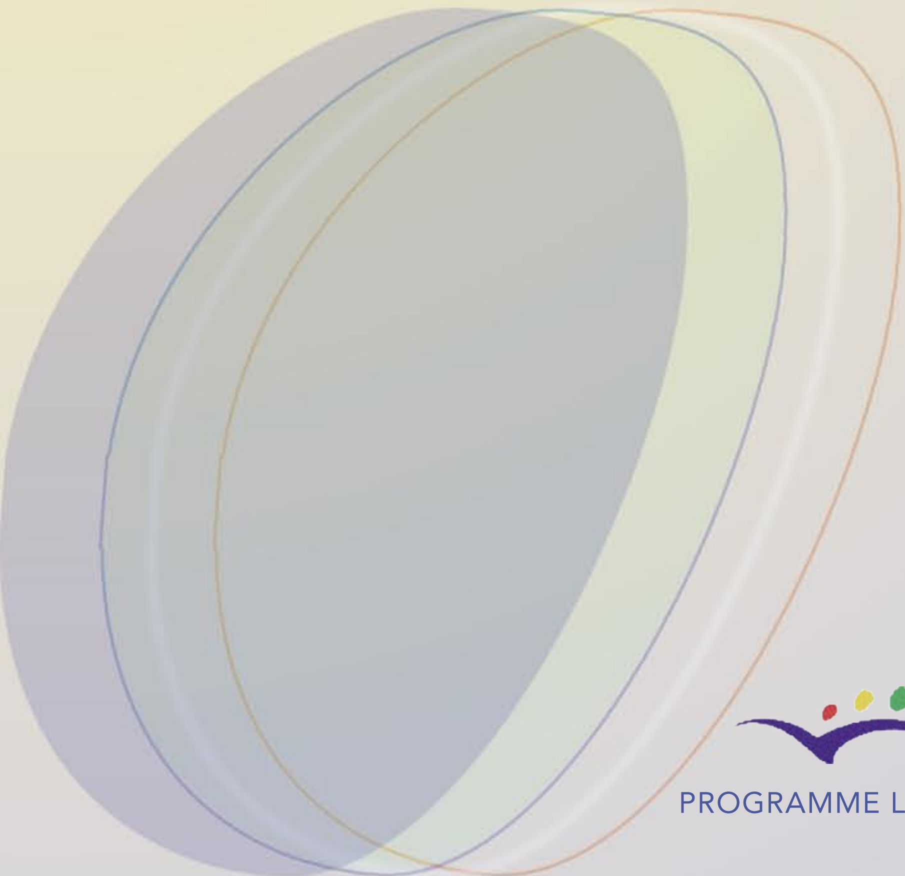

PROGRAMME LEONARDO DA VINCI

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ACHIEVEMENTS SO FAR

TELETRAINING, RESEARCH AND INFORMATION AROUND DUAL DIAGNOSIS

PROJET PILOTE - PROGRAMME LEONARDO DA VINCI

Edited by Jackie West,
Triadd Project Co-ordinator, June 2004.

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CHAPTER I

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 is 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 and so on can, 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 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 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

We have so far:

- 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
- 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.*

The web 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,
- Treatment – medical and therapy, services
- 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
- We are further developing the training courses and resources available in different languages on the website.

1.4. THE TRIADD PARTNERSHIP

The Triadd partnership is made up of service providers, a training institute an 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**[4], the main European Commission instrument for the development of innovative vocational projects.

[4] *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, front-line staff members from Belgium, France, Italy, Luxembourg 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 – forty nine clients in total from five different countries.

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

1. The major problems caused 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 (SUMMARY OF ALL QUESTIONNAIRES)

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

Behavioural: aggression – verbal and physical, unpredictability, overreactions, clients need constant attention, bizarre behaviour not understood or appreciated by others, frequent challenges to authority (but often needing approval), will not fit into group schedule and activities.

Communication problems, lack of motivation, withdrawal and anti-social behaviour. DD and all its possible behavioural manifestations (self-injury, depression, aggression, withdrawal) - all added up to a drain on staff and resources.

Staff wanted to help and to keep things positive for everyone but said themselves that they lacked the necessary training to cope.

Difficult co-operation with psychiatric services, who only intervened in times of acute crisis. Dual Diagnosis added to their already heavy burden because these clients required co-operation with other services.

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.

2.3. FOR THE FAMILY

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

The majority of users had extremely difficult if not traumatic family circumstances where parents themselves had problems such as depression, illness and alcoholism. Some were physically/sexually abused and also had siblings with similar problems.

