Editorial – Journal of Psychiatric and Mental Health Nursing

Learning Disability Nursing in Secure Settings: working with complexity

The care of people with learning disabilities and an offending background is currently in transition, with in-patient beds in the process of significant reduction (25-40% of national specialist-commissioned beds) by 2018 as part of the overall initiative to reduce hospital provision (NHS England, 2015). This is coupled with an ongoing challenge to alter the way in which we approach physical interventions, with a paradigm shift perhaps taking place (McDonnell, 2010) as alternative ways are sought to respond to service users with particularly complex needs. The first of these issues is a continuation of de-institutionalization, a global phenomenon emerging during the final decades of the twentieth century, and which affected many population groups but is frequently most associated with people with mental health issues and those with learning disabilities. In the context of this latter group, Sweden, Norway, Canada, USA and the United Kingdom (UK) constituted the first batch of countries to make wholescale changes in care provision, and the movement slowly spread to encompass Belgium, the Netherlands, Germany and other countries in Europe, with the former eastern-bloc countries being the most recent to follow the trend (see Beadle-Brown et al., 2007, for a comprehensive discussion of progress achieved by the middle of the first decade of the 21st Century). One key difference between the care of people with mental health issues and those with learning disabilities, however, is that nursing, as the predominant means of directly supporting people, has been less recognized and applies only to a handful of countries, namely the UK, Ireland and New Zealand. In contrast, mental health nursing is widely recognized throughout the world as the most pertinent way of addressing direct care needs and supporting people to recover from severe psychological and emotional distress. Nursing care of people with learning disabilities dominated institutions in the UK and such skills proved transferable to community settings for working with people with particular needs. These needs related to behaviours that challenge services, mental health, physical health and caring for offenders in secure settings. Basic residential support has generally not been considered to warrant nursing input, other than the involvement of a community learning disability nurse to support with health and the development of the skills necessary to promote independent living.

Those with a learning disability and an offending background, however, sometimes need support in conditions of security, and, as Lovell and Bailey (2016) point out, are cared for in many countries by mental health nurses. These services tend to be fully integrated into the psychiatric system, which is usually not accorded high, medium and low secure status, whilst in the UK there is a completely separate learning disability secure service, with nurses providing the main focus of care. This system of care is well-established, progressive, in the sense that it abides by the principle of care being provided in conditions of least security and addresses seriously the difficult question of what happens to someone once hospital detention is no longer necessary. The Bradley Report (DoH, 2009) had established a programme of change in secure care, since many people with mental health issues and/or learning disabilities appeared to be inappropriately incarcerated in the prison system (Talbot, 2008). One consequence of the report was to precipitate a re-negotiation of the boundaries between

prison, high, medium, low secure and community settings, with an emphasis on diversion where appropriate. This has meant that, as this re-negotiation process has taken shape, the composition of those currently detained within learning disability secure services has necessarily altered. Many people with a mild learning disability and an offending background have always been close to the boundaries of mental health, forensic and learning disability services (Barron et al., 2004), but the extent of the current change has been considerable and the implications for nurses not fully considered.

One such implication relates to the increasing complexity surrounding many of those with an offending background being cared for by learning disability nurses in varying conditions of security. Lovell & Bailey (2016) describe the manifestation of such complexity as relating to increased concerns around additional diagnoses in the areas of mental health, borderline personality disorder, autism spectrum disorder and attention deficit hyperactive disorder. Sometimes individuals have multiple diagnoses, with additional concerns in relation to experiencing periods of homelessness, engaging in a lifestyle potentially vulnerable to increased risk, difficulties with substance misuse, and being younger than normally would be the case in secure learning disability services. This level of complexity, furthermore, is exacerbated by the background of most of this population, who have frequently drifted through a process of multiple rejections throughout childhood and adolescence (Hackett et al, 2013). The combination of these factors, particularly when complicated by the likelihood of significant childhood abuse (Stinson & Robbins, 2014), means that learning disability nurses are currently in the process of adjustment to working with such complexity, with the value of personal attributes not insignificant. The second issue identified at the beginning of this editorial, the challenge to the use of physical interventions, is of significance here since it also anticipates that nurses develop more sophisticated responses to complexity, such as different understandings and approaches to de-escalation, even, perhaps, richer and more mature relationships.

