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ACHIEVEMENTS

PROJET TRIADD

TELETRAINING, RESEARCH AND INFORMATION AROUND DUAL DIAGNOSIS

PROJET PILOTE - PROGRAMME LEONARDO DA VINCI

Edited by Jackie West,
Triadd Project Co-ordinator, April 2005.
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CHAPTER 1

THE PROJECT

CHAPTER I – THE PROJECT

1.1. BACKGROUND - WHAT IS THE TRIADD PROJECT ?

TRIADD is a European training project for staff who work directly with people who have an intellectual disability and mental health problems – also known as Dual Diagnosis. It became clear to us, through talking to various members of the Arfie network (Association de Recheche et de Formation sur l'Insertion en Europe) – that meeting the needs of this target group within the usual intellectual disability sector was posing problems to front-line staff and services in more than one country.

1.2. WHAT IS DUAL DIAGNOSIS?

We use Dual Diagnosis as an indexing term in this project to describe a range of issues relating to people with an intellectual disability and mental health problems, but recognise that the term Dual Diagnosis (DD) has different meanings in different countries – and even within countries. Our aim was to increase the recognition that people labelled as having dual diagnosis are not simply patients or problems, but individuals worthy of special understanding.
Approximately 1% of the population have a moderate or severe intellectual (developmental) disability and estimates indicate that around 30-50% of these also have mental health problems and psychiatric disorders. The possible reasons for this are numerous: family rejection, negative childhood experiences at home or in institutions (people with disabilities are four times more likely to suffer abuse, neglect or exploitation than other adults[1]) – inability to express feelings and solve problems, inability to make sense of the world and other's behaviour in the same way as those without a cognitive disability. Other factors such as repeated changes in care staff, bereavement, lack of autonomy, exclusion from society can all, quite understandably, lead to instability, depression and other mental health problems, quite apart from the intellectual disability itself.

The cognitive and communication difficulties inherent in the disability make identification, diagnosis and treatment of mental health problems notoriously difficult to diagnose (diagnostic overshadowing). `There are many factors that suggest that people with intellectual disability are more at risk of developing mental disorders than the general population. The risk factors for this population include biological, psychological and social factors, as well as relational factors such as parental rejection, institutionalisation, social stigmatisation, social role devaluation and lack of friends' [2]

Due to the traditional separation of intellectual disability and psychiatric services in most countries, neither the mental disability sector nor the mental health services are geared up to serving this user group, with the result they people with dual diagnosis are often misunderstood and have a poor quality of life. Relatively few practitioners have the skills necessary to assess and devise appropriate therapies for these individuals.

[1] *Canadian Mental Health Association*
[2] *Prof. Germain Weber, Compte Rendu du Séminaire Européen: Advances in Mental Health and Intellectual Disability, Vienna 2000*

There is also a lack of training courses for front line staff: `There is a common need amongst all people working with people with learning disabilities for a core understanding of basic psychotherapeutic principles. At present this is sparsely and inconsistently provided` [3] Support staff can therefore be tested to their limits. The Triadd project aimed to take the existing expertise in a number of countries in the field of staff training, to develop it and make it more widely available – basing it on a person-centred approach which considered the individual with a disability as a person in their own right entitled to dignity and quality of life.

1.3. THE MAIN OBJECTIVES OF THE PROJECT

- To bring together existing knowledge and training practices for professionals concerning dual diagnosis
- To perform a needs analysis survey amongst care professionals on key elements to be included in future training
- To develop new training packages for professionals supporting this target group
- To advance the availability of continuing training in Luxembourg (promoter's country), where little training exists on this issue
- To offer this new training product to a broad European target group of care workers, other social sector professionals and training institutions
- To offer tele-training (e-learning) to front-line staff on the issues involved in supporting people with dual diagnosis.

How did we achieve these objectives? Key Phases of the Project

During the project we:

- Conducted a survey into staff training needs
- Researched resources useful to staff, not simply clinicians or researchers
- Devised a number of training courses to address these needs
- Delivered these training courses with verbal and written evaluation
- Circulated a follow-up questionnaire to trainees and organised a transnational meeting of front-line staff
- Transposed key elements of a basic training course into an e-learning format
- Set up a web site in English and French offering resources to staff and service providers, such as an interactive case-study message board and resources in other languages (see chapter 2 point 2.7 on the subject of staff and computers).

[3] *Dr. Roger Banks, `Psychotherapy and learning Disability – the Present position and options for future development' Dr. Roger Banks, Royal College of Psychiatrist, July 2003.*

1.4. THE WEB SITE:

Teletraining Research and Information around Dual Diagnosis.

Welcome to the TRIADD project website.
This site has information on the TRIADD project, including information on the training courses the project developed and delivered to front line staff in partner countries across Europe.
There are evaluations of the training on the site, as well as online training materials for you to use.
You will also find a range of resources including a bibliography, case study material etc.
Use the navigation buttons on the left to navigate the site, or use the search box to find exactly what you are looking for.
Please do contact us and let us know what you think, and also if you know of resources that we can add to the site.

WWW.TRIADD.LU CONTAINS THE FOLLOWING

- Presentation of the project and how to be kept informed
- Project partners
- Key words listing: General concepts, Major Mental Health Problems
- Report in English and French analysing staff questionnaires
- Reports on each training course with programmes
- Evaluation report on each course
- Four case studies with questions for staff, English and French
- Resources and articles
- Links to other web sites
- Possibility of e-learning about dual diagnosis

1.5. THE TRIADD PARTNERSHIP

The Triadd partnership is made up of service providers, a training institute and information/ consultancy service, a university and two European NGO's from six countries: Luxembourg, Belgium, France, Ireland, Italy and the United Kingdom (see annexe I for full partner details). The Triadd project is co-financed by the **Leonardo da Vinci programme**[1], the main European Commission instrument for the development of innovative vocational projects. `The programme promotes transnational projects based on co-operation between the various players in vocational training - training bodies, vocational schools, universities, businesses, chambers of commerce, etc. - in an effort to increase mobility, to foster innovation and to improve the quality of training. The Leonardo da Vinci programme aims at helping people improve their skills throughout their lives' (Source: European Commission web site, Leonardo da Vinci, April 2005).

[1] *See: http://europa.eu.int/comm/education/programmes/leonardo/leonardo_en.html*

CHAPTER II

THE NEEDS OF STAFF AND SERVICES

CHAPTER II– THE NEEDS OF STAFF AND SERVICES

At the beginning of the project and before we designed the training courses, front-line staff members from Belgium, France, Italy, Luxembourg, Ireland and the United Kingdom filled in detailed questionnaires about the people they cared for on a daily basis who, for various reasons, were diagnosed or identified as having Dual Diagnosis – seventy service users in total from six different countries and seven different services.

The responses given constitute a revealing and valuable source of information which can be analysed from a number of different perspectives. The main focus we placed was on two aspects:

1. The major challenges posed by Dual Diagnosis to all concerned, and the preferred solutions as expressed by the staff
2. Training – what staff had received in the past and what they felt they still needed.

2.1. THE MAJOR CHALLENGES OF DUAL DIAGNOSIS

List of the most difficult problems from the point of view of the service – as expressed by staff:

Behavioural: aggression – verbal and physical - directed at staff and peers - was fairly common. Unpredictability, overreactions, people needing constant attention, bizarre behaviour not understood or appreciated by others, frequent challenges to authority, compulsive obsessive behaviour, sexually inappropriate behaviour, constant screaming or crying, self-harming behaviour, complete withdrawal from the group for long periods of time. At the very least service-users refused to fit into the group schedule and activities.

Communication problems came up frequently as an issue; how to reach and interpret the needs of people with little or no verbal expression. All these manifestations of mental illness added up to an extra drain on staff and resources.

Staff often said that they wanted to help and to keep the atmosphere positive for the whole group but they lacked the necessary training to cope. Some even recognised that their own reactions exacerbated the situation for certain clients, but they didn't know how to change things.

They often cited the difficult co-operation with psychiatric services, who only intervened in times of acute crisis and usually only with sedative medication.

2.2. FOR THE INDIVIDUAL'S IMMEDIATE ENVIRONMENT

Behaviour created great tension and anxiety in the group, undermined trust, created conflicts; it was difficult to integrate the person with DD and this in turn aggravated their feelings of rejection and isolation. The person with DD could also be very unfocused and have difficulty recognising limits. There was sometimes alcohol abuse, stealing, sudden and unexplained screams or laughter. They could be frightening, show unpredictable extremes and sexually inappropriate behaviour towards staff and other residents/service users.

2.3. FOR THE FAMILY

Many staff said their service users had little or no contact with the family, which in some cases exacerbated the psychological problems; one or two staff members mentioned the hiding or disowning by the family of their child with dual diagnosis.

Many service-users had extremely difficult if not traumatic family circumstances where parents themselves had problems such as depression, illness and alcoholism. Some had been physically/sexually abused as children and also had siblings with similar problems.

On the other hand over-protection was also mentioned a few times, with family members `turning up' at a group home frequently and unexpectedly – not always to the delight of the service-user.
There were also support workers who knew nothing about the family circumstances, since written records were patchy or non-existent. A large number of staff members found it difficult to communicate with families who were concerned about the welfare of their son/daughter – there was a distinct lack of communication and understanding on both sides.

2.4. FOR THE INDIVIDUAL HIM/HERSELF

The majority of the individuals with Dual Diagnosis seemed to be going through nothing less than mental torment – to differing degrees and in various ways, but torment nonetheless. They were anxious, depressed, self-injuring, frightened, confused, angry, frustrated and often at a loss as to how to get out of that state. The picture was the same in every country - this user group was enduring very real distress, which seemed to be worsened (and to some extent probably caused by) the communication and understanding difficulties inherent to the developmental disability.

2.5. SOLUTIONS – ACCORDING TO THE STAFF SURVEYED

What would support workers like to do, given the specific problems they were faced with?