Over-protection was also mentioned a few times. Some support workers 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 those families who were interested in the real state of their son/daughter – there was a distinct lack of communication and understanding on many levels.

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 had `no inner peace' were anxious, depressed, self-injuring, frightened, confused, angry and frustrated and often at a loss as to how to get out of that state. The picture was the same in every country - this client group was enduring very real mental suffering 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?

Interestingly, 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, help them integrate better into the group and be accepted. Many staff members were frustrated that they felt 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 one carer could better deal with the client 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 and under-valued. Whenever there was mention of 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 by quoting a support worker as 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 neuroleptics 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 forty one support workers filling in these questionnaires, only seven 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?
- 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.

2.7. WEB SITE AND KNOWLEDGE OF INTERNET AND E-MAIL

Only thirteen of the forty one respondents said that they had ever 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 a 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 – a number specifically requested face-to face 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 and the option of discussing cases online with an expert. The web site also serves as a documentation centre with resources specially chosen for their `accessibility'.

CHAPTER II

CHAPTER

THE TRAINING COURSES

CHAPTER III – THE TRAINING COURSES

What we aimed to do in the TRIADD training courses - Guidelines

Given this situation as presented by the partners and faced with the above requests for training, our obvious next move was to focus on the areas most cited by staff as causing them difficulty in their everyday work, and these were remarkably similar across countries and types of service.

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 four project partners in Luxembourg, France, Belgium and Italy 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 fifth course will reflect elements and approaches of the four courses already run, and will take place in Dublin in October 2004.

The following is an overview of each course to date, detailing:

- Title
- Type, Dates, Venue,
- Trainers, Description, Objectives, Programme, Methods, Documentation, Target audience, Language, Evaluation, Follow-up.

3.2.1. THE LUXEMBOURG TRAINING COURSE

Title

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

Type

Face to face training course

Date(s)

1st- 3rd 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

Venue

UFEP – Domaine du Château, Bettange-sur-Mess, Luxembourg.

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

- Key words (Triadd résumé) and 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

Methods

- Theoretical exposés, case studies
- Presentation of experiences and critical evaluation
- Work in small groups

Documentation

Key words, TRIADD

Target audience

Support staff, workshop monitors, psychological staff.

Languages

German and Letzeburgisch

Evaluation

This group differed from the others in that 11 of the 12 participants had actually visited the web site and all 12 had read the key words. 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 course had five lecturers (the evaluator being present for the whole course and participating in 2 half days). On the first day several formal instruments for diagnosis were presented (e.g. PASS-ADD) together with a discussion on the issues of 'challenging behaviour'. On the second day a presentation was held on psychiatric services in Luxembourg. Case studies within a psycho-dynamically orientated framework comprised the rest of the course, with some time (although not enough) for the participants to present their own cases.

Other general results were:

1. course objectives
   39 positive points 8 negative
   (23 no response)
2. course organisation
   50 positive points 15 neutral/ negative points
3. learning effectiveness
   34 positive points 14 neutral/ negative points

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.

3.2.2. THE FRENCH TRAINING COURSE

Title

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

`La prise en charge institutionnelle des personnes handicapées mentales présentant des troubles graves de la personnalité et du comportement'

Type

Face to face training course

Dates

30 June – 2nd July 2003

Trainers

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

Venue

Institut le Val Mandé, 7, rue Mongenot 94165, Saint Mandé, France

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.

Methods

Theoretical exposés by experts working as service directors and having written on this subject. Each participant was asked to read key words (translated into French) to enhance basic understanding of concepts and to prepare a case study or situation 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

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.

Target audience

Pedagogical professionals, support staff, workshop monitors, paramedical staff, directors of services.

Language

French

Evaluation

There were 20 participants, 4 men and 16 women. The evaluator was present for the first two and a half days of the course.

The first day of the course was devoted to basic issues in the area of dual diagnosis. The second day was devoted to case studies. On the third day the issues of service provision were presented and discussed. Each day was held by a different course lecturer and all had been involved in planning the course.

It should be noted that this was a rather heterogeneous group of participants in that their qualifications and experience ranged widely. Some participants only been trained very recently and had little practical experience, others were directors of a service with many years experience. 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.

Only two participants had visited the web site before the course and only four had read the key words. Those who had had these experiences were however generally quite satisfied with the content. 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.

Follow-up

Follow-up questionnaires by participants are still being received and assessed.

