

**Psychosocial interventions in a medium
secure unit for people with learning
disabilities:
A service development**

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Abstract

Psychosocial Interventions (PSI), a whole systems approach, is an integral part of the agenda for modernising mental health services. It is advocated as an effective approach for services in promoting the recovery of people with schizophrenia and other psychoses. The literature relevant to the approach is reviewed. However there is a dearth of literature with regard to PSI in mental health services for people with learning disabilities. This absence is particularly marked in secure settings where there is no established evidence based model of care. This paper describes the implementation of PSI in such a setting, including the central tenets of individual and group therapy, family intervention and formulation based care planning. This is supported by group supervision, staff training and the explicit support of the centre's clinical management team. The implementation is still in progress. The evaluation strategy is also described.

Key words: learning disabilities, psychosocial interventions, secure services

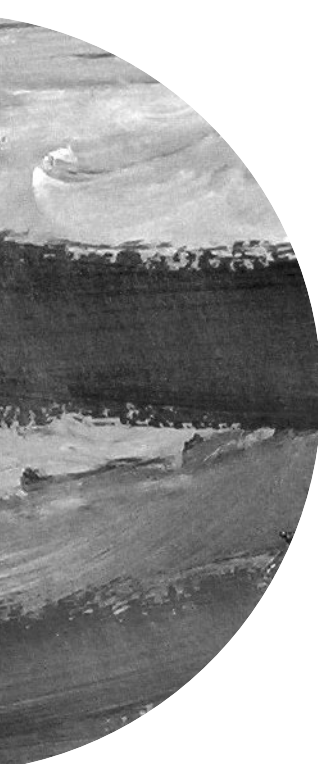
Background

There is a dearth of literature with regard to the severe mental health problems of people with learning disabilities. Raghavan (2004) identifies this situation as being due to inconsistencies in assessment and diagnosis, and comparative paucity of published evaluation of intervention strategies. This lack of literature is even more significant for the learning disabled population cared for within secure psychiatric settings.

Services for people with learning disabilities have been dominated by the ideologies of normalisation and applied behavioural analysis and the training of nurses (RNMH/RNLD) has been in keeping with this (Gilbert, Todd and Jackson, 1998). However, it has been suggested that whilst behavioural technologies may tackle overt features of a person's presentation the underlying level of psychotic symptomatology remains unaffected (Tarrier, 1992). Psychosocial Interventions (PSI) have been advocated as a complement or alternative to behavioural and pharmacological models of intervention (McCann, 2001). What follows is a brief description of psychosocial interventions, their relevance to secure care for people with learning disabilities who have severe mental health problems and their implementation in a service for that population.

What are Psychosocial Interventions?

Psychosocial Interventions is a term which describes the use of psychological and social approaches alongside medical and pharmacological therapies in dealing with a variety of conditions (both physical and mental). With regard to services for people with schizophrenia, intervention may take many forms but they all rely on interpersonal interaction for therapeutic gain. They target people with enduring mental health needs to improve functioning and reduce distress. The interventions are drawn from the following areas; individual cognitive behavioural interventions, psycho-educational approaches for patients and carers (to increase recognition and understanding of signs and symptoms associated with schizophrenia and to maintain compliance with medication) and finally family interventions to reduce relapse (McCann, 2001). Combinations of these methods have been shown to promote mental health and well being (Pilling; Bebbington, Kuipers, Garety, Geddes, Orbach, Morgan, 2002), reduce burnout in nurses (Ewers, Bradshaw McGovern and Ewers, 2002) and to be in keeping with current policy frameworks (Williams, 2002; Department of Health, 1999). Recent Guidance from the National Institute for Clinical Excellence (NICE, 2002) states that these interventions should be available to people with schizophrenia and their families, but do not extend this directive to groups where there is 'co-morbidity' e.g. people with learning disabilities and concurrent mental health problems.