Generally, the majority of support workers filling this in did not consider the wider context of service provision but focused specifically on the individuals in their care. Many spoke of wishing to understand the person better, wishing they had more time to devote specifically to that person, to be able to reassure them, give them more confidence, trust and hope and help them integrate into the group and be accepted. Many staff members were frustrated that were unable to help end the misery. In this vein quite a few mentioned the need for quiet and a place in the centre or service where carers could communicate with the person with DD on a one-to-one basis, but this did not seem to be on offer in most services.
A number also called for better team co-operation and more support from supervisors in order to allow more individual attention. The staff in all countries surveyed felt over-stretched, under-valued and (in the case of the UK) underpaid – with salaries barely above the minimum wage. Whenever they mentioned mental illness in their clients they didn't feel as though they were taken seriously, and they didn't know to whom they could turn for support. Outside support seemed to be offered in times of acute crisis rather than be systematic and on-going (which might have helped avoid the acute crises).

Regular and systematic co-operation with the psychiatric and psycho-therapeutic services was therefore specifically requested. The Italian questionnaire report summed it up with a support worker saying: `We need to develop a shared language: On the one hand, when I report a case to a psychiatrist I do not know which elements are central to his work, on the other hand, the psychiatrist tends to underestimate a number of elements that I know the importance of.'

A number cited intensive individual therapy (for the client) as necessary, not just drug intervention. The great majority of clients in this survey were taking neuroleptic drugs and anti-depressants long term.

2.6. TRAINING

Many support workers also referred to their need for **training and better understanding of this condition**, because they currently had to rely on common sense, and this clearly wasn't enough.

Previous training:

Of the sixty one support workers filling in these questionnaires, only thirteen had received any training on the issue of mental health and mental disability, and two specifically on the issue of Dual Diagnosis.

The subjects requested for further training were:

- Basic training on Dual Diagnosis with specific case studies and real solutions – not in clinical terms with medical terminology
- Theoretical background and explanation to these problems

- How to recognise pathological behaviour and what to do
- What are the boundaries between psychopathological behaviour and disability and what are the overlaps; to what extent does the developmental disability affect the psychiatric disorder and conversely to what extent do these illnesses impair cognitive functioning? Clearly there are no ready answers to this complex issue of diagnostic overshadowing and each case is different; however it merits far greater specific attention.
- Challenging behaviour & aggression – how to react and deal with it in a residential setting?
- Specific therapeutic approaches
- Basic psychology and counselling skills
- Management skills and organising the service
- How to collaborate better with psychiatric services – develop a shared language and avoid jargon, sharing the work load
- Medication – an explanation about the drugs and their effects
- Health and dietary needs
- Communication with families, also about finances and relationship problems
- Staff motivation
- Communication tools between support worker and client
- How to promote integration into a group of workers (and manage a group)
- Training on Borderline syndrome
- Grief counselling and coping strategies for clients coming to terms with death of family members.

2.7. KNOWLEDGE OF INTERNET AND E-MAIL

One third of the sixty one respondents said that they had never used internet or e-mail. It was clear from talking to services, staff and analysing their questionnaires that three key problems stood in the way of an e-learning (tele-training) approach:

There was a distinct lack of IT culture in the services, limited or no access to computers, and relatively little experience of using internet or e-mail.
There was also scepticism about the usefulness of this – one staff member said: `What e-learning does not do is share feelings, disappointments and experiences. This work is not KNOWLEDGE based it is about exchange with other people who understand the problems'[1]. A number specifically requested traditional face-to face training courses, saying that computers required too much time and discipline.

Since we had limited scope to turn this situation around by providing computers and training before devising the courses, we opted for a compromise solution of offering information on the web site before the courses. The web site also serves as a documentation centre with resources specially chosen for their `accessibility'. We have also transposed very basic knowledge about Dual Diagnosis into an e-learning format and delivered all the training courses in a traditional format with live (animated!) trainers.

[1] *Quote from Irish participant during staff evaluation, March 2005*

CHAPTER III

THE TRAINING COURSES

CHAPTER III – THE TRAINING COURSES

3.1. TRIADD – GUIDELINES FOR TRAINING COURSES

We developed common principles and guidelines to inform the Triadd courses, as well as specific elements which should be addressed and included in each course.

1. Enable staff to understand the person with Dual Diagnosis in his/her environment

- Convey the message to staff that people with intellectual disabilities can have problems like anyone else (give explanation of major dysfunctions) and say that these problems can interfere with the normal `functioning' of the person
- Give concrete examples of HOW these changes can present themselves
- Convey the message that people with an intellectual disability and mental health problems are first and foremost people, whose complex histories and set of circumstances all have a bearing on their current well-being. Try to take a holistic approach with the ultimate goal being the improved quality of life and respect for the dignity of the person concerned.

2. Help staff to reflect on the possible reasons for these problems/changes

With which tools, observation, etc. can these changes be observed, documented, foreseen, even anticipated?

3. Help staff to draw on their own resources of adaptation, of change in attitude, to review their socio- educational approach in relation to these new issues

- Re-examine (in a constructive way) their approach/intervention – Show that their relationship, their attitude is a decisive factor in the issue, either as catalyst or in a reactive way.

4. Enable staff to formulate problems in a more systematic way

Help them to construct schemes of solutions which will allow them to constantly recreate 'new' and/or adapted answers and solutions (analysis of practice……)

5. Make reference to measures which can be taken within a multi-disciplinary team as a possible resource.

Suggest measures which can be put in place regarding co-operation with exterior partners.

6. Highlight the realities of the service in which these solutions must be found

Provide the teams concerned with analysers /indicators on the impact of the course on their service/institution.

7. Allow time for the presentation, analysis and discussion of specific cases/ vignettes.

To optimise this debate ask staff to prepare one or two cases each before the course, to be structured along the following lines:

Description of the situation and individual they work with

Definition of the problem

Solutions already tried by the staff, team…

Questions and other points raised

3.2. THE TRIADD TRAINING COURSES

The third phase of the project saw six project partners in Luxembourg, France, Belgium, Italy, Ireland and the UK devising courses which were a combination of:

- Solutions to meet local demand, based on their experience and the results of the survey
- Differing approaches based on their own expertise and in discussion with the whole Triadd partnership
- Training Guidelines of the project.

The following is a brief overview of each course. For more information see the previous publication: Achievements so far (June 2004), detailing:

- Title, type, dates, venue, trainers, description, objectives, programme, methods, documentation, target audience, language, evaluation and follow-up.

3.3. THE LUXEMBOURG TRAINING COURSE

Title:

Supporting a person with Dual Diagnosis (Encadrement d'une personne avec un Double Diagnostic) October 2003

Trainers:

Dr. Germain WEBER, Professor of Psychology, University of Vienna
Johan DE GROEF, Director Zonnelied, Psychologist
Dr. Paul BERRY, Chartered Psychologist & TRIADD observer

Description:

A three day in-house training course with a combination of expert exposés and participant input.

Objectives

- Basic understanding of dual diagnosis
- Analysis of existing service solutions in Luxembourg
- Consideration of the different means of support available in Luxembourg and the educational readjustment necessary to support people with dual diagnosis in the various structures catering for them

Programme

Staff issues: the effect of dual diagnosis on the support staff and the user concerned

- The effect of psychological problems on the disabled person
- Comments on certain notions and basic texts
- Methodologies of observation and analysis
- Understanding behaviour and emotional aspects
- Reactions of support staff faced with dual diagnosis
- Reactions of counter-transference
- Value of educational objects used

Readjustment of the educational/ support approach

- Adapting the educational objectives in relation to the person with dual diagnosis
- Flexibility in educational approach
- Reaching the educational objectives despite the illness(es) of the person cared for
- The different interventions possible
- The multidisciplinary team
- The systemic approach

Evaluation

Most participants were well-trained front line staff supporting at least one client with dual diagnosis. Two were psychologists, one of whom also presented an overview of the services for clients where most participants worked.

The participants rated their knowledge of dual diagnosis as (mean) 3.0/5.0 before the course and (mean) 3.7/5.0 after the course. It seems that this group was generally better informed of the nature of this problem than participants in the other groups.

The participants in this group provided a good deal of general and quite specific feedback in their comments. These can be summarised as follows:

1. more time needed for discussion of case studies
2. more time needed for the presentation and discussion of cases which the participants were currently dealing with
3. more time in general – three days was not enough
4. follow up study days with specific course staff
5. more on psycho-pharmacy
6. more on the issue of ageing, especially dementia
7. more on the need for and the ways to address the problem of psychotherapy for the difficult clients with dual diagnosis
8. more on how to establish and co-ordinate work in multidisciplinary teams.

A fuller evaluation report and quotes from the participants is available on request.

Follow-up

Follow-up questionnaires filled in by participants to assess the impact of the training six months after the course confirm its benefit to their general understanding of dual diagnosis and their work directly with clients. What still needed improvement was work in multidisciplinary teams outside their own service. Certain participants requested recommendations for further theoretical input.

3.4. THE FRENCH TRAINING COURSE, JUNE/JULY 2003

Title

The care offered by services to people with intellectual disabilities presenting severe personality disorders and challenging behaviour

(`La prise en charge institutionnelle des personneshandicapéesmentalesprésentant des troubles graves de la personnalité et du comportement')

Trainers

Gérard ZRIBI, Director, AFASER ;Ariane VIENNEY, Director Foyer AFASER; Thierry BEULNE, Directeur, Atelier AFASER; Dr. Paul BERRY, Chartered Psychologist; François LERASLE (facilitator)

Description

A three day in-house training course with a combination of expert exposés and participant input, attended by TRIADD observer and therapist, who also discussed case studies presented.

Objectives

- To give professionals the possibility of acquiring basic knowledge and a better understanding of people with dual diagnosis (intellectual disability/ mental health problems)
- To reflect on the best means of care and support for this target group.

Programme

About the person

- Presentation of the main mental health problems and psychological dysfunctions.
- Approach to different types of learning disability
- Looking at psychological, sociological, social, cultural elements in order to reach a fuller definition of the personality and problems
- Methodology of observation and understanding different behaviours.

