result is a random occurrence. If the p value is .05 or lower, the result is seen as significant, as was the case with the groups' scores; if it is higher than .05, the result is seen as nonsignificant. As the intervention was offered during a global pandemic with national guidelines implementing isolation, anxiety levels were probably heightened in general; therefore, scores could be seen as positive.

Outcomes from the Glasgow Depression Scale (GDS-ID) showed people's mood was lower in the main postintervention when measured. The GDS-ID is a 20-item self-reporting scale of depression symptoms (Cuthill et al., 2003) with a maximum score of 40. It is specifically for people diagnosed with a mild intellectual disability. The cut-off point for detecting depression symptoms is 13. We found n = 3 of the five participants had depressive symptoms pre- and postintervention with a mean reduction in depression symptoms postintervention of 3.6. Scores can be seen in Table 3, which show individual pre- and postintervention outcomes and group mean scores from the four measures used.

3.3 | Self-esteem and well being

There was only a small reduction in the mean scores from the Rosenberg Self-esteem measure, postintervention (19.4–18.8) and again little change postintervention from the CORE LD measure (8.8–8.0). The pandemic was at its peak during the delivery of group intervention, which meant external factors, such as people's measurable activities and meetings with family and friends was greatly reduced, something that would normally support a person's wellbeing and be encouraged outside of the group intervention. Therefore we felt any mean reduction in scores or increase in self-esteem was positive considering the circumstances.

3.4 | Excessive service use

We found that service use was reduced while the group ran online. We monitored service use in terms of any hospital admissions to Treatment and Assessment units or contact with crisis teams due to any mental health decline. Monitoring service use helped us understand if the group was offering additional support to a person and their wellbeing while it was running.

3.5 | Group feedback

We gathered group feedback at the end of the sessions. This was taken during the postgroup telephone call and alongside the four outcome measures. Comments from group members include:

“I don't want the group to end’, ‘It has been such fun’; “I like having someone to talk to’ and ‘I have made new friends’.

4 | DISCUSSION

The online group offered people an opportunity to learn new skills, as none of the participants had used remote platforms to engage in a group before this group started. People were given the chance to engage in new technology, as the world around them was adapting to the Covid-19 pandemic, communicate with other people similar to themselves in a similar situation and share any difficulties or
challenges they were facing with professionals and peers. Having weekly sessions appeared to reduce people's loneliness a little, feel included in advancing technology and the adapting society, as well as learning new skills that were then used outside of the group to connect with family and friends.

The aim of the service evaluation was primarily to assess the acceptability of the online delivery of this kind of group to people who had an intellectual disability and mental ill health. Delivering this kind of group had its challenges, particularly setting it up, with potential participants needing to have some form of access to remote devices and or free Wi-Fi, which caused restrictions in terms of people who could attend. Retention was good and similar to the face to face groups. All group members reported learning new skills in using remote technology, which helped them to feel included in the use of digital communication.

The assessment of outcomes looked at the potential clinical benefits of this kind of group in reducing service use, such as acute general hospital admissions and contact with crisis teams. During the group no-ones mental health decreased and so service use did not increase. Benefits that may have supported a person’s wellbeing were new friendships, skill development (including communication through technology), a regular link with professionals whom they could see and a structure to their week.

Although the number of participants who completed the group was small (n = 5), outcomes do show the online group met the aims of the intervention, which included offering participants a space to share difficulties and reflect on their narratives and stories with learning disability specialists and facilitators. Surprisingly, within a national pandemic, the members of the group reported a reduction in anxiety levels following the intervention with a p value of .02 post-intervention. This suggests that the intervention significantly reduced people’s anxiety, even though anxiety outcomes were still in a clinical range. Participcents' depressive symptoms also reduced collectively postintervention but again still in the clinical range. Other outcomes, such as self-esteem and well-being had little change, which might have been related to external factors, such as the pandemic and reduced access to positive activities and meeting face to face with relatives. It would be interesting to repeat this group with the same measures when a global pandemic was not taking place, and see if scores reduced postintervention below a clinical range.

The group was set up as a necessity and response to the Covid-19 pandemic and the need for clinical services to be available to vulnerable adults who were self-isolating. Understanding the acceptability of delivering this kind of group has proved beneficial, and group members were keen to attend a second group, which we implemented. We can see that online platforms are another way of meeting and engaging with people. They can offer real benefits for people with intellectual disabilities to engage not only through the context of a pandemic but when face to face meetings have tangible difficulties, such as remote living locations or long term health conditions and/or mobility disabilities, which might have previously prevented people to access in-person therapy sessions (Zubala et al., 2021).

Remote groups can be an option for people who cannot access venues due to reasons not related to self-isolating or a pandemic but rather due to other difficulties, which might include remote locations, physical health problems or expenses and travel costs. The pandemic brought challenges but clinical adaptations have successfully been trialled and as this online group informed us there are benefits that can still be achieved from remote groups when face to face groups are not possible. Although social restrictions are now reducing, remote groups could/can offer ongoing benefits for this population as an alternative way to offer a direct intervention, particularly when accessibility is challenging for a person to attend a venue.

5 | RECOMMENDATIONS

1. Online groups for people with learning disabilities could be a beneficial alternative when face to face groups are not possible or challenging to access, as they can still offer people a chance to meet with peers, build relationships and improve confidence as well as learn new skills in technology.

2. Online dramatherapy groups give people an opportunity to play and share stories and experiences creatively without the need for costly travel expenses and long journeys.

3. Online groups with people with learning disabilities and mental ill health allow easy links with healthcare professionals, weekly, so that immediate concerns can be highlighted, which potentially can reduce the need to access specialist or emergency/crisis services.

4. Further online dramatherapy groups could be implemented to further test and research the benefits of this intervention.

6 | SUMMARY AND CONCLUSION

Online groups are an option for people with learning disabilities and mental ill health living in the community.

- Online groups offer people a chance to link with professional's regularly.
- Online groups can be cost-effective as they reduce venue and travel costs.
- Friendships can be made through online platforms.
- Free time within the group is helpful for people to communicate with each other, which promotes skill development.
- When participants shared objects and items from their environment it brought their environment into the group experience.
- Story telling allows people to share their experiences indirectly, try out different endings and role play difficult situations.

ACKNOWLEDGMENTS

Cumbria Northumberland Tyne & Wear NHS foundation Trust's Arts Therapies Department & Northumberland Learning Disability Community Team.
DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ORCID

Jane Bourne https://orcid.org/0000-0001-8534-4264
Simon Hackett https://orcid.org/0000-0002-7861-5991

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How to cite this article: Bourne, J., Brown, C., Corrigan, D., Goldblatt, P., & Hackett, S. (2022). Advances for future working following an online dramatherapy group for adults with intellectual disabilities and mental ill health during the COVID-19 pandemic: A service evaluation for Cumbria, Northumberland Tyne and Wear NHS Foundation Trust. *British Journal of Learning Disabilities*, 1–9. https://doi.org/10.1111/bld.12462