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AN OUTREACH TREATMENT APPROACH OF MILDLY MENTALLY RETARDED ADULTS WITH PSYCHIATRIC DISORDERS

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Introduction

Research studies have reported an incidence of behavioural and/or psychiatric disorders in the mentally retarded varying from 14-17% (Eaton and Menolascino, 1982; Jacobson, 1982) to 36-39% (Iverson and Fox, 1989; Reiss, 1990), depending upon the methodology applied. In the most recent study carried out in the Netherlands, it appeared that 10% of the mentally retarded living in institutions exhibited severe problem behaviour (Kramer and Schoep, 1991). It is generally held that the same disorders occur in mildly mentally retarded persons (IQ 50-70) as in persons who are not retarded (Parsons, *et al.*, 1984; Reiss, 1985). It is generally supposed, however, that the chance of psychopathology is greater for persons who are mentally retarded than for those who are not (Dosen, 1990; Jakab, 1982; Menolascino, *et al.*, 1986). The main reason given for this is the combination of their biological vulnerability and adverse circumstances stemming from life-style and environment (Lund, 1988), such as frequent placement in and transfer to institutions impeding the creation of a social network (Reiss, 1985), rejection and stigmatization by society (Reiss and Benson, 1984), deficiency in social and problem-solving skills (Nezu, *et al.*, 1991; Reiss, 1985) and difficulty in adapting to change (Reiss, 1985; Lund, 1988; Hull and Thompson, 1980).

For mildly mentally retarded persons there are some additional factors that may be important for the

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development of psychopathology; they are often very much aware of their inadequacies (Reiss and Benson, 1984) and given their normal-like appearance in comparison to the severely mentally retarded, their capacities are frequently overestimated, with the result that they have an increased chance to experience failure.

The Outreach Treatment Programme

In the Netherlands, there are five clinics that specialize in inpatient treatment of mildly mentally retarded persons with severe behavioural disorders. Nieuw Spraeland is one of the five. Some of the advantages of inpatient treatment are that the patient's behaviour can be monitored, the patient can be put on a particular medication, the patient's immediate family and friends are relieved of the burden of care, and specialist help is readily available.

Admission to the clinic also carries with it, however, a number of disadvantages. The number of places in the clinic is limited, which means that patients sometimes have to wait before they can be helped. The patient is removed from familiar surroundings, causing a disruption in his or her domestic and social life. Furthermore, the system factors that may contribute to the causes and continuance of the problems of the patient cannot be incorporated into the treatment programme. Admission to a clinic or transfer from one to another, creates an additional difficulty for mentally retarded persons, given the emotional problems connected with retardation: problems such as inflexibility, limited social adaptability and a decreased ability to endure stress.

These considerations led Nieuw Spraeland to set up an outreach treatment programme for mildly mentally retarded persons with severe behavioural and/or psychiatric disorders. The outreach team is multidisciplinary and living-situation oriented. It consists of a psychiatrist, a pedagogue, a social worker, three social psychiatric nurses and a coordinator. All members of the team are specialized in the treatment of the dually diagnosed. The outreach team treats persons in their own environment, which can be at home with their parents, in institutions, in group homes or in sheltered homes. One member of the team is appointed to be the patient's contact person and therapist. This contact person visits the particular patient, observes the home and work environment of the patient, and also observes how the patient is treated by group leaders, group members and/or parents. On the basis of these observations the outreach team therapist makes a report. After discussing the report in the outreach multidisciplinary team, a strategy of intervention is established, including diagnostic assessment and treatment programme. The treatment programme is multidimensional, which means that the attention of treatment is focused not on the patient only. Every important person in the daily life of the patient becomes actively involved in the treatment programme.

The following case histories provide an illustration of how the outreach team works.

Case 1: Carol

Carol is a mildly mentally retarded, 36 year old woman (VIQ 40, PIQ 100). She has been living in an institution for the mentally retarded since she was twelve. She is described as a loner who only enters into contact with people when it is functional or necessary.

In terms of psychopathology, she exhibits self-injurious behaviour. In 1987, following changes in the make up of her group and in its leadership, the incidence and severity of her self-injurious behaviour increased. Medication (Chlorpromazine and Chlordiazepoxide) and modifications in supervision brought about a significant reduction in her complaints.