The project of the service-provider (`Le projet institutionnel') and the role of the different players

- Making the service-provider's project and the individual's project fit together (L'adéquation entre projet institutionnel et projet individuel)
- The multi-disciplinary team
- The link with external partners
- Example of the functioning of a workshop (CAT) and other services (foyers) for people with dual diagnosis
- Development of an individual care plan project and the constraints of the service (élaboration d'un projet d'accompagnement individuel et contraintes institutionnelles).

Partnership and complementarity between the psychiatric services and the social and socio-medical sector.

Documentation

Key words from Triadd project

ZRIBI,G,POUPEE-FONTAINE,D, Dictionnaire du handicap – Editions ENSP 4ième édition, 2002
ZRIBI, G, SARFATY, J, sous la direction – Handicapés mentaux et psychiques – vers de nouveaux droits, Editions ENSP, 2003
GALLAND, A, L'enfant handicapé mental – Editions Nathan, 1993
ALBERNHE, TH, Psychiatrie et Handicap – éditions Masson, 1997
CTNERHI, Classification internationale des handicaps – CTNERHI, 1989.

Evaluation

It should be noted that this was a rather heterogeneous group of participants in that their qualifications and experience ranged widely. The overall results were reported to be satisfactory or better on most points of the course, but the less experienced participants were more positive than their very experienced colleagues, as is usually the case.

A point system was allocated to the questionnaire enabling the evaluator to judge whether the results tended to be positive or negative – a useful context for the comments. The results were:

1. course satisfaction:
   59 positive points
   21 neutral/negative points
2. course objectives:
   60 positive points
   20 neutral/negative points
3. learning effectiveness:
   47 positive points
   33 neutral/negative points
4. improvement due to the course – level of knowledge before the course was reported as 47/100 points, after the course 65/100
5. 14 of the 20 participants reported substantial improvement of knowledge of dual diagnosis due to the course
6. 18 of the 20 participants commented that the course content was appropriate for their work.

General comments from the French participants included :

1. the basic lectures on the first day provided an excellent starting point for the course especially the explanation of the differences between mental disability and mental health problems
2. there were very positive comments on the cases studies presented on the second day, the vignettes being especially helpful
3. case discussions in smaller groups were considered to be a powerful method of learning to understand the problems facing staff both in the area of diagnosis and treatment
4. the detailed discussion of services and the issues facing staff, families and service administrators was positive, especially in the context of community living for this group was positive
5. on the negative side, there was a tendency to state that the course was not long enough and that there was not enough time to discuss the cases to the degree of detail the participants would have liked.

3.5. THE ITALIAN COURSE

Title

Training for Staff in Dual Diagnosis

Trainers

Dr. Gianpaolo La Malfa, "Careggi" Hospital, Florence; Vice President SIRM; Dr. Prof. Marco Bertelli, Direttor SIRM and Direttor AIsQuV
Dr.ssa Claudia Cavalieri, USL Agency of Bologna.

Description

From a basis of stimulating theoretical ideas and clinical experience presented by the trainers, the participants were divided into two groups in order to analyse two real cases. In the first, participants were asked to identify the diagnostic elements and to suggest an intervention strategy. In the second, participants were asked to adapt the socio-educational support and assistance, bearing in mind the medication received by the user.

Objectives

- To provide the basic elements of knowledge necessary to promote a dialogue and collaboration between professionals and various departments concerned
- To lay the foundations for a future collaboration on the methodology of managing people with dual diagnosis, between the various services and various operators.

Programme

- Two parallel sessions, one in the morning, one in the afternoon, on the same day.
- Thirty trainees, maximum, for each session
- Sixteen hours each session, subdivided into 4 half days of 4 hours each

First Day: 17th October 2003

- Theme: What is dual diagnosis: diagnostic criteria, roles and limits of therapy
- Trainer: Gianpaolo La Malfa

Second Day: 29th October 2003

- Theme: Transference and theories of intervention
- Trainer: Marco Bertelli

Third Day: 13th November 2003

- Theme: Medication in the rehabilitation of patients with DD: drawbacks and opportunities
- Trainer: Claudia Cavalieri

Fourth Day: 27th November 2003

- Theme: The relationship with the patient with Dual Diagnosis: what is there to know?
- Trainer: Gianpaolo La Malfa

Documentation

CD Rom: containing the background to the Triadd project in general, the specific preparation and setting up of the course in Bologna, the guidelines to training agreed with the Triadd partners, the Key Words translated into Italian. The CD Rom also contains all the documentation relative to the Italian training course – the presentations given, bibliography, other partners' courses, the programmes of cooperatives which took part in the course.

Evaluation

All but one of the 49 participants reported increased knowledge of dual diagnosis since attending the course. Compared to the other courses the average increase from a mean of overall knowledge of dual diagnosis of 2.9/5.0 to 3.3/5.0 reflects the general trend - namely that the course had a positive effect on learning for the participants.

The course participants were very positive about the objectives and pedagogical methods of the course and rated the course lecturers very highly in their competence and knowledge of dual diagnosis. A high ratio, 42 of the 49 participants said they would be able to use the course content in their job.

An issue raised later concerns the mix of professionals taking part in this course. Twenty one of the participants - almost half - reported that the participants were not well mixed.
The participants made numerous comments on their evaluation questionnaires. Many reported that they liked the enthusiastic lecturers, the material on diagnostic procedures and the multi-disciplinary approach. The major criticism was the lack of participation of personnel from the mental health department and in particular psychiatrists (21 participants stated this). One person stated that the 'course was totally ineffective' because of this absence.

3.6. THE BELGIAN TRAINING COURSE

Title

Training Cycle – Zonnelied: Adults with Intellectual Disabilities, September 2003

Trainers

Johan De Groef, director, Zonnelied, Psychotherapist
Dr. AM Geussens, Psychiatrist
Eddy Weyts (director of Observation and Treatment Psychiatric Cli1nic of Bierbee)
Dr. Paul BERRY, Chartered Psychologist

Objectives

- To familiarise professionals with one single framework of reflection: the theory of 'anthropopsychiatry'.
- The application of this framework, on the basis of case studies
- The further clarification of this framework through the use of practical examples
- To situate this work in the framework of the regional care circuit and the Dual Diagnosis group within this network.

Programme

1) Six training modules

- Introduction
- Definition/different theories
- Observing/interpreting transfer/subjectivity
- Presentation of the anthropopsychiatric model
- lines of development
- structures
- normal and abnormal
- at an individual/group/institutional level.

2) Contact (`le contact')

- Mood/ambience
- Problems of mood

3) `Le sexuel'

- the body
- perversion
- aggression

4) The Paroxysmal

- Rules and norms
- Neuroses
- Function/role status

5) The Ego (`Le moi')

- identity (the verbs : to be and to have)
- psychoses

6) Therapeutic Methods

- medication
- psychotherapy
- the pedagogical milieu
- the family
- the group
- the service/institution as a therapeutic tool
- the care circuit in the Brabant Flemish province

Second part

At least 8 case studies (each case 2 hours) brought by the support workers.

Methods

Theoretical exposés by experts (psychiatrists, therapists service directors) having written on this subject. Each participant was asked to prepare three case studies or situations relating to their work directly with users. Discussions on presentations and exchanges took place on cases presented by participants.

Documentation

Key words from Triadd project
V. Sinason: Mental Handicap and the Human Condition
S. Korff-Sausse: Le Miroir Brisé
Johan De Groef : Psychoanalysis and Mental Handicap

Evaluation

The Belgian course took place on three separate days. The evaluator attended only at the end of the course and only 7 questionnaires were received. The course differed from the others in that it was specifically psychodynamic/ psychoanalytically orientated.

Of the 7 respondents, not one had visited the website nor read the key words. The participants however rated the face to face course positively. For example they rated their knowledge of dual diagnosis as (mean) 3.3/5 after the course compared to (mean) 2.6/5 before the course. Of the 7 participants responding, it must be noted that three were psychologists, the others being trained as care staff and in pedagogy.

They rated other aspects of the course as follows:

1. course objectives
   15 positive points
   7 neutral/negative points
2. course organisation
   28 positive points
   7 neutral/negative points
3. learning effectiveness
   20 positive points
   8 neutral/negative points

Comments on the course suggested that the case studies presented were especially important. The participants commented that the theoretical aspects of the course were especially meaningful and that this aspect and orientation of the course helped these front line staff in the process of self reflection. This point was emphasised by almost all the responding participants. One criticism was that it might be better to have a three day intensive course rather than three one day separate sessions. The general feeling was that this rather specific orientation (i.e. psychodynamic approach) seems to be a useful approach in the diagnosis and treatment of people with dual diagnosis.

3.7. THE IRISH TRAINING COURSE, OCTOBER 2004

Target group

front-line staff of the South Side Intellectual Disability Services, South West Area, Health Services Executive.

Trainers

Johan de Groef (Belgium) and Paul Berry (Luxemburg/Germany)

Course Outline:

Day 1 a.m. Introduction of course leaders and front line staff and identification of current issues in the work of staff with specific cases
Day 1 p.m. Aspects of psycho-dynamic work with people with dual diagnosis

Day 2 a.m. Case discussions in small groups

Day 2 p.m. Case I - Presentation, role play and analysis

Day 3 a.m. Case 2 – Presentation and discussion on Psychopharmacology by Dr. John Hillery, Consultant, Stewart's Hospital, Dublin, and President of the Irish Medical Council, Dr. Philip Dodd, Consultant with the St Michael's House Service

Day 3 p.m. Case 3 – Presentation, role play and analysis. Course conclusion and evaluation

Evaluation

16 Evaluation forms were completed.

Basic Qualification as follows:	
RNMH	7
RNMH/Psychiatric Nurse	4
Care Assistant	2
General Nurse	2
Psychiatric Nurse	1

Current Occupation	
Psychiatric Nurse	6
Care Assistant	3
Nurse Manager	3
Day Service	1
Director of Nursing	1
Clinical Nurse Specialist	1
Development Manager	1

Length of Service	
< 1 year	3
2-4 years	7
5-10 years	2
10-15 years	1
15-40 years	1
40 years	1
* 1l.o.s not completed	

Use of Website

Of the 16 participants who completed the form, 13 had NOT visited the website prior to coming on the training.