Psychosocial Interventions and People with Learning Disabilities

A comprehensive review by Hatton (2002) identifies a small literature relating to psychosocial intervention with people with learning disabilities, including those with psychosis and those in secure settings. The evidence is limited but positive with regard to the approach. However these two areas of literature do not overlap; the former consists of case study reports (Mace, Webb, Sharkey, Mattson and Rosen, 1988; Leggert, Hurn and Goodman, 1997) and the latter focuses mainly on offence related issues (e.g. Lindsey, Neilson, Morrison and Smith, 1998). Stenfert Kroese, Dewhurst and Holmes (2001) reviewed the literature relating to psychiatric diagnosis and prescription of psychotropic medication for people with learning disabilities. They found that relying solely on these interventions could be insensitive to the persons needs, intrusive and in many cases was not sufficiently supported by the evidence base. They advocated staff training and the use of psychosocial interventions as a more appropriate and ethically sound mode of intervention. Numerous small scale studies demonstrate that people with learning disabilities can engage in and benefit from Cognitive Behavioural Therapy (CBT) to deal with anxiety, depression and anger (Hatton, 2002). Caine and Hatton (1998) and Stenfert Kroese, Dagnan and Loumidis (1997) suggest ways in which the therapy can be adapted so that it can be used with this population. CBT forms the mainstay of work with individuals in the PSI framework; therefore using this approach with people with learning disabilities who experience psychosis seems appropriate. Many people with learning disabilities depend on substantial support to enable them to cope with everyday tasks therefore health services often intervene either with families (Bromley, 1998) or with residential services (McBrien and Candy, 1998). The established importance of this wider context supports the case for the applicability of PSI to systems of care for this client group

Psychosocial Interventions in Secure Services

The vast majority of published work in the field of PSI concerns community and acute inpatient psychiatric services (none of which addresses the needs of people with learning disabilities). A UKCC scoping paper into nursing in secure environments (1999) dismissed the evidence base in Forensic Nursing as 'clinical anecdote' (p.80). The paper recommended post registration training in PSI as a way to increase the competence of nurses in secure environments and to move forensic nursing away from practice based on incident and inquiry towards evidence based practice. Baker, O'Higgins, Parkinson and Tracey (2002) describe a pilot study of PSI implementation in a low secure service and anecdotal evidence of positive impact. They and McKeown, McCann and Forster (2002) identify a literature concerning problems in implementation of PSI in psychiatric services generally and in inpatient services in particular. They suggest systemic and organisational factors are crucial to deliver and maintain improvement, placing strong emphasis on training and supervision as well as managerial support. In general, inpatient services have been criticised for almost exclusive focus on the delivery of medication (SNMAC, 1999), it is hoped that the planned programme outlined below will demonstrate substantial developments beyond this.

Implementing PSI in the Medium Secure Service for People with Learning Disabilities

The service described is a specialist inpatient facility for 10 men with mild/borderline learning disabilities (IQ = 60-80) all of whom are detained under the Mental Health Act 1983. All the men have a psychiatric diagnosis of schizophrenia or another psychosis, though they may have other additional and complex physical and mental health needs.

PSI is a 'whole systems approach' rather than a discrete intervention. A person's care is informed by Formulation, a theoretically informed integration of information drawn from a holistic assessment process. Formulation provides a way of understanding how problems developed and are maintained. It also points to how one should intervene to promote well being. This understanding informs nursing care plans which allow a broadly consistent approach and the use of targeted interventions by all members of staff.

Patients

In addition to routine care informed by the approach patients can also participate in individual psychological intervention and/or a Mental Health Issues Group. The primary purposes of this are for patients and professionals to develop a shared understanding of the patient's difficulties in context, and empower them to use coping strategies to improve and maintain their mental health. The individual and group work relies on a slower pace, careful work to establish a common language, pictorial representation, repetition and more attention to behavioural signs and behavioural experiments. Caine and Hatton (1998) write of the effectiveness of simplified CBT techniques such as self instruction and cognitive restructuring. Some time has to be spent to understand the impact of the person's learning disability on their illness and vice versa. This contextual understanding can be important e.g. auditory hallucinations where voices talk about 'being stupid' or looking different may be connected with experiences of bullying. Less ability to communicate coupled with suspicion can lead to isolating, impulsive and self destructive behaviours.

