CONTEMPORARY ISSUES IN LEARNING DISABILITY NURSING — A UK PERSPECTIVE

C Minto

ABSTRACT

There have been many changes in care provision for people with learning disability in the UK. The constantly changing face of healthcare provision in this area inevitably means that nurses in this specialist area of practice have had to develop new roles and will continue to further develop these roles and responsibilities in the future. An overview of policy developments, the changing nature of learning disability nursing, training and education issues, legislative considerations, practice development issues, and recruitment and retention issues is provided.

Keywords: *Learning disability, Learning disability nursing, Nursing*

INTRODUCTION

The issues raised in this article are only some of a wide range that impact on nursing practice in the field of learning disability nursing. These issues undoubtedly provide challenges for the profession, which need to be addressed. The areas discussed here can be examined within 5 broad categories:

- policy
- legislation
- training and education
- nursing practice
- recruitment.

It is this author's view that these issues (and those that other commentators may choose to highlight) are inevitably and inextricably linked. The problems that face learning disability nurses in any of these areas can best be resolved by ensuring that the voice of this group of nurses is heard at the highest levels of policy making, thus preserving the future of the profession. This is not to say that there has not been any contribution by learning disability nurses to the discussion in any of these areas — some of the authors referred to in this article for example have contributed to these debates. However, the involvement of learning disability nurses at the appropriate strategic levels within the profession must continue.

One way for these nurses to make a valued contribution is to describe and disseminate their practice within a research and development framework so that areas of practice can be legitimised and credited with providing reliable evidence. This will help to provide a distinct identity to the unique nature of learning disability nursing within the UK. In the Northgate and Prudhoe National Health Service (NHS) Trust, a strategy is now in place whereby nurses have an active role in a major development referred to within the UK NHS Executive Research and Development office as 'research capacity building'. It is not the purpose of this article to describe this process in detail. However, it is important to say that the strategy allows for nurses (historically the least exposed of the health care professionals) in the service to engage in the process of developing the whole range of research skills.

POLICY CHANGES

Historically, there are various significant points that could form the basis of this discussion. However, the emphasis here is given to the period from the mid 1960s onwards. There is no doubt that the policy changes introduced throughout the 1970s and 1980s have been, in part, driven by the backdrop of public scandals and enquiries into both psychiatric and learning disability institutions. Those institutions were developed in the 19th and 20th centuries as part of a moral awakening and desire for better care and treatment for these groups of people.

Some of the recent policy changes which have impacted on learning disability services in the UK include: Working for Patients;[1] Caring for People — Community Care in the Next Decade and Beyond;[2] The NHS and Community Care Act;[3] The Patient's Charter;[4] Priorities and Planning — Guidance for the NHS 1996/97;[5] and Griffiths' management proposals.[6] There have been many developments since the Jay Committee report in 1979.[7] In 1996, The UK National Health Service Executive set out a series of markers for 6 medium term priorities, defined to enable its regional offices, health authorities, general practitioners, and service providers to integrate their efforts.[8] Parrish suggests that these priorities will have profound effects on the way services are developed and, consequently, how nurses practice, for example "work towards the development of a primary care led NHS requires that decisions about purchasing and provision of health care are taken as close to the service user as possible."[9]

In a separate policy context, a major influence for nurses working within mental health and learning disability settings

is that of the legislative frameworks that surrounds their practice. In the UK, sources of mental health law can be traced back as far as the 14th century even though much of the care of people suffering from mental disorder occurred outside the realms of statute. It was not until the 18th and 19th centuries that mental disorder featured increasingly within statutory jurisdiction, and not until the Mental Health Acts of 1959 and 1983 that mental health legislation was contained within one comprehensive framework.

LEGISLATIVE ISSUES

Legislative issues have a direct bearing on learning disability nurses. The development of mental health legislation can be traced back approximately 250 years in the UK. The model of development has, in varying degrees, been replicated around the world. The intimacy of the relationship between past, present, and future should not be underestimated. As a result of the changes in mental health legislation, mental health policy has tended to be reactive, and "as a consequence has had to continually live with its ghosts in terms of physical plant, professional discourse, vested interest and, to a greater or lesser extent, public perceptions."[10] Inevitably these major policy changes impact on the nurses who work within the very systems that apply the law.

A major source of contradiction during this period has been that the policy of successive governments since 1960 has been to propose that the preferred model of service delivery of mental health and learning disability services should be in the form of 'care in the community.' Bartlett and Sandland further suggest that the contradiction has been that for the past 40 years, mental health law, in the form of the Mental Health Act of 1959 and the current act of 1983, has been predicated on the view that 'confinement' is the norm; a position that is an inheritance from earlier legislation that gave expression to such policies.[10] The paradox in this position is that mental health (and therefore learning disability) policy simultaneously deals with mentally disordered persons as being both 'of the community' and therefore needing and deserving of its care; and as 'outsiders' from whom the community needs some kind of protection. In fact, the White Paper of 1998 leaves us in no doubt that "maintaining the highest possible levels of public protection will remain our top priority."[11] If this leads to a quasi form of institutionalisation within a community context and perhaps a greater level of supervision and control than may be the case at present, then there is no doubt that community-based nurses will be in the front line of having to provide this extra supervision.