2 Participants had visited the website (both senior people in the organisation) and both commented that the site needed updating, or that there was little available.

Knowledge of dual diagnosis before and after the course.

Participants were asked to rate their level of knowledge of dual diagnosis on a five point scale, before and after the course.

Of the 16 participants, two did not rate, and one rated their knowledge as less after the course than before. (this may have been a misunderstanding of the direction of the scale). For the other thirteen participants, 7 rated themselves the same before and after; 3 rated themselves one place higher after the course, 2 rated themselves two places higher, and one person rated themselves three points higher.

The number of people showing no movement may have been a reflection of the high self ratings before the course, as 5 people rated themselves as three, 7 people as 4, and one as 5, where 1 = 'no knowledge', and 5 = 'fairly full knowledge'.

Comments from the forms:

The commentary associated with the rated answers however were almost universally positive about the course and the course facilitators. Comments like 'I loved the course' and "excellent course overall" and "brilliant, found the course excellent" went alongside comments like - "wanted more time to explore the psychodynamic approach".

Many respondents made comments around their understanding after the course of the importance of history, and the impact of key events in people lives.

There were many responses about the length and balance of the course, both stating that the course could have been longer, and perhaps spread over five days with more case studies, and also with more time to explore psycho-dynamic theory.
One theme through the responses was the need to be able to apply the learning in the workplace, with comments about the need for management support and the introduction of supervision and support to assist this.

Overall the course was rated very highly on the evaluation. This was a group with a good deal of experience, some in senior positions in the organisation, and also many respondents had professional qualifications. It was clear that as well as taking a good deal from the course, participants were keen to see some follow up, and an opportunity to put into practice what they had learned, with support and under appropriate clinical supervision.

Notes on verbal feedback after Dublin Training course, 13th-16th October 2004 (Attended by John Northfield and Jackie West).

1) What went well? (miscell. comments)

`It broadens your mind to look at the history of a person'
`Importance of resolving emotions'
`Important to ask: How are you? & think about 4 questions put up by Johan (in powerpoint)
`Like the case studies, we're dealing with individual people - as a service - how do we manage all the emotions coming up?'
`I liked the delivery of the course - it was formal but delivered in an informal way; understandable language'
`I liked the fact that PB & JdG spoke from personal experience'
'The role play was very powerful'
'The session on psychiatry and medication was a good counterbalance to the previous two days'
'The last day's session was a good refresher on medication - there was enough time given to this session'

2) What should be different?

'It would have been useful to link the four questions (how are you, what do you like etc) to the cases to see how they can really be applied'
'There was too much time spent on the first case and not enough time on the others'
'I would have liked a more theoretical explanation of the psychodynamic approach before the cases'
'There was not enough time to discuss the cases'
(in answer to the above')'This course was not a case conference; what would have been useful is a sort of aide-mémoire of this approach to help us help clients more, including the historical timeline and milestone identification etc'
'we would have liked more on staff burn-out and coping strategies'
'Would have liked more on aggression'.

3) What will we take away?

'Do we have a policy on bereavement?'
'The studio 3 & person-centred low-arousal approach is complementary to this approach - clinical supervision is another layer'
'We need more time to talk about our cases on a regular basis'
'We don't have easy access to the kind of support we need with behavioural problems'
'It would be good if Paul & Johan could come back in a few months to review our cases'.

3.8. THE BRITISH TRAINING COURSE, 23RD-25TH FEBRUARY 2005-05-03, ST. LEONARD'S HOSPITAL, HACKNEY, LONDON, UK.

Towards the end of the project we were approached by a Learning Disability Service in London which had heard of Triadd via our web site. They were very keen to offer training to their front-line staff, so we agreed to set up a training course for them, with shared costs. The course followed the same basic outline as the Dublin one, with staff having filled in the training needs questionnaire beforehand, describing specific cases of users with dual diagnosis they were working with every day.

Trainers

Johan de Groef (Belgium) and Paul Berry (Luxemburg/Germany), Smythy Thiru, Community Mental Health Nurse in Learning Disability, City & Hackney Primary Heath Care Trust.

Course Outline

Day 1 a.m. Introduction of course leaders and front line staff and identification of current issues in the work of staff with specific cases

Day 1 p.m. Aspects of psycho-dynamic work with people with dual diagnosis

Day 2 a.m. Case discussions in small groups

Day 2 p.m. Case I - Presentation, role play and analysis

Day 3 a.m. – Presentation of Psychiatric Disorders in People with Learning Difficulties, Smythy Thiru, Community Mental Health Nurse in Learning Disability, City & Hackney Primary Heath Care Trust.

Day 3 p.m. Case 3 – Presentation, role play and analysis. Course conclusion and evaluation

There were thirty participants on this course – it was a multi-cultural group - many of whom were not native English speakers.
Twenty evaluation forms were returned, from which the following data can be gleaned:

Basic Qualification as follows:	
Social work	5
Bsc Psychology/ Counselling	2
Mental Health Promotion diploma	3
Support worker	4
BA Cert. Education	1
NVQ Care/Independent living/Health promotion	3

Current Occupation	
Care Manager	9
Support worker	6
Nurse	2
Day Service	1
OT Manager	1
Person-centred planning co-ordinator	1

On the assessment of how their knowledge of mental health and learning disability had changed as a result of the course, two said it had not changed, thirteen said it had increased by one or two marks out of five, and two said it had decreased (again, possibly a misunderstanding of the scale).
The majority of comments were positive about the course, especially the case study work. The following are some of the verbatim comments from staff on the course. which give a reflection of the views of the whole group:

' I found the web site very easy to understand and helpful to understand the psychological terminology'. Nevertheless only four participants out of nineteen had actually visited the web site, despite knowing about it several weeks before the course.

'The case study work was very good. Too short.'
'it was very refreshing to redefine ways and look at new approaches……Request: Further alternative methods on communication and gentle teaching'.

'I really enjoyed the course and felt it put complex issues into everyday language and more importantly into practice with lots of examples'.

'I am going away very enthused'

'The group was too large. I would have liked more on psychodynamic theory'.

'I would have liked more examples on how to apply these ways of working'.

'There was bad time-keeping and the group was too big'

'This was valuable knowledge in dealing with complex issues'

'I would like to know more about working with families in this way.'

'Is there any chance of a follow-up?'

3.9. THE PSYCHODYNAMIC APPROACH

The Belgian, Irish and British courses followed a psycho-dynamic therapeutic approach, as explained here by Dr. Paul Berry:

Introduction for Service-Providers to a psycho-dynamic approach in working with people learning disabilities and mental health problems.

Target group

Front line staff working with people with dual diagnosis.

The aim of the course is to help front line staff to think very carefully about all aspects of the client, especially at the biographical, emotional and relationship levels, so that work of the front line staff will make more sense.
This training course is based on psycho-dynamic work with people with dual diagnosis. Each course is tailored to the questions, issues and problems faced by the team (**front line staff etc**) attending the course. The trainers, experienced in working within this framework with front line staff for many years, tailor the course to the individual and team needs of the participants. They do this through practice - the **analysis of cases** brought to the course by the front line staff, and psycho-dynamic theory. The theory is meshed into these concrete cases and is practice-orientated.

What is emphasised in the course is the need to ask questions about the individual's life – to write a **biography** of the person linked to a diagnosis and options for therapy and a 'life-future'. What were the early experiences? How was family life? Where did the person live and under what circumstances? What are they experiencing now? How does the person feel about his/her life? How does the person seek contact? This process is essential in the diagnostic phase.

Much of the course is concerned with the discussion of **the person** and especially his ego functions (such as frustration tolerance/ mental level,etc). Depending on the cases presented by front line staff, there is always time to discuss major aspects as **aggression/auto-aggression** in this work. What does it mean? Where were the origins of these 'acting outs'?
Four basic questions (referring to a psy-chodynamic framework for the whole field of human mental health problems) must be asked in order to understand a person (any person):

1. How do you do? **(MOOD)**
2. What do you like? **(PLEASURE/PAIN)**
3. What may you do, with whom, when and where? **(RULES AND LAWS)**
4. What do you want to be and what do you want to have? **(IDENTITY)**

These questions are discussed in **small group work** with the trainers in order to create a realistic but lively picture of the person. This 'creation' of the personality, the feelings and the aspirations of the person will help staff to understand that person. These are also important for the front line staff to understand THEIR role (transference) in that person's life. How do they feel about their work with the client? How do they communicate this to them and their front line staff colleagues? In addition to the small group work there is an important component of the course which involves **role play**.

The trainers are aware of other approaches to working with people with dual diagnosis and attempt to place psycho-dynamic theory within a broader framework. This is especially important in the context of **team work** and the roles of all the professionals who play a major role in creating a **life of quality** for people with learning disabilities and mental health problems.

3.10. GENERAL POINTS ABOUT THE COURSES

Each partner had the flexibility to tailor their course to local needs, keeping to the general guidelines and the recommendations emphasising front-line staff as the key target group. The aim was to de-mystify dual diagnosis and empower staff to act appropriately, offering basic diagnostic tools and trying to build on the foundations of knowledge most of them already had, by putting these into a more theoretical framework. Clearly staff are hungry for more training in this area and especially eager to discuss their specific cases. The thematic emphasis and therapeutic approach differed depending on the course, but in all courses a number of issues still need further development and resolution, namely:

1. the problems of co-operation with psychiatrists, many of whom have little or no interest in this field

2. the issue of emotional development in clients with dual diagnosis; the issue of bereavement and how to offer counselling

3. the issue of treatment of clients with dual diagnosis and communication problems (i.e. who cannot communicate verbally with staff, who have in turn extreme difficulty in understanding their needs)

4. the problem of multidisciplinary work – how to contact other external professionals; how to build up a good team and work effectively together in the same service.