3.2.3. THE BELGIAN TRAINING COURSE

Title

Training Cycle – Zonnelied: Adults with Intellectual Disabilities

Type

Face to face basic introductory training course (`formation de base')

Dates

September 2003

Trainer(s)

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

Venue

Zonnelied, Tau-Groep, Lennik, Belgium

Description

A 40 hour training course in two parts:

1) 6 modules of 4 hours
2) Follow-up: case studies, 4 X 4 hours.
The first part was a combination of expert input and group discussion.

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

Six training modules

1)

- 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 : Psychoanalyis and Mental Handicap

Target audience

Pedagogical professionals, support staff, psychologists.

Language

Dutch, English.

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. This rather specific orientation (i.e. psychodynamic approach) seems to be a useful approach in the diagnosis and treatment of people with dual diagnosis.

3.2.4. THE ITALIAN COURSE

Follow-up

Follow-up questionnaires by participants are still being received and assessed.

Title

Training for Staff in Dual Diagnosis

Type

Frontal training course with guided exercises.

Dates

17th October 2003 – 29th October 2003 – 13th November 2003 – 27th November 2003

Trainer(s)

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

Venue

Bologna, viale Silvane, in rooms made available by the Regione Emilia Romagna and the Azienda USL.

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

Methods

Theoretical elements – Presentation of clinical cases – Work in small groups – Report back in plenary.

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.

Typology of the participants

Sex	N°	%
Males	14	20,90
Females	53	79,10
Total	**67**	**100,00**

Age									
Range	20-25	26-30	31-35	36-40	41-45	46-50	> 51	No Ans.	Total
N°	1	3	8	15	9	8	3	2	49
%	2,04	6,12	16,33	30,61	18,37	16,33	6,12	4,08	100
AVERAGE AGE	**39,89**								

Studies	N°	%
Social Assistant	10	20,41
Educator	11	22,45
Pedagogue	7	14,29
Psychologist	3	6,12
Nurse	1	2,04
High School	9	18,37
Graduate (generic)	5	10,20
No Answer	3	6,12
TOTAL	**49**	**100,00**

Real role	N°	%
Social Assistant	9	18,37
Basic Assistant	1	2,04
Educator	30	61,22
Pedagogue	0	0,00
Psychologist	0	0,00
Nurse	0	0,00
Coordinator	9	18,37
TOTAL	**49**	**100,00**

Trained	
YES	2
NO	47
No Ans.	0

Notes:
The 2 «yes» answers regard the supervision on D.D. clinical cases
No one had specific training on Dual Diagnosis before this course

Evaluation

The Italian course, which was held over a series of one day meetings, like the Belgian course, was completed at the end of November. Forty nine participants were involved (approximately one third being women). The results of the evaluation were similar to the other courses.

Only three of the forty nine participants had visited the web-site and six had read the key words. However, of this small proportion, all reported that the site and the key words were useful or very useful. The overall effectiveness of the course is reflected in the responses to the participants' knowledge before and after the course. Before the course 22 participants report ratings of 1- 3 on the five point scale (5 being the highest rating) and 8 rated their knowledge as 4 or above. At the end of the course the ratings were so that 33 participants scores a rating of 2/3 out of 5, and 14 rated their knowledge as 4 plus. Indeed all but one participant report 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 actual jobs of the participants were as follows:

- 30 educators
- 9 social assistants
- 9 co-ordinators of services

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.

One person said 'I don't think I learned a new method, but I received many hints for reflection which will lead me to an approach which is different to the one I had in the past'. Another said 'I would appreciate more work on concrete cases which we have to face in our work'. On a final positive note one person said 'it would be great to organise a follow-up course in 2004 with the same teachers'. A full summary of the comments is available on request.

It is interesting to note that several of these critical points were also mentioned in the survey carried out before the courses were held.

3.3. 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 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
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 professionals; how to build up a good team and work effectively together.

We shall try to address at least some of these issues in the final training course in Dublin.

CHAPTER IV

ELEMENTS OF QUALITY

CHAPTER IV - ELEMENTS OF QUALITY

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

Assessing Staff Needs

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

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

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

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

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

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

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

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

(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!.

4.2. 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.

4.3. THE NEXT STAGES FOR THE TRIADD PROJECT

Between now and the end of the project in Spring 2005, we will concentrate on wider dissemination of Triadd in the training and social sectors at European level and networking with people and organisations working in this field, starting with the Lisbon conference in July 2004. We will be building on the collaboration we have already begun with Hôpital Neuropsychiatrique in Luxembourg and have organised joint training courses with them. We will also be building on collaboration with the psychiatric and psychiatric sectors in Luxembourg and in the partnership as a whole.