Two years later, there was evidence of an increase in severity of Carol's self-injurious behaviour; pinching her breasts and punching herself in the stomach, hard enough to cause injury. This time, too, the behaviour appeared to be a reaction to change: institutional relocation and changes in hospital staff. A treatment programme was begun in which Carol spent the greater part of the day and all night (20 hours in total) in bed, restrained by means of wrist-bands and a Swedish band. During this time she was on 10 mg. Clopentixol, three times a day and the Chlorpromazine and Chlordiazepoxide were discontinued. There was no change in her problem behaviour, and it was therefore decided to call in specialist help from the outreach team. A member of the outreach team went to the unit concerned for a few days in order to observe Carol in her current setting.

It was observed that the group leaders first tried, either verbally or physically, to prevent Carol from self-injury and, if this did not work, resorted to restraint. The restraint was linked to the behaviour exhibited by Carol. The group leaders themselves felt emotionally stressed; when should we or should we not restrain her? Is it protection or punishment? The interactions between Carol and the group leaders were charged with emotion. In fact, the whole situation caused considerable tension in the unit, for the group leaders and fellow group members as well as for Carol herself.

The outreach team diagnosed Carol as "self-injurious behaviour in a woman with a pervasive developmental disorder". The assumption of the working hypothesis of the outreach team was that though Carol did desire contact with people, she could not deal with the considerable amount of emotional stimuli engendered by changes. In order to feel safe, it was concluded that Carol would need an extensive amount of structure in her daily programme. A four phase treatment plan was proposed.

The *first phase* objective was stimulus reduction, to be achieved by structuring time and space. Her daily programme was altered in three two-weekly stages, resulting in all her activities taking place in her own room. Supervision was carried out by those staff in whom Carol appeared to have most trust, and the activities offered to her were structured

and limited. The periods of restraint were continued, since this was the only way at that time to achieve a reduction in self-mutilation. The pattern of restraint was, however, altered; it was no longer associated with Carol's behaviour, but was carried out at fixed times. Supervision thus took on a more consistent character.

During the *second phase*, registration of the symptoms was undertaken. The frequency, of her self-mutilative behaviour, were observed and recorded by group leaders during her activities. In the first months, self-mutilation took place 40-200 times per week. Observation revealed that Carol had difficulty coping with noise and was calmer when in the company of just one person or with familiar persons. Furthermore, explicit attention was given to the establishment of a strong relationship between Carol and her group leaders.

The objective of the *third phase* was to use the insights gained in the second phase and to take action based upon them. Using the observations as a guidance, changes were gradually introduced into her programme. Her activities were extended in terms of space as well as in terms of variety. Three months later the frequency of the self-injurious behaviour dropped to less than 20 times per week and five months after the start of the third phase it had disappeared. Carol was then spending six hours a day unrestrained. She became more oriented towards her surroundings, made more eye contact with people and was better able to complete activities.

In the *fourth phase*, an attempt was made once again to gradually extend her daily programme. As in phase one, this was done in three two-week stages. In the first stage, the number of activities was increased. In the second stage, the number of hours she spent in restraint was reduced. Finally, in the third stage, the level of supervision was decreased. After the third stage, the self-injurious behaviour began again, so it was decided to revert to the treatment programme as carried out in phase three. This was a success; the self-injury stopped again. After that the fourth phase was started again with good results.

The staff supervising Carol met once a week to once a month for discussion, depending on the treatment phase, in order to ensure that the programme was geared towards Carol's needs as much as possible. All meetings were attended by the outreach team therapist, who was responsible for devising the treatment programme, giving advice on programme implementation, and encouraging the team to persist with the intensive method of treatment.

Discussion

A number of aspects of the treatment described are worth highlighting. The first important aspect is that the treatment programme is highly structured. Through this structure the interactional problem, which was assumed to play a role in perpetuating Carol's problems, could be dealt with.

A second important aspect, is the gradual and planned reduction and subsequent exposure to stimuli geared to the patient's capacity. Given the fact that

mentally retarded persons find it relatively more difficult to adapt to change than persons without retardation, the importance of exposure to graduated, patient-centred changes should be stressed.