CHAPTER IV

EVALUATION AND IMPLICATIONS FOR SERVICES

CHAPTER IV – EVALUATION AND IMPLICATIONS FOR SERVICES

4.1. PROJECT EVALUATION

We took a number of steps to evaluate the project throughout its duration, notably internal partner evaluation (verbally at the meetings and via questionnaire) evaluation of the training courses at the end of each course (the results of which appear in each training section) and we also enlisted the help of a professional research institute in Italy: La Società Italiana per lo Studio del Ritardo Mentale (SIRM)conducted by Dr. Marco Bertelli.

The following report shows his findings after summer 2004 (before the two final training courses) and includes a more thorough scientific approach to the assessment of service competence in dealing with dual diagnosis, as well as a table for the assessment of general outcome measures following training:

EVALUATION of the TRIADD PROJECT 2004/5
(SUPERVISION Supplement A)
Dr. Marco Bertelli, SIRM

Areas of evaluation: work programmes (work packages, meetings), products (courses, WEB site and publications), results, limits, future developments and improvements.
Parameters of interest: characteristics of trained staff and professionals, characteristics of trainers, methodology and topics of training.
AIM OF THE PRESENT PAPER

The present overview aims at extending suggestions and criticism of the previous report in a discursive and less formal way.

Introduction

Multidisciplinarity, life-span, evidence-based guidelines, and Quality of Life (QoL) are the key words in the most modern theories of intervention on DD.
Mental health assessment should be multidisciplinary, including different health and social care professionals. Carers and all front-line staff members are fundamental contributors to the assessment process since they can provide important information about the person, the way he/she expresses their emotions and thoughts, the real nature of the problem, and changes that have happened.
It is generally believed that it is not just one factor that causes a person with ID to develop a mental health problem, but a combination of biological, psychological, and social factors. When facing a mental health problem all front-line staff members should look for causal factors throughout the life span of the person with ID.
Quality of life is the basic concept that has extended or even changed the intervention on

intellectual disability and mental health problems over the last decade. According to this concept the intervention should not aim at reducing the differences between a person with ID and a person without ID (what is called normalisation), but it should aim at helping the person with ID to live a life of satisfaction. Practitioners who carry out assessments, interact with, care, or plan interventions need to blend QoL concept into their work. They need first to look at the presenting issue in terms of the person and the environment within which he/she lives and consider interests, wishes, priorities, and the actual level of satisfaction.
Due to the pervasive lack of knowledge, the lack of valid and reliable instruments, the lack of standardised guidelines and the terminological confusion, references to evidence-based findings are fundamental in this field.

Evaluation of achievement of triadd objectives

OB. NUM. 1 – To bring together existing knowledge and training practices for professionals concerning dual diagnosis

Add a data centre with links and addresses of the resources that could be useful to the front line staff members. For every reference the centre should give indications of quality and specific usefulness.

OB. NUM. 2 - To perform a needs analysis survey amongst care professionals on key elements to be included in future training

Control if main point from the international literature on staff needs have been taken into account by the project.

Staff are often supporting clients with a range of challenging behaviours, including aggression and sexually inappropriate behaviour in community settings, and such staff are likely to be the victims of assault.
Both health and social care staff have been found to be lacking knowledge about the basic defining features of an intellectual disability or a dual diagnosis and their duty of care to intervene if clients put themselves or others at risk.
Staff have been found to be lacking knowledge, training and confidence in managing challenging behaviour and sexually inappropriate behaviour.
Staff behaviour has been shown to affect the occurrence or non-occurrence of challenging behaviour.
Some attention needs to be drawn to staff that find it difficult to transfer the ideas and knowledge they obtain in the training to their work settings. For these staff continuous training applied to their daily activity and their work site on the issues presented in the workshops should be a valuable supplement to the training package.

Evaluating the effectiveness of staff training is difficult. The outcome of training can be affected by a number of factors; the social, organisational and political context that the staff work in (i.e. if changes in staff attitudes, knowledge and behaviour are not supported in the work environment they are unlikely to be maintained over time); staff characteristics (i.e. experience, skills and knowledge); the perceived quality, relevance and applicability of the training itself.

It would be important to investigate how different teams (across Europe and within each country) work and with what organisation. Through the web site or future publications, 2 or 3 tables could be provided to summarise how a team for DD should be organised and on what theoretical principles. The same tables could be used by trainees to make a sort of self-evaluation of the team they are working in and principle or practice they are following. Examples are enclosed below.

PROFESSIONAL	
Assistant	
Educator	
Consultant Psychiatrist*	for adult
	for child and adolescent
Psychologist	
Nurses	Specialist
	Manager
Social Workers	Principal
	team leader
Consultant General Physician	
Consultant Specialist Doctors	
Occupational Therapist	
Speech and Language Therapist	
Physiotherapist	
Other Therapist (Music, Art, Dance, etc.)	
Administration officer	

*dually trained in general psychiatry and ID psychiatry

What are the theoretical grounds on which your team's activities are founded ?
(for which you've been trained at some level)

	YES	NO
Basic notions on DD		
Psychological problems		
Presentation of symptoms		
Educational perspective		
Multidisciplinarity		
Evidence-based practice		
Psychodynamic		
Medication		
Therapeutic methods		
Life span approach		
Quality of life		

It is important to establish clearly the type and nature of the training needs of the service in question and to establish which goals the training is designed to meet and which outcome measures will be used to evaluate effectiveness.
There is currently insufficient evidence to unequivocally establish the effectiveness of staff training alone in improving staff practice. Thus, the gathering of feedback on usefulness of training from the participants would be very important. The organisation of a structured research of outcomes could even bring to add important knowledge to the main literature.

OB. NUM. 3 - To develop new training packages for professionals supporting this target group

The analysis of the characteristics of the courses displays a lack of homogeneity of topics and professional figures among trainers and trainees. Three out of the four courses (run in Luxembourg, France, Belgium and Italy) did not take into account fundamental topics like QoL approach, life span, medication. Only two of the four dedicated an appropriate space to the description of the multidisciplinarity issues.
For the future it could be useful to pay more attention to this homogeneity to make international comparisons and cooperation easier. Topics that are considered crucial by the prevalent literature should be included in all courses.
Another important point for further activities is that front-line staff members need not only technical but also psychological and emotional support. It is important for them to know what help is available and to learn how to manage stress levels. Some areas of training could also underline the value of working with ID, show how to increase the sense of being in control and how to have a positive impact on mental well-being.

OB. NUM. 5 - To offer this new training product to a broad European target group of care workers, other social sector professionals and training institutions

To this purpose it would be important to establish further collaboration with main European scientific associations, professional organisations, and training agencies. See also OB N.1.

OB. NUM. 6 - To offer tele-training to front-line staff on the issues involved in supporting people with dual diagnosis

For those staff members who are able to use computer and internet resources, the WEB site should be improved with interactive spaces. This would be useful to gather feedbacks from the users and occasional visitors and to give them the opportunity to make questions or express suggestions on what is more important for their daily practice. A FAQ list (for frequently answered questions) would be also nice.
Working on case reports seems to be more useful than just giving theoretical notions. Thus presentations and discussions on cases could be appreciated by front-line staff members. More generally, all future trainings should be case-orientated.

General outcome measures

The only available evaluations are those given by participants to courses. Evaluations of web-site visitors are lacking. The evaluations of participants to courses are mostly referred to characteristics of the course itself rather than to the TRIADD product as a whole. Furthermore the areas surveyed in the post-course questionnaire (knowledge gain, course objectives, course organisation, learning effectiveness) seem not to cover all the potential outcomes of a training programme. A more comprehensive list of measure could be the one reported below.

		LOW	MODERATE	HIGH	VERY HIGH
	Usefulness				
Subjective	Validity				
	Quality				
Cognitive	Knowledge Gain				
Behavioural	Impact on Behaviour				
Client centred	Impact on Clients				
Organisational	Impact on the Work Organisation				

Subjective i.e. what staff report about the usefulness, validity, and quality of the training; Cognitive i.e. knowledge gain; Behavioural i.e. the impact of training on staff behaviour; Client centred i.e. the impact on clients; and Organisational i.e. the impact on the work organisation. (Dr. Marco Bertelli).

4.2. FURTHER REFLECTIONS ON IMPLICATIONS FOR SERVICES

A useful guide has been drawn up by the UK Department of Health (Valuing People Support Team) in which they say: `most psychiatric disorders are more common in people with learning disabilities than in the general population. As with their other health needs, people with learning disabilities should be enabled to access general psychiatric services whenever possible…' It is acknowledged, though, that there needs to be: `…access to an acute assessment and treatment resource for a small number of individuals with significant learning disabilities and mental health problems who cannot be appropriately admitted to general psychiatric services, even with specialist support'[1]. This `Service improvement toolkit' includes an Easy to read summary; What's expected and what wanted from services; Putting policy into practice; Moving forward in your local area.' It emphasises the need for a partnership in this exercise with mental health services, learning disability services and service-users themselves.

See Annexe III: Some Advice for service-providers.

[1] *Green light for Mental Health – How good are your mental health services for people with learning difficulties?-A service improvement kit, www.valuingpeople.gov.uk*

4.3. THE VIEW FROM A SERVICE PROVIDER AFTER TRAINING

One of the last courses we organised - the one in Dublin in October 2004 – seems already to have brought about an attitude change on the part of staff and supervisors. All services were asked for their views but to date this is the only response we are able to publish in this brochure:

1) What, for you or your organisation, has been the value of the transnational activities of the Triadd project?

The value of seeing how other countries are managing these service issues in a client focused way. Looking beyond managing the behaviour but working with the person in a longitudinal way. Looking at how the client with personal history is affecting the present and working with that history to change the future for that client in a positive manner. This has been enhanced by the transnational approach/perspectives/values of different countries/cultures and the approaches learnt have been of great value to us as a service.

2) What would you say are the main achievements at national or transnational level?

Benchmarking of approaches and values in seeing are we in step with our European neighbours. The value of information exchanges and resulting confidence in examining our own services approaches to see can we do it in a better way.

3) What did you do/write to disseminate news of the Triadd project?

We made all the information and website address available to all our staff and encouraged discussion on the whole area.