There will be the completion of external evaluation of the project, to be undertaken by SIRM (Società Italiana per lo Studio del Ritardo Mentale, Italy) and the organisation of final training course, Dublin, October 2004, encompassing the most successful elements of the four previous course and tailored to meet local need.

There will be further development of web site and interactive message-board for staff on specific individuals with dual diagnosis. Even though the project will officially end in April 2005, the contacts, the web site and above all the mission to develop staff training at European level will, we are certain, continue.

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')

ANNEX I-II-III

TRIADD PARTNERS & QUESTIONNAIRE

ANNEX I : TRIADD PARTNERS

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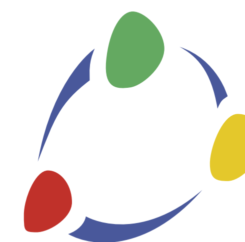
ANNEX II: STAFF NEEDS QUESTIONNAIRE



TRIADD
TELETRAINING, RESEARCH AND INFORMATION AROUND DUAL DIAGNOSIS
PROJET PILOTE - PROGRAMME LEONARDO DA VINCI

Questionnaire for Support Workers
Group leaders, Heads of Service….

This questionnaire was drawn up within the framework of the Leonardo da Vinci programme for the pilot project entitled « TRIADD » (TELETRAINING, RESEARCH AND INFORMATION AROUND DUAL DIAGNOSIS)

We have defined people with `dual diagnosis´ as those who have both a learning disability and mental health problems.

This questionnaire should be filled in by experienced front-line staff who support people with a learning disability combined with mental health problems (dual diagnosis), or group leaders, heads of service, workshop directors – those who know the users well. We are looking for descriptions of about ten users per partner.

By filling in this questionnaire as fully as possible you are helping us to make a European comparison of the difficulties of supporting people with dual diagnosis, **of which the main objective is to better understand your further training needs.**

For more information about the project, please go to our project web site (currently under construction) : www.triadd.lu

Your name (optional) :

Your basic training :

Your current work :...

Your employer :..

First name of the person with a learning disability:......................... Age : .... Gender : ....

How long have you been working with this person ?..

0. Briefly describe the background of this disabled person and what has happened in recent months

....
....
....
....

Treatment :

1. Is there a known psychiatric diagnosis for this person? Yes ☐ No ☐

Do you know what it is?..

2. If these problems have been evident for some time, has this person already received treatment in a psychiatric unit or service? :
   - In hospital /psychiatric department? .... ☐
   - Partial hospitalisation (Day hospital) ? .... ☐
   - Outpatient treatment (consultation in a health centre) ? .... ☐

3. Is this person currently receiving psychiatric medical treatment ?
   - In hospital/psychiatric unit? .... ☐
   - Partial hospitalisation (day hospital) ?.. ☐
   - Outpatient treatment (consultation in a health centre)?... ☐

4. As far as you know, does this person take any form of drug therapy?:
   - Neuroleptic drugs, anti-depressants, tranquillisers, etc. Yes ☐ No ☐
     occasional ☐ long term ☐
   - Anti-epileptic Yes ☐ No ☐
     occasional ☐ long term ☐

Living environment

5. Where does this person live?
   - Family .... ☐
   - Residential care... ☐
   - Supervised group flat/home... ☐
   - Own home with a support service.. ☐
   - Own home.. ☐

Schooling :

6. Did this person attend school?
   - Mainstream school? Yes ☐ No ☐
   - Special school? Yes ☐ No ☐

7. Up to what age?...

Training and vocational experience

8. Does this person have a diploma or professional qualification? Yes ☐ No ☐

9. Has s/he carried out a normal job? Yes ☐ No ☐

If yes, for how long? ....

10. Is s/he working at the moment? Yes ☐ No ☐
If yes, is this work in :
   - Sheltered workshop... ☐
   - Open employment .... ☐

11. Does s/he work full time? Yes ☐ No ☐

12. Does s/he receive any supplementary support?
   - with personal care (ie. day hospital) Yes ☐ No ☐
   - specialised support (occupational day centre…) ? Yes ☐ No ☐

13. If this person does not work
   - Is s/he cared for by a psychiatric unit? Yes ☐ No ☐
   - Does s/he receive support in an establishment or specialised service
     Yes ☐ No ☐

Behaviour

14. How would you describe the learning disability?

....
....
....
....