A long awaited major review and reform of the mental health legislative framework is currently underway. The government has established a 'scoping study review team' with the remit of considering a "root and branch rewriting of mental health law."[10] The panel reported to the government in July 1999 with a response from the government in the form of the Green Paper — Reform of the Mental Health Act 1983: proposals for reform.[12] This Green Paper invited views to be put forward by 31 March 2000. It is difficult to say at this stage what the actual implications for nurses will be.

PRACTICE OF LEARNING DISABILITY NURSING

CHANGING ROLES

Seal suggests that the development of the nursing profession in the field of learning disability has inevitably taken place within the context of the policy changes described above.[13] It is further suggested that despite these major changes to how services are being delivered, learning disability nurses are making a significant contribution to meeting the diverse range of needs that people with learning disabilities may present. The value of the nursing contribution is endorsed by recent documents such as Continuing the Commitment[14] and the response document from the English National Board for Nurses, Midwives and Health Visitors.[15] Parrish suggests that during the next 10 years, learning disability nursing will continue to change as a consequence of the major policy changes in this area.[9]

It is suggested that nurses will work as independent practitioners or as independent consultants. It is further suggested that they will continue to be professionally accountable to another nurse and will practice within the United Kingdom Central Council (UKCC) Code of Professional Conduct. It is clear that learning disability nurses will be needed across a variety of agencies. Nurses' roles will be more specific and specialised. Already many nurses have formal academic qualifications such as first degree, master's degrees, and doctorates. Some of those nurses have retained a place in nursing practice while others have opted for a teaching or research role. Those who have consolidated their practice experience as nurse specialists have done so in areas such as behaviourism, counselling, health education, community care, and other areas relevant to the needs of people with a learning disability. A specific example of how nursing roles and boundaries have altered can be illustrated by the Residential Care Home Regulation.[16] Here, nurses are employed as home managers. Rather than using their specific 'nursing skills', they may need to take on more of an advisory role to ensure that primary health care needs are met and that service users have access to a wide range of services.[13] The nurses who now take on these different roles have been prepared for practice by a new form of education and training. It is a myth that learning disability nurses are only working within a framework of nursing concepts.

The curricula for learning disabilities nursing in the UK, which took a dramatic shift with the inception of Project 2000 nurse training, covers a wide range of contemporary topics. For example, the issues of advocacy, bereavement, budget management, sexuality, and care management (a particular meaning within the UK arising out of community care legislation) are but a few of the areas where learning disability nurses historically would not have been given credit for their input.

The nature of learning disability nursing has changed out of all recognition. From a predominantly custodial role within institutional settings, community care has provided nurses with a framework to develop and deliver high-order therapeutic interventions to people with a learning disability and their families. Within institutional settings, where some specialist services continue to develop, nurses are also contributing to therapeutic programmes. For example, nurses are having a significant impact

within cognitive behavioural approaches. Current research is ongoing within the Northgate and Prudhoe NHS Trust to examine the role and perceptions of nurses involved in a major controlled trial of an anger treatment programme.[17] Similarly, the role of nurses involved in developing, implementing, and evaluating a sexual awareness package is also currently under investigation.[18]

CLINICAL SUPERVISION

The current emphasis on clinical supervision for nurses in the UK cannot be overstated and the same applies to nurses working in learning disability services. A review of the current literature has identified a multitude of aims relating to how clinical supervision is utilised in practice situations. In an exploratory qualitative study, the previous experiences of some nurses in a forensic learning disability service with regard to clinical supervision were examined.[19] Arguably, clinical supervision, can be explored from both macro (organisational and professional) and micro (personal and individual practitioner) perspectives. Although the study mentioned above is inevitably more concerned with micro perspectives, it cannot be ignored that the macro perspectives are inter-related. From a macro perspective, clinical supervision can clearly be regarded as a professionally driven concept. The central aim of clinical supervision should be to support the delivery of optimum care by safeguarding standards and by developing professional expertise in practice. Developing and sustaining nursing practice should be a high priority for the whole profession. The role of the skilled nurse is constantly evolving in order to address and adapt to the changing socio-political priorities that face the NHS.