4) What, for you or your national contacts, were the 'value-added' innovative aspects of the project?

A raised awareness of staff of what many may have felt intuitively that it is important to see our clients beyond a set of behaviours and value them in context to their lives and the experiences both past and present that they have felt.

5) Have you planned any activities to further develop the project results?

We are examining the development of further training in the area to inform frontline practice. The whole experience has raised for us the value of supervision and reflective practice to allow staff to value the client in perspective of the life they have and are living.

6) Do you intend to transfer any of these results to other organisations in your country?

We are including the approaches learnt in any discussions with other service providers especially those involved on challenging behaviour. P. Galvin

Director of Nursing, South Side Intellectual Disability Services, South West Area, Health Services Executive

CHAPTER V

ELEMENTS OF QUALITY

CHAPTER V - ELEMENTS OF QUALITY

5.1 SOME SUGGESTIONS FOR THE ORGANISATION OF TRAINING COURSES...

Assessing Staff Needs

1. We cannot stress enough the importance of assessing staff needs before devising a training course, although it is mostly common practice now, especially in Leonardo da Vinci projects. If staff are allowed to express where they need training and what their difficulties are, you clearly have a higher chance of delivering appropriate, relevant training and satisfying demand. In this way the trainees are also involved from the outset, rather than imposing a service initiative on them 'for their own good'. Training should build on a foundation knowledge participants already have.

Training not lecturing

2. Methodology: bear in mind that a training course is different from a seminar – it should not recreate a classroom situation whereby experts deliver their expertise in lecture form while participants take note. Training is more interactive. The objectives of the course should be reiterated at the beginning and approved by the trainees. A classic formula is to have a trainer give a theoretical presentation at the beginning and have the trainees work from this and develop solutions for themselves, in small groups, via role play or with a specific task and then come back together as a group to share and discuss.

Trainer Communication skills

3. It goes without saying that a trainer should be knowledgeable and competent in his/her field, should preferably be a practitioner rather than just an academic, but what is often overlooked is the ability to communicate ideas. A good trainer should essentially be this: a good communicator, with the gift of explaining, stimulating, and enthusing participants for the subject concerned. Such individuals are fairly rare –for this reason it is always useful to have on hand someone who can assume the role of facilitator (like the chairperson at a meeting) who will be present throughout the course, put speakers and subjects into context, facilitate debate, be the interface between trainer and trainees if needed, move the whole course on smoothly through the various elements of the programme.

Programme development

4. The participants trainee needs assessment will already have provided key elements for the programme, but the actual development of the programme should be done in a small team, either brainstorming or working around a proposal, and if this team consists of a trainee supervisor, a trainer and/or facilitator, someone familiar with the official requirements (if the training has external funding) then the programme is more likely to cover all necessary elements, and certainly more than can be considered by only one expert in the subject field. In a social sector training course which necessitates the exploration of different psychological or therapeutic approaches, a small team has more chance of representing various theoretical approaches and achieving a good balance.

Define the Target group

5. A common criticism in course evaluations is that participants are too heterogeneous in experience or background or professional level, and that the knowledge is therefore too unequal for comfortable group discussion. While it can always be argued that differing levels can only result in benefit, our experience is that mixing qualified experts with untrained staff might benefit those who are confident and articulate – but it might also hinder others from speaking out and make it difficult for the trainer to pitch the delivery at the right level. We have tried to stick to an approach which demystifies dual diagnosis for front-line staff and draws on their undervalued experience, avoiding jargon wherever possible and constantly bearing in mind the real application of theory into practice.

Preparation beforehand

6. Since training courses are usually fairly compact and time-limited, this time can be maximised through preparation beforehand. Participants should be presented with the programme about two weeks before, along with limited essential reading and, crucially, be asked to prepare a task or presentation. In the Triadd project participants were all asked to prepare specific case study vignettes in a structured way a few weeks before the course. If there has already been active involvement before the course participants are keener to discuss.

Training methodology

7. A variety of methods works best, as does ice-breaking warm-up game at the beginning, small group role play to enable participants to have constructive feedback. and it is easier to assimilate visually presented information (overheads, video, powerpoint etc.) Bear in mind that the average person has an uninterrupted concentration span of about twenty minutes. If the physical comfort factors of the room and schedule are not right (room too small, wrong temperature, poor air, late lunch, too heavy a lunch etc.) then concentration will be even further diminished! So take some time to check these externals BEFORE the course and make sure the equipment you use actually works in the room chosen. Obvious points but if not right can lead to real distraction and time-wasting.

Timing

8. In our experience training was appreciated more when delivered in one block of two or three days, with a follow-up session a few months later to check on usefulness and go over any problems which may have arisen in the meantime. A series of separate one day courses was found to be unsatisfactory by participants, in terms of coherence and opportunity to develop ideas and discussion.

Course evaluation

9. If you really want a 100% return on your evaluation questionnaires, build in some time (maximum one hour) at the end of the course for written feedback on your questionnaires. While the answers might benefit from reflection and hindsight after the course, in reality few questionnaires are returned once trainees resume their normal activities and other things take over. The evaluation questionnaire should be clearly structured to reflect the different elements of the course and could offer a combination of one word answers and blank space for comment. Bear in mind how you will analyse and compare them all at the end!.

5.2. BENEFITS OF EUROPEAN COLLABORATION

It may not seem so at the time of meeting the administrative and bureaucratic demands of a European project application (in this case a pilot project under the Leonardo da Vinci programme) but on balance there are definite advantages, as well as challenges, to organising a training project at European level.

The first, being totally honest, is financial – without the support of the Leonardo da Vinci project this initiative would not have been possible. Front-line staff training in dual diagnosis would have remained a localised national concern for many partners, in an already over-stretched training budget curriculum, and not received the prominence it has now been given. In at least three of the countries involved the training may not have taken place at all, and there would certainly be no web site accessible to staff in English and French.

There would also have been no collaboration between seven European countries on the specific topic of front-line staff training, and the meeting of cultures and traditions that this entails in a project partnership, where the occasional temptation to go it alone and carry on as before has to give way to a certain compromise within the framework of the project partnership. The European Model ideal also has to withstand compromise, in as far as it is almost impossible to agree on a single one-size-fits-all model at the European level, so there has to be the flexibility to allow this while still calling it a European project. A useful method of encompassing these differences was the principles and guidelines approach; core values which all partners can agree and which need to be reflected to a certain degree in the `decentralised´ components of the overall product.

5.3. WHAT NEXT FOR THE TRIADD PROJECT?

Although the project has officially ended (contract period with the Commission) we very much have the feeling that there is still work to be done on this issue, other angles to explore in greater depth and other training approaches to develop. We will still maintain the web site for the time being, publish our materials in other languages (French and Italian) and disseminate the results of the project more widely. We have also organised three dissemination events (Lisbon, Luxembourg, Charleroi) at which we presented the project and invited outside speakers to discuss what is happening in this field and further develop this theme. The collected presentations are currently being published by Arfie and are available soon (arfie@arfie.info). The existing Triadd partners remain active on this issue within the ARFIE network.

Sources:
Triadd Project documents, reports and partners.

Report/Compte rendu – Expert Round, Séminaire Européen, Advances in Mental health and Intellectual Disability, Vienna, 2000, edited by Germain Weber & Raymond Ceccotto.

`Psychotherapy and learning Disability – the Present position and options for future development' Dr. Roger Banks, Royal College of Psychiatrist, July 2003.

`Mental Health in Adult Developmental Disability' Dual Diagnosis Training Kit for Professionals and Service providers meeting the Mental Health Needs of Adults with an Intellectual Disability' School of Population health, The University of Queensland, 2003.

`Count us in' – the Report of the Committee of Inquiry into meeting the mental health needs of young people with learning disabilities, The foundation for People with Learning Disabilities, December 2002.

Internationalising vocational education and training in Europe – prelude to an overdue debate, a discussion paper' compiled by Jon Sogaard and Norbert Wollschläger, CEDEFOP (European Centre for the Development of Vocational Training').

5.4 USEFUL WEB SITE ADDRESSES, ARTICLES ANDBIBLIOGRAPHIES ON INTELLECTUAL DISABILITY AND MENTAL HEALTH ISSUES:

www.thenadd.org (National Association for Dual Diagnosis, US)
www.uq.edu.au (Queensland Centre for Intellectual & Developmental Disability)
www.fpld.org.uk/pagepublications (Foundation for People with Learning Disabilities)
www.inclusion-europe.org
www.estiacentre.org
www.aamr.org (American Association on Mental retardation)
http://www.blackwellpublishing.com (Journal of Intellectual Disability Research)
http://www.iassid.org (International Association for the Scientific Study of Intellectual Disability)
www.mhe-sme.org (Mental Health Europe)
www.ispn-psych.org (International Society of Psychiatric Mental Health Nursing)
www.schizophrenia.com
www.world-schizophrenia.org
www.bipolar.net
www.autismeurope.arc.be
www.worldautism.org
www.alzheimer-europe.org
www.learningdisabilities.org.uk
www.doh.gov.uk/vpst (Valuing People Support Team, UK Dept. of Health)

Sites and Articles in French:
www.ejmd-rehm.com (Revue Européenne du Handicap Mental)
www.unapei.org
http://perso.wanadoo.fr/maurice.villard/CV.htm
www.siwadam.com
http://www.psybermentor.ca/ressources/d_retard_DD.asp
http://www.fissaaj.be/SPIP/article.php3?id_article=148
http://www.hug-ge.ch/QuickPlace/devmental/Main.nsf/h_Toc/33ad0a10105f3ff9c1256e4d002fb5b0/?OpenDocument (Unité de Psychiatrie du développement mental-Recherche et publications)

ANNEXE I : TRIADD PARTNERS

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ANNEXE II

TRIADD Resources: Keywords (from web site)

General Concepts:

Dual Diagnosis

Definition

Here the definition of dual diagnosis refers to the co-occurrence of a diagnosis of intellectual disability and a mental illness. The intellectual disability may be mild, moderate or severe – all people with learning problems can present with psychiatric problems – and the mental illness can be diagnosed from the whole spectrum of such illnesses. A major issue in this population has been termed diagnostic overshadowing. This refers to the fact that the learning disability itself decreases the diagnostic significance of the accompanying behavioural problem. In such cases a real mental health problem, such as fear may not be diagnosed as a phobia when the person has also learning disabilities.