Furthermore, it is important to observe and register the problem behaviour in relation to any changes brought into the treatment programme. By doing so, effects of the treatment programme can be evaluated. Finally, it seems important to develop a treatment programme which anticipates the possibility of relapse.

Case 2: Leo

Leo is a mildly mentally retarded, 24 year old man (IQ 50). Since he was four years old he has spent periods of short or longer duration in children's homes or institutions for the mentally handicapped. Since 1986 he lives in a sheltered home, interspersed with periods in his own home with his parents. Leo is described by others as a bossy young man, with a very competitive spirit, whose attitude towards persons of his own age is not very positive, and he is sometimes aggressive with others.

He has exhibited a variety of behaviour problems, which have increased while he has been living in the sheltered home. These problems include verbal aggression, occurring daily, and occasional overt aggression towards people. For this behaviour he has been on 40 mg. Pipamperon twice daily, without result.

Therefore, the outreach team was consulted. After a period of observation in the sheltered home where Leo lived, the outreach team diagnosed him as "Conduct disorder aggressive type". The working hypothesis, based on observations, was that Leo's problem behaviour persisted because the group leaders overestimated him and were then inconsistent in their treatment of him when he could not satisfy their (excessive) demands.

Treatment was aimed at getting the group leaders to adopt a clear, neutral stance in their dealings with Leo. To reach this, a behaviour regulation system was chosen. This was implemented after a period in which the group leaders involved were given information and were motivated towards adopting a behavioural therapeutic approach.

A behaviour regulation system aims to influence behaviour positively in a systematic manner, by providing clarity for Leo as well as for his group leaders. The desired behaviour is determined, in advance, with Leo. He was given a list from which he could determine each day in concrete terms, what behaviour he had to exhibit (e.g., tidy up his room, undertake some activity with a fellow resident, talk over his anger with the group leaders). In Leo's case, the list was drawn up in pictographic form, since he was unable to read. The list was reviewed with him daily, to evaluate whether the required behaviour had been exhibited.

Rewards and punishments were also decided upon in advance and were given directly after the evaluation had been made. For Leo, desirable behaviour was rewarded with money and undesirable behaviour resulted in loss of privi-

leges. In the first few days he had to undertake 30% of the desired actions, then 50%, and so on. As time went by, the behaviour regulation system was focused more and more on the problem behaviour.

The behaviour regulation system achieved its objective. Leo was addressed at a level appropriate to his capacities, and there was consistency in the way he was dealt with when he failed to do what was required of him. There was a positive development in Leo's behaviour since the adoption of the behaviour regulation system. Verbal aggression decreased to once/twice a month and there were no more incidents of physical aggression since the start of the outreach treatment programme. In addition, it has been possible to take him off medication. He is now described by others as a young man with a pleasant disposition.

The outreach team therapist made approximately 10 visits to the sheltered home to set up the behaviour regulation system, to evaluate it and make any necessary adjustments, and to support the team at the unit in carrying it out. Positive results having been achieved, the case was closed after a year.

Discussion

Th above treatment method made use of a behaviour regulation system. The advantages of such a system are that those persons involved with the patient help to correct the problem behaviour in a systematic and consistent manner, without paying explicit attention to the behaviour itself, and that the demands put on the patient are pre-structured, so that the patient is addressed at an appropriate level. This last point is particularly important, since the capabilities of mildly retarded persons are often overestimated, making the development and maintenance of problem behaviour rather more probable.

Closing Remarks

What makes the outreach treatment method unique is that it is accommodating in nature, so that the treatment is carried out by specialists, yet in the patient's home environment. The two case histories given above demonstrate that mildly mentally retarded persons with severe psychiatric disorders can be treated successfully in this way.

Significant advantages of this method of treatment are that attention can be given to the environmental factors that affect and influence the problem behaviour, that the patient does not have to face yet another change in his surroundings, and that the people who are part of the patient's everyday life (group leaders and family) are actively involved in the treatment, so that expertise is gained and continuity of the treatment is assured. Furthermore, patients can be helped immediately, and more patients can be helped at the same time.