The nursing profession has been relatively slow to accept that nurses at all levels, from students to senior nurses, need a relationship that focuses on the process and experience of nursing. This view is not intended to undervalue the contribution of unqualified nurses. While it has been argued that nursing is nothing if it is not practice, yet nurses have been quite prepared to practice without being properly clinically supervised. Nursing has tended to rely on 'hands on' experience. The importance of implementing formalised systems of clinical supervision has been stressed by both the Department of Health and the nursing profession.[20,21] Significant drivers have included the UKCC code of conduct[22] and scope for professional practice.[23] The recognition of the importance and value of clinical supervision for the development of nursing resulted in extensive consultation which culminated in the UKCC's 1996 position statement.[24] Clinical supervision, however, is not only about the profession, it is also about what nurses do for patients, outcomes, and clinical effectiveness of nursing practice, and the issue of constantly linking nurses with the people who are being nursed. Clinical supervision is a process that must be based on clinically focused professional relationships between the practitioner engaged in clinical practice and the clinical supervisor.

The issues facing practitioners in a learning disability forensic setting are many and varied. Although it is not the intention to go into detail here, it has to be reiterated that the nature of the work is inevitably highly complex and sensitive. Clearly clinical supervision should be high on the agenda for providing efficient, effective, and clinically credible services to patients and their families.

TRAINING AND EDUCATION ISSUES

The training and education initiatives needed to prepare the range of practitioners involved in providing services to the learning disabled population are constantly being reviewed and explored so that the needs of service users are appropriately met at different levels. Approaches to shared training across agencies (statutory and non-statutory) should be valued as complementary rather than competitive. In the UK, the main frameworks for professional training are provided within the university-based diploma/undergraduate nurse education programmes and the system of National Vocational Qualifications.

The 2 most recent reports which impact on the future of nurse education in the UK are The Commission for Education, UKCC, [25] and Making a Difference.[26] In the former, it is recognised that both the health services and higher education have been subjected to radical reviews and reforms to meet the demands from patients, clients, and students. It is further acknowledged that the nursing professions and their educators have achieved much during the past 10 years, although there are reported to be some shortcomings in terms of preparing nurses for registration. The report is structured around notions of lifelong learning, future trends, increasing flexibility, fitness for practice, and working in partnership. The commission makes recommendations to build on these achievements and to make good any deficiencies. In the latter, the report is structured around the themes of making a difference, new nursing in a new national health service, recruiting more nurses, strengthening education and training, developing a modern career framework, improving working lives, enhancing quality of care, strengthening leadership, modernising professional self-regulation, working in new ways, and making it happen.[26]

RECRUITMENT AND RETENTION ISSUES

Recruitment and retention of nurses within the UK NHS has attracted significant amounts of interest. In recent years, an acute shortage of nurses has been identified.[27] This has placed issues of recruitment and retention in the profession high on the political agenda. The nursing profession is often described in the media as being in a state of 'crisis', as demonstrated by a considerable shortage of trained nurses in many NHS hospital trusts. This has led to increased concern, both in the profession and in government, about whether the stock of trained nurses is adequate to meet the future health service needs of the population.[14,28-30]

The extent of the recruitment and retention problems is considerable. Between 1987 and 1995, intakes to nurse training fell from 19,600 to 14,200 per annum,[30] while an investigation of the 1991 census showed that only 68% of those of working age with nursing qualifications in England were working in the profession. Turnover in the NHS currently stands at around 9%, but is far higher for nurses who have recently completed their training.[30,31] Beishon et al. suggest that around 40% of nurses are expected to leave the NHS within the next 3 years.[32] The fact that turnover is highest for nurses aged less than 30 years is said to be of significant economic importance considering the average cost of £50,000 to train each nurse.[27]

Moreover, it costs approximately £5,000 for a hospital trust to replace a core staff nurse.[33] The net result of poor recruitment and retention of nurses is that many NHS hospitals and services have been forced to operate with vacancy rates for nurses of up to 20%, which in 1996 amounted to a national vacancy rate of around 6,600 full-time posts.[34] More recently, estimates suggest that the nursing shortage is closer to 15,000.[35] Hospital trusts have responded to this situation by increasingly relying on nursing agencies and temporary 'bank' nurses to meet their immediate staffing requirements.

CONCLUSION

This article has briefly reviewed some key issues that have had, and continue to have, an impact on nursing as a profession and learning disability nursing as a specialist area of practice. The historical context of learning disability services has been reviewed along with the development of learning disability nursing.

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Mr C Minto, MSc, LLB (Hons), PGCE, RGN, RMN, RNMH, Senior Lecturer/Academic Nurse Consultant, University of Northumbria, Newcastle, and Northgate and Prudhoe NHS Trust, Northumberland, UK.

Address for correspondence: Mr C Minto
Senior Lecturer/Academic Nurse Consultant
University of Northumbria
Newcastle NE7 7XA
UK.