Key reference

Szymanski L. (1995) Mental retardation and mental health: concepts, aetiology and incidence. In Bouras N.(ed.) Mental Health in Mental Retardation. CambridgeUniversity Press, Cambridge

Challenging Behaviour

Definition

Challenging behaviour is behaviour in a client which challenges front line staff and services in general. People with challenging behaviour often present with one or several of the following symptoms: verbal aggression (screaming, being verbally offensive), physical aggression (attacking staff or other residents, biting others), aggression against the environment (smashing furniture, hurling objects), auto-aggression (banging arms or head against objects, biting oneself), running away, inappropriate sexual behaviour (exposure in public, public masturbation, sexual abuse of others), stereotypic behaviour (rocking, walking around in circles), deliberate incontinence (playing with faeces), illegal actions (paedophilia, stealing, setting fire), deliberate vomiting. Not all challenging behaviour in people with learning disability is associated with a mental health problem. It can also be learned behaviour over a long period.. In these cases good pedagogical methods (such as behavioural techniques) may be very successful. In many cases however challenging behaviours are signs in people with learning disability of a deeper mental health problem. The causes of this can be medical (for example living with epilepsy) or genetic (for example Lesch-Nyhan syndrome in which people with this condition often present with self biting behaviour) or in people diagnosed within the autistic spectrum.Thus an effective diagnostic procedure involving medical behavioural and support staff is essential.

Key reference:

Holt G.(1995) Challenging Behaviour. In Bouras, N. (ed.) Mental Health in Mental Retardation. Cambridge University Press, Cambridge.

Further reading:

Emerson,E (References in Luxemburg)

Hogg, J. and Harris, J (2001) Positive approaches to challenging behaviour. BILD publications.

Mental health/illness

Definition

The World Health Organisation has defined 'health' as 'a state of complete physical, mental and social well being and not merely the absence of disease or infirmity. People who are mentally ill tend to present with three kinds of symptoms a). mental symptoms such as unusual moods and feelings such that they cannot cope with normal everyday events, hearing voices b). physical changes such as eating/drinking disorders, sweating and c). behavioural symptoms such as strange actions, inappropriate social behaviour. These signs or symbols lead the front line staff to pose questions as to their client's mental health status.

Key reference

See Szymanski in Bouras

Learning disability

Definition

Learning disability (other terms – mental handicap, mental retardation, intellectual disability) refers to a major impairment in a person's ability to learn and develop skill to live and function appropriately in the society in which the person lives. Generally speaking a person with learning disability functions below the level one would expect of an average functioning person in the same society. Learning disability can be mild, moderate severe or profound. Often the level of intellectual disability is referred to in intelligence quotient terms (IQ). All persons with learning disability have the possibility of an additional mental health problem, just as in the general population.

Key reference

See Szymanski in Bouras

Epidemiology

Definition

Generally, epidemiology refers to the study of the extent to which a medical condition occurs in a society. In the case of dual diagnosis it is difficult to say exactly how many people with a learning disability also have a mental illness. The existing studies are inadequate because they tend to be undertaken on special populations (i.e. people referred to special clinics, people in institutions), or because the diagnosis of the mental illness has not been clear. Studies vary widely in the extent to which dual diagnosis occurs – from a little as 10% to as much as 40%.

Key reference

See Symanski in Bouras page 26-29.

Aggression

Definition

Aggression is a major concern for front line staff, and while aggression alone is not the only factor concerned with the identification and diagnosis of mental illness in people with learning disability it is an issue which causes the most problems. It is very important to define the various forms of aggression and also the meaning of aggression.

Major forms of aggression are:
Auto-aggression or self injurious behaviour: this concerns a form of aggression aimed at oneself. It often manifests itself in head banging. – either using one's own fist or hand, or alternatively banging one's head or other body parts against an object or wrist or arm biting.

Aggression against others (physical): this concerns attacking others – staff and other people with learning disability or others (parents, strangers). The behavioural manifestations are physical (i.e. hitting, kicking, pinching, biting, spitting)

Aggression against others (verbal): this occurs when a person with learning difficulties shouts or screams at others.
Aggression against objects: this occurs when the person with learning difficulties attempts to or actually destroys objects such as furniture, clothing, food throwing.

Sexual aggression: this involves rape or aggressive and unwanted sexual advances or interaction.

The meaning of aggression: This is perhaps the most important point here. It is essential to attempt to analyse why a person with learning difficulties becomes aggressive in one or several of the above ways. It may be because he or she is disappointed (for example not involved in a desired activity, an expected visit did not take place, a favourite staff member has left or a new one joined the team). It may be that the person has weak self-control (ego functions) such as frustration tolerance, reality testing, anticipation problems. It can also arise when a person feels depressed or wants attention. In people with learning disabilities, especially those who have additional communication problems and are not able to express their feelings verbally, it is very important to understand the meaning of the aggression. It is also very important not to over interpret the meaning of aggression in any of its forms as double-diagnosis.

An aggressive outburst can be caused by a one-off situation – fairly easy for front line staff to identify and possibly control. On the other hand it can be a deep seated response to a very hurtful and recurring memory. This information may not be known to front line staff (and maybe not to other supporting professionals). Here one needs to work closely together in a team to understand and formulate a treatment plan for this very challenging behaviour.

TRIADD Resources: Keywords

Major Mental Health Problems:

DSM 4

Definition

This refers to the Diagnostic and Statistical Manual of the American Psychiatric Association and is one of two the reference works in which mental illnesses are defined. It is used widely in monitoring the incidence and prevalence of mental illness throughout the world.

ICD 10

Definition

This is the second major reference book relating to mental illness. It is the Classification of Mental and Behavioural disorders published by the World Health Organisation.

Depression

Definition

Depression is normally characterised by an overall lowering of mood often accompanied by lack of motivation, reduced concentration, low self esteem, disturbed sleep and loss of interest. In people with learning disabilities symptoms may include non-compliance, withdrawal, thumb sucking (regression to childhood behaviours), aggression, self injury, screaming and crying. The diagnosis of depression in people with learning disability is a complex process and it is not always possible to use diagnostic criteria applicable to non-learning disabled persons. It is important for front line staff to seek help in the diagnostic phase. This can be obtained by structured interviews and the administration of specially devised instruments such as the PASS-ADD system. Because symptoms of depression can be difficult to interpret, it is probable that depression is under diagnosed in people with learning disabilities.

Key reference

Reiss, S (1995) Psychopathology in mental retardation. In Bouras, N (ed.) Mental Health in Mental Retardation. Cambridge University Press, Cambridge

Psychosis

Definition

This term refers to a group of mental disorders which are characterised by a severe lack in the ability to recognise reality. The symptoms tend to be: hallucinations, delusions, hearing voices, strange and bizarre behaviours and impaired thinking and judgement. Psychoses are often diagnosed in people with mild learning disabilities since they can often better communicate their symptoms and problems through language.

This not to say that people with learning disabilities who also have communication difficulties do not present with this mental illness.

Personality disorders

Definition

In general psychiatry there is a long list of personality disorders from specific disorders (such as paranoia, schizophrenia, through to disorders such as pyromania (setting fires), kleptomania (stealing), disorders of sexual preference and several others. Many of these have been found in people with learning disability. All of these disorders are characterised by behaviours which vary significantly from the way the average individual in the specific culture reacts. The patterns of behaviour in these individuals affects both the person him/herself as well as others.

Each diagnosis is classified according to the predominant symptoms. Some examples affecting people with learning difficulties are:
Paranoid personality disorder: excessive sensitivity to setbacks, bear grudges, recurrent suspicions.

Schizoid personality disorder: few activities provide pleasure, emotional coldness, solitary activities, lack of close friends.
Dissocial personality disorder: unconcern for the feelings of others, rejection of social norms, low frustration tolerance, blaming of others for the patient's own abnormal behaviour, unable to express guilt.

Emotionally unstable personality disorder: outbursts of anger, violent behaviour, tendency to act impulsively, threatening behaviour.
Borderline personality disorder (often termed 'narcissism`): unclear self image, feelings of emptiness, intense unstable relationships with others (often leading to crises), feelings of suicide or self harm. Can be very manipulative.

Pathological stealing

Pathological fire lighting

Fetishism: relying on a concrete object for sexual arousal (e.g. shoes)
Paedophilia: a sexual preference for young children. Some people with learning disability are especially interested in children who are functioning at their own mental age (e.g. a 25 year old mentally handicapped person with a mental age of 6 years my be especially interested in children aged chronologically 6 – this is a complex state and requires special understanding and treatment, and this differs from paedophilia in the general (almost wholly male) population.

Exhibitionism: the recurrent tendency to exhibit sexual organs in public, often accompanied in people with learning difficulties with public masturbation.

Schizophrenia

Definition

The symptoms are generally hallucinations, hearing voices, changes in relations with other people (e.g. ignoring others), unpredictability and aggression. It is difficult to diagnose schizophrenia in this target group because the symptoms may be similar to other psychotic diagnoses or even depression and often a person with learning disability has additional communication problems. A full case history is essential here.

Key Reference

Fraser, W. and Nolan M. (1995) Psychiatric disorders in in mental retardation. In Bouras, N. (ed.) Mental Health in Mental Handicap. Cambridge University Press, Cambridge

Autism

Definition

Referred to as the autistic continuum or the autistic spectrum, since the symptoms can appear in mild or extreme forms and over the whole range of learning disabilities. Generally diagnosed before the age of three, there are three major clusters of symptoms: (a) delay and deviation in the development of social relationships, (b) problems in the general area of communication, both verbal and non-verbal (c) restricted range of interests and activities. Often people with autistic symptoms have stereotypic behaviours (such as hand flapping, twisting and turning) or obsessive and unusual interest in specific objects (such as bits of wire or pieces of plastic).