Maguire and Piersel (1992) studied so-called mobile intensive treatment teams, a treatment option which seems similar to the outreach treatment approach. They found that the mobile

intensive treatment was highly successful in treating severe maladaptive behaviour in the mentally retarded. Besides that, it seemed an efficient treatment option, in the perspective of duration because the average duration of treatment was less than 3 months.

This method of treatment is not, however, suitable for all patients. The risks of suicidal and severely aggressive behaviour must be weighed and the social network must have a great enough support potential. It is important to keep open the possibility of admission to hospital in case of crisis.

Despite the above reservations, it may still be said that the Nieuw Spraeland's outreach team treatment of mildly mentally retarded persons is a valuable addition to the range of treatment approaches available in this area. A joint research project with the University of Nijmegen is currently investigating the effectiveness of this treatment programme.

Summary

In the Netherlands a new treatment strategy for mildly mentally retarded adults with behavioural and psychiatric disorders has been introduced, in which persons are treated in their own home environment by an outreach team. This article gives a description of the treatment strategy, illustrated by two case histories.

References

Dosen, A. (1990). *Psychische en gedragsstoornissen bij zwakzinnigen: Een ontwikkelingsdynamische benadering.* Boom: Meppel.

Eaton, L. F. and Menolascino, F. J. (1982). Psychiatric disorders in the mentally retarded: Types, problems and challenges. *American Journal of Psychiatry, 139,* 1297-1303.

Hull, J. T. and Thompson, J. C. (1980). Predicting adaptive functioning of mentally retarded persons in community settings. *American Journal of Mental Deficiency, 85(3),* 253-261.

Iverson, J. C. and Fox, R. A. (1989). Prevalence of psychopathology among mentally retarded adults. *Research in Developmental Disabilities, 10,* 77-83.

Jakab, I. (1982). Psychiatric disorders in mental retardation. Recognition, diagnosis and treatment. In: Jakab, I. (ed.). (1982). *Mental Retardation.* New York: Karger pp. 270-326.

Jacobson, J. W. (1982). Problem behaviour and psychiatric impairment within a developmentally disabled population 1: Behaviour frequency. *Applied Research in Mental Retardation, 3,* 121-139.

Kramer, G. J. A. and Schoep, H. F. (1991). Ernstig probleemgedrag bij geestelijk gehandicapten. *Nederlands Tijdschrift voor Zwakzinnigenzorg, 12(4),* 183-195.

Lund, J. (1988). Psychiatric aspects of Down's syndrome. *Acta Psychiatra Scandinavia, 78,* 369-374.

Maguire, K. B. and Piersel, W. C. (1992). Specialized treatment for behaviour problems of institutionalized persons with mental retardation. *Mental Retardation, 30(4),* 227-232.

Menolascino, F. J., Gilson, S. F. and Levitas, A. S. (1986). Clinical care update. Issues in the treatment of mentally retarded patients in the community mental health system. *Community Mental Health Journal, 22(4),* 314-327.

Nezu, C. M., Nezu, A. M. and Arean, P. (1991). Assertiveness and problem-solving training for mildly mentally retarded persons with dual diagnosis. *Research in Developmental Disabilities, 12(4),* 371-386.

Parsons, J. A., May, J. G. and Menolascino, F. J. (1984). The nature and incidence of mental

illness in mentally retarded individuals. In: Menolascino, F. J. and Stark, J. A. (ed.). (1984). *Handbook of Mental Illness in the Mentally Retarded,* New York: Plenum Press.

Reiss, S. and Benson, B. A. (1984). Awareness of negative social conditions among mentally retarded, emotionally disturbed outpatients. *American Journal of Psychiatry, 141(1),* 88-90.

Reiss, S. (1985). The mentally retarded, emotionally disturbed adult. In: Sigman, M. (ed.) (1985). *Children with Emotional Disorders and Developmental Disabilities. Assessment and Treatment.* New York: Grune & Stratton pp. 171-192.

Reiss, S. (1990). Prevalence of dual diagnosis in community-based day programs in the Chicago metropolitan area. *American Journal on Mental Retardation, 94(6),* 578-585.