The recovery-orientated model of mental health is of relevance here, with its emphasis on preparing people for re-engaging with their previous lives and learning how to cope with adverse circumstances. Such an ideological impetus might prove fruitful for those with learning disabilities, particularly with the increasing emphasis on community packages for those with complex backgrounds. The learning disability itself is the most important factor in determining the service, but nurses working with this population require support, particularly educationally, in fully comprehending how this factor (the learning disability) interacts with other factors, such as personality disorder, substance misuse and a history of neglect. Learning disability nurses understand how dreadful personal biographies can contribute to offending behaviour, and they are aware that enhanced personal resilience and taking responsibility for one’s actions are critical considerations. The multi-disciplinary and multi-agency nature of care is important, liaison with other disciplines constituting the framework for care, even more so as institutions continue to decline. The therapeutic relationship itself, though, as nurses grapple with engaging with complexity, might seek guidance from mental health, whether with regard to continuing to employ nurses with both mental health and learning disability nursing qualifications, or drawing more deeply on the knowledge base of

mental health. Learning disability nurses, I remain convinced, have the expertise to understand the impact of personal history on shaping an individual's present and future, and those with learning disabilities and an offending background appreciate their involvement, though more research is needed in this area. Learning disability nurses need to develop new strategies of working with complexity, continuing to emphasise their knowledge of learning disability and empathy with the client group, but enhancing their competence through analysis of their own skill and knowledge deficits, and perhaps engaging more closely with mental health nursing as the means for negotiating toward the most effective care packages for this population. Learning disability secure provision is likely to be responding to vicissitudes for some time and the future service structure for this group is uncertain and potentially distressing to service users (Taylor et al., 2016). An increasing number are experiencing care within secure mental health services, and others continuing to drift between different sectors, both statutory and independent, and cared for by disparate professional groups. Many mental health nurses are consequently involved in their care, and would benefit, just as learning disability nurses would, from enhanced knowledge around the ways that people with a learning disability experience multiple diagnoses and fluctuate in their life circumstances. The training needs of both groups of nurses would appear to be a clear priority as the current period of change unfolds.

References

Barron.P, Hassiotis.A and Banes.J (2004) Offenders with intellectual disability: a prospective study. *Journal of Intellectual Disability Research* 48: 69-76

Beadle-Brown.J, Mansell.J and Kozma.A (2007) Deinstitutionalization in Intellectual Disabilities. *Current Opinion in Psychiatry* 20: 437-442

Bradley.K (2009) *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*. London: DH

Hackett.S, Phillips.J, Masson.H and Balfe.M (2013) Individual, family and abuse characteristics of 700 British child and adolescent sexual abusers. *Child Abuse Review* 22: 232-245

Lovell.A and Bailey.J (2016) Nurses' perceptions of personal attributes required when working with people with a learning disability and an offending background: a qualitative study. *Journal of Psychiatric & Mental Health Nursing*

McDonnell.A.A (2010) *Managing Aggressive Behaviour in Care Settings: Understanding and applying low arousal approaches*. Chichester: Wiley-Blackwell

NHS England (2015) *Building the Right Support.* NHS England, 2015 (https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-nat-imp-planoct15.pdf).

Stinson.J.D and Robbins.S.B (2014) Characteristics of People With Intellectual Disabilities in a Secure U.S. Forensic Hospital. *Journal of Mental Health Research in Intellectual Disabilities* 7: 337-358

Talbot.J (2008) *No One Knows: Prisoners' Voices – Experiences of the criminal justice system by prisoners with learning disabilities and difficulties.* London: Prison Reform Trust

Taylor.J.L, McKinnon.I, Thorpe.I and Gillmer.B (2016) Special Article: The impact of transforming care on the care and safety of patients with intellectual disabilities and forensic needs. *BJPsych Bulletin* 40(5) 1-4 doi: 10.1192/pb.bp.116.055095