Key reference

Wing, L. (1995) The autistic continuum. In Bouras, N. (ed.) Mental Health in Mental Retardation. Cambridge University Press, Cambridge

Mania

Definition

The person is generally of very high spirits, elated, excited. In people with learning disabilities there can be a tendency to be very demanding on front line staff through lack of self control and the need to be over friendly.

Key reference

Fraser, W. and Nolen, M (1995) in Bouras (see above)

Further reading

Manic/depressive

Definition

People who are sometimes manic, then sometimes depressed. The two dimensions are low mood and high mood. The person tends to either one of these extremes.

Rapid cycling

Definition

Another form of manic/depression.

Bipolar disorder

Definition

Yet another form of manic/depression.

Dementia/Alzheimer's disease

Definition

A general impairment of overall functioning. This can be rapid or rather slow. The major symptoms are forgetfulness (loss or impairment of long and short term memory), problems with orientation (for example inability to find one's way around a familiar building or environment), personality changes (the person may become suddenly aggressive), decline in personal care or hygiene and a general loss of skills and abilities which were previously intact. Dementia is found more frequently in people with Down syndrome. The disease is progressive and irreversible, although there are many therapeutic techniques and ways in which the environment can be changed to help people with dementia cope better in their daily lives. These include medication and a psychiatrist should always be involved in the development of a treatment programme.

Key reference

Holland, A. (1995) Down's syndrome and Alzheimer's disease. In Bouras see above.

Offenders (sexual and other)

Definition

People with learning disabilities, especially those whose learning disability is mild or moderate, may also commit criminal offences. This is not a large group of the population, but one which causes great concern for those providing services. Major offences tend to be aggressive behaviour (assault), stealing (kleptomania), fire setting (pyromania) and sexual offences (paedophilia or sexual harassment). A major issue here is whether a person with learning disabilities is functioning at an intellectual level adequate for him or her to know that they have committed and offence. Much has been written on this theme, as well as the theme 'consent' for treatment. There has also been some progress in providing services for this special group. This is a difficult and specialised area in dual diagnosis. Front line staff should seek out specialist help (from a psychologist or psychiatrist where possible) when confronted with intellectually disabled people who offend.

Key reference

Day, K. (1995) Psychiatric services in mental retardation: generic or specialised provision? In Bouras (see above).

Anxiety disorders/neuroses

Definition

Neurotic, stress related anxieties comprise a large group of mental disorders. In people with learning disabilities panic reactions can occur under many circumstances (such as visits to a doctor or dentist, fear of being enclosed in a car) or obsessive behaviours (such as ritual hand washing, or testing all the doors in a room are shut before going out). Often the response is so great that medication (such as a tranquilliser) must be given to ensure that the person receives appropriate treatment.

Key reference

Fraser, W. and Nolan, M. (1995) Psychiatric disorders in Mental Retardation. In Bouras (see above)

Treatment – medication

Antipsychotic medication

Definition

The main use of antipsychotic medication is in the treatment of psychoses (see above) As many antipsychotic medications have a sedative effect, these are often used to help control people with challenging behaviour (see above). Since the medications have a calming effect, they are often used to control anxiety (see above) Besides having a sedative effect, however, these medications may have undesirable side effects especially dribbling saliva, or tremors (such as found in patients with Parkinson's disease).In addition these medications tend to have a worsening effect on epilepsy from which may people with mental handicap also suffer, and hence anti-epileptic medication must also be carefully controlled.

Anti-depressants

Definition

Anti-depressants are medications used to compensate for lack of certain chemicals in the brain. They are used not only in people with depression (see above) but also those with high levels of anxiety. The effects of these medications are usually observed after a period of two to three weeks, and they should be taken for a period of six months once the person has positively responded. There are many new medications currently available. The older medications had side effects such as dry mouth, constipation, restlessness and dizziness. The newer anti-depressants tend have less of these unwanted side effects. The side effects also tend to decrease within a few weeks.

Mood stabilising medication (anti manic)

Definition

The treatment of manic-depression is frequently with the use of a medication known as lithium. The medication is a mood stabiliser and a sedative. It is also used to treat depression. Lithium can cause kidney damage and people on this medication must have regular blood tests. Other side effects are nausea, hand tremors (Parkinson effects) and drinking a lot as well as passing a lot of urine. Another medication which is called carbamazepine is beginning to be used also with people with learning disability and mood disorders and challenging behaviour. Carbamazepine is actually an anti-epileptic medication but has been found in many cases to have the same effect as lithium with less problematic side effects.

Tranquillisers/hypnotic medication

Definition

Valium, diazepam (and other hypnotic medication) generally induce sleep and reduce anxiety. They are also used in the treatment of epilepsy. This medication is however addictive and cannot be used over a long period of time. It is useful however in the short term treatment of challenging behaviour when it is acute as the medication has a quick sedative effect when injected.

Key reference for this section

Crabbe, H. (1995) Pharmacotherapy in mental retardation. In Bouras (see above)

Treatment – therapy

(It should be noted here that all forms of therapy must take into account the cognitive ability of the individual, but specific treatment should not necessarily be eliminated for this reason alone)

Behavioural approach

Definition

The behavioural approach is probably the most well known form of therapy for people with learning disability and behavioural problems. The method is used to assess the nature of the problem through functional analysis – this involves an analysis of the person himself, the person's environment and life style, and an analysis of the significant people in the person's life. In other words the function of the behaviour itself is of key importance. Front line staff must ask the question "what is the function of this behaviour for this person. Frequently the ABC system is used (antecedent, behaviour and consequence). This involves an analysis of what occurs before the behaviour takes place, what the exact behaviour is and what follows the behaviour. Through the careful use of consequences – especially reinforcement, but also punishment – it is possible for front line staff to modify the problem behaviour of a client. The method has also been used very effectively to aid the learning of new skills.

Key reference

Gardner, W. I. and Graeber, J. (1995) Use of behavioural therapies to enhance personal competency: a multimodal diagnostic and intervention model.

Psychotherapy (general)

Definition

This generalised term refers to a form of therapy which attempts to understand a person's present situation and current problems in the light of the person's past experiences. The therapy is usually undertaken by a clinical psychologist or psychiatrist. It may take various forms such as behavioural therapy, psychoanalytic therapy, psychodynamic therapy, cognitive behavioural therapy etc. (see this section for more definitions).

Psychoanalytic therapy

Definition

This form of therapy based on psychoanalytic theories is especially important when working with emotional as aspects of a person with dual diagnosis. It was thought until recently that psychoanalytic therapy was not suitable for people with learning disabilities, but this is not the case. With its emphasis of emotional understanding, and not on cognitive functioning, even profoundly handicapped individuals are able respond to the emotional and physical attention of the therapist. Individual, family and group therapy may be undertaken. Special emphasis in this form of therapy is placed on the role of the person's personal history and relations with significant other people.

ANNEXE III

Dr. Paul Berry also drew up **Some Advice for Service-Providers**:

`One of the most important points emerging from project TRIADD is that front line staff working with people with learning difficulties and with very severe behaviour problems **need a forum to discuss the cases with which they are confronted**. Front line staff, given the opportunity to discuss cases with relevant professionals, are able to define problems and solutions – but very often they do not seem to be given this chance. In order to discuss a complex case it is necessary to have a whole working day at the disposal of the trainer and trainees. What emerges from such a course is **that relevant theory can be demonstrated and taught through the cases themselves** – and not the other way round.

In general service providers should recognise the immense stress faced by front line staff in working with people with dual diagnosis. A case orientated discussion, in depth, not only helps the staff to understand the problems and the history of the person (often extremely complicated and unbearable), but also presents an opportunity for the staff to express their own feelings, frustrations and emotions which apparently does not often happen. It helps them understand themselves and their own role better.
In addition, when cases by front line staff are presented, a useful tool in the training process is **role playing**. A staff member can play the role of the client and others the role of the front line staff, the mother or father or other relevant professionals working with the case. These sessions can be very emotional but help everyone to understand the real problem. Such a dynamic course can only scratch the surface of the real case, but front line staff have then a procedure which they can themselves practice after the training session. Together with their own professional staff they can designate training days to discuss their work and their clients.

The need for supervision

Service providers might also consider offering formal supervision for these front line staff. While certain professionals have access to formal supervision (medical staff and psychologists for example), the front line staff who are faced with working with very difficult and often dangerous people with dual diagnosis do not seem to have the opportunity to pose and discuss their questions in formal supervision settings. **Yet these are the staff who work all day and night with the clients and for whom stress is very great factor in the workplace.**
Issues in the role of psychiatry and medication:

Another area of concern in the training sphere concerns the role of psychiatry and medicine. There is no doubt that services differ greatly in this respect. The main questions which front line staff pose in the area of psychiatry relating to medication are:

1. what are the **major effects** and **side effects** of the medication?
2. when is **medication changed** (not only when different medication is prescribed but when dosages are altered) and what can they expect?
3. what are the **long term effects of the medication** (many front line staff report that some clientshave been on medication for years and it has seemingly never been properly reviewed)
4. how does the **medication interact with other medication** which the client takes (the main problem here appears to be **how psychopharmaca interact with medication prescribed for epilepsy** which many clients with dual diagnosis have).

Team work and service systems
In some cases different sections of a service were working with a client wholly unaware that other departments also were working with the client. In one situation there was no doubt that all the teams were themselves working quite efficiently, but their reports on the same client were remarkably different!

Communication problems and clients with severe learning disability:

Front line staff need help in communication with such clients - both in understanding their needs and ensuring that the client has understood the staff member. This is especially the case at the emotional level. Such cases should be discussed in training sessions.

The need for many therapies and approaches:

Finally, service providers should be aware that many forms of therapy are relevant for people with dual diagnosis. These should range from therapies such as psycho-dynamic, behavioural, cognitive behavioural etc., through to music therapy, physiotherapy, sand therapy, ride therapy and so on. People who have a psychiatric disorder have the right to the whole palette of therapies available to the general public'.