Families

Interventions with key members of a patient's family are integral to the approach and comprise tailored psycho-educational components. These are underway with the families of several patients at present. The service is fortunate to have a high level of involvement by families and carers in patient care and following a pilot group a carer support group will be established that will have a psycho-educational and supportive function. There is strong evidence that high Expressed Emotion (EE) within families; meaning strong articulation of hostility, criticism or overprotection, is detrimental to mental well being and increases the risk of relapse. The context of having a family member with a learning disability has to be considered (Bromley, 1998) including the difference this makes to levels of stress and ways of coping.

Staff

A Training Needs Analysis of current members of staff has been conducted using the 'Management of Schizophrenia Questionnaire' (Berkowitz and Heintz, 1984). This asked direct care staff (N=13) to write an account of how they would respond to a range of situations that may be experienced in working with people with schizophrenia. The responses have been analysed using a qualitative methodology based on Grounded Theory (Strauss and Corbin, 1998). The findings will be presented in a subsequent paper; but briefly members of staff used strategies to explore the situation and to reassure, support and direct patients. When one compares this to a PSI approach the latter gives patients more ownership of the strategies and, one could speculate, is based on a more sophisticated understanding of mental health. Also relevant is the fact that qualified nursing staff are predominantly trained in Learning Disability Nursing (RNLD/RNMH) rather than in mental health. Despite this there were also examples of good practice within staff responses. These findings will inform the training programme that will support the implementation of the approach. Following the training period ongoing supervision will be provided to all levels of staff to refine formulation and intervention.

Organisation

Crucial to the continued momentum of this initiative is the support of the organisation as a whole for the clinical team in its widest sense at ward level (Baker et al., 2002). An ongoing commitment to post registration training by the service will ensure that the 'critical mass' of committed and competent staff is maintained. Also, flexibility in the staffing profile will allow a larger number of people to become involved in the full range of components of the approach, improving patient care and job satisfaction.

Evaluation of the Service

Given that PSI is an integrated approach with several modes for intervening identifying ways of evaluating the individual components in a relatively small service is not straightforward.

To measure the impact of family interventions the Knowledge about Schizophrenia Interview (KASI) (Barrowclough and Tarrier, 1992) and Relative Assessment Interview

(RAI) (Barrowclough and Tarrier, 1992) will be used. Individual and Group interventions will be evaluated by repeated measures of The Psychotic Symptom Rating Scale (PSYRATS) (Haddock, McCarron, Tarrier et al. 1999), the KGV (Modified) Symptom Scale, Version 6 (Lancashire 1998), The Liverpool University Neuroleptic Side Effect Rating Scale (LUNTERS) (Day, Dewey and Bentall 1995), The Brief Psychiatric Rating Scale (BPRS) (Overall and Gorham 1962), The Beck Hopelessness Scale (Beck and Steer 1987), The Rosenberg Self Esteem Scale (Rosenberg 1965), The Glasgow Depression Scale (Cuthill, Espie and Cooper 2003) and The Calgary Depression Scale (Addington, Addington and Maticka-Tyndale 1993).

To monitor the overall impact the Ward Atmosphere Scale (WAS) (Moos, 1974) will be used. This is a 100 item questionnaire comprising statements to which the respondents answer 'true' or 'false'. It will be completed by patients and staff at 6 month intervals (2 sets of data have already been collected). Though 30 years old the WAS is still widely used in clinical settings for programme evaluation. It has been identified as a positive step towards the objective measurement of the therapeutic environment provided by a ward (e.g. Smith, Gross and Roberts, 1996). The responses are clustered to provide scores on the following subscales; involvement, support, spontaneity, autonomy, practical orientation, personal problems orientation, anger and aggression, order and organization, program clarity, and staff control.

Service users have been consulted regarding the developments above and the implementation reflects their desire to understand their problems more clearly and to have increased control over symptoms. Additionally they wanted staff and their families to understand illness better and to appreciate the role the family played in maintaining good mental health.

The results of further evaluation will be added to the literature in this area, a field that is still very much in its infancy.

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