15. What leads you to say that this person has dual diagnosis?
    Please describe the mental health problems

....
....
....
....
....

16. What, in your opinion, are the most difficult problems :
    - From the point of view of the service?

....
....
....
....
....

    - From the point of view of his/her immediate environment?

....
....
....
....
....

    - From the family's point of view?

....
....
....
....
....

    - For the person him/herself?

....
....
....
....

17. What would you like to do, given the specific problems you are faced with?

....
....
....
....

Training

18. Which training courses have you already followed on the issue of dual diagnosis?
    Please list them :

    1. ....
    2. ....
    3. ....
    4. ....
    5. ....

19. What in your opinion are the subjects and contents of training courses which should be developed in order to work with people who have dual diagnosis?

Please mention all the elements that you would like to see in a training course on dual diagnosis. For example :

- challenging behaviour (please specify)
- integration into a group
- communication with families
- others

....
....
....
....
....
....

20. Do you already use information technology such as the internet, e-mail or distance learning?

....
....
....
....
....
....

MANY THANKS FOR YOUR CO-OPERATION

ANNEX III : EVALUATION OF TRAINING COURSE QUESTIONNAIRE

TRIADD
TELETRAINING, RESEARCH AND
INFORMATION AROUND DUAL DIAGNOSIS
PROJET PILOTE - PROGRAMME LEONARDO DA VINCI

www.triadd.lu

TRAINING EVALUATION FORM

Please take some time to fill in this questionnaire – all your comments are very important for the evaluation of this course and the pilot project.

Course:
Dates:

Name : .... *(optional)* Sex: ☐ M ☐ F Age :....................

Your basic training/qualification

....

....

Training courses you have already attended on this subject:

....

....

Your current occupation:

....

....

How long have you been doing this job?

....

....

Which groups of people (clients) do you work with?

....

....

BASIC INFORMATION & PREPARATION	Comments
1) Did you visit the TRIADD web site? YES NO	....
2) Did you find the web site useful? YES NO	....
3) Did you read the Key Words for Front-line staff? YES NO	....
How useful were they? Very useful ☐ Quite useful ☐ No use ☐	....
Were you given any preparation material	....
or reading matter before the course?	....
How would you assess your level of knowledge on Dual Diagnosis before this training course? (1= no knowledge, 5= fairly full knowledge) 1 – 2 – 3 – 4 – 5	....

EXPECTATIONS & OBJECTIVES	Comments
Did you set any objectives for yourself? YES NO	....
Were you able to express your expectations during the training course? YES NO	....
Were they taken into account? YES NO	....
Were objectives set for every day of the course? YES NO	....
Were these daily objectives met? YES NO	....

CONTENT OF THE COURSE

Comments

Were you satisfied with the content of the course?

YES MORE OR LESS NO

Was the content presented well and clearly (not too much terminology and jargon?)

YES NO

Do you think you will really be able to use the contents of this course in your work?

YES NO

IF NOT, please try to explain why.

Can you communicate the contents of this course to your colleagues?

YES NO

What would you have liked to see/hear more of?

ORGANISATION OF THE COURSE

Comments

Did you find the timetable of the course OK?

YES NO

Did the length of the course seem right?

YES NO

Did the trainers and speakers seem to be well-informed and on top of their subject?

YES NO

Were you able to express yourself as you wished during the course?

YES NO

Was the group as a whole well-balanced and suited to this course?

YES NO

SUPPORT

Comments

Did you find the methods of support used (documents, slides, videos etc.) satisfactory?

YES NO

WHAT YOU GAINED

Comments

Do you think you increased your knowledge (know-how) on this course?

YES NO

Did you learn any new methods, techniques, tools that you can use in your work?

YES NO

Did you become aware of any new opinions, attitudes and approaches…?

YES NO

Did you become aware of any new means of communication?

YES NO

How would you judge your level of knowledge and know-how about this subject now (after the course)?

1- 2 – 3 – 4 –5

SUGGESTIONS AND OTHER COMMENTS	Comments
Please number the elements you particularly appreciated in this course (3 things)	1. .... 2. .... 3. ....
Please number the elements you think should be improved (3 things).	1. .... 2. .... 3. ....
Would you like to be offered a training course on any other subject – if so, what?	....
Do you feel you know where to go for more Information about Dual Diagnosis?	....
Any other comments :	....

Many thanks for your co-operation. We will be getting back to you in about six months' time for a re-evaluation of the usefulness of this course and to hear your suggestions.