



## The impact of staff initiated referral and intervention protocols on symptoms of depression in people with mild intellectual disability

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### ABSTRACT

It has been estimated that people with ID experience the same and possibly higher levels of depression than the general population. Referral to a General Medical Practitioner (GP) for primary care is recommended practice for people with depression and cognitive behavioural (CB) therapy is now an accepted evidence based intervention. A growing body of literature indicates that people with ID and depression may benefit from CB strategies. The aim of the current study was to compare (i) CB group intervention strategies with referral to a GP; (ii) CB group intervention strategies only; and (iii) referral to a GP only on symptoms of depression among people with mild ID. Staff from six participating agencies received training in (a) how to identify and screen individuals with mild ID for depressive symptoms and risk factors for depression, and (b) supportive referral of identified individuals to GPs for mental health services. In addition, staff from four of the agencies undertook (c) training on how to deliver group CB intervention strategies. Eighty-two participants were allocated to one of the three intervention groups. Depressive symptoms and negative automatic thoughts were assessed prior to the intervention, at the conclusion of the intervention, and at eight months follow-up. Compared to GP referral alone, those participants who received CB strategies both with and without GP referral displayed significant reductions in depressive symptoms. The use of CB strategies only also resulted in a significant reduction in frequency of negative automatic thoughts. The findings of this study support routine screening of individuals with mild ID for depression and the delivery of group CB intervention programmes by trained staff within community-based disability agencies.

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It is generally recognised that people with intellectual disability (ID) are more likely to experience mental health disorders than the general population (Gibbs, Brown, & Muir, 2008; Lowry, 1998; Morin, Cobigo, Rivard, & Lepine, 2010; Moss, 2001). It has also been reported that people with ID have the same, if not higher, levels of depression than the general population (Smiley & Cooper, 2003). Prevalence estimates among adults with ID range from 2.2% to 8.9% (Cooper, Smiley, Morrison, Williamson, & Allan, 2007; Davis, Judd, & Herrman, 1997; Deb, Thomas, & Bright, 2001; White, Chant, Edwards, Townsend, & Waghorn, 2005) with reported rates likely to be an underestimate due to difficulties associated with detection and diagnosis (Antonacci & Attiah, 2008; Kerker, Owens, Zigler, & Horwitz, 2004; McBrien, 2003; Perez-Achiaga, Nelson, & Hassiotis, 2009).

A number of life circumstances place people with ID at particular risk of developing mental health problems, including depression. Factors such as poverty, unemployment, impoverished social support and exclusion from social and community

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participation, family stress, and abuse are associated with poor mental health (Dagnan & Jahoda, 2006; Emerson, Hatton, Felce, & Murphy, 2001; Hastings, Hatton, Taylor, & Maddison, 2004; Lunsy & Benson, 2001; McGillivray & McCabe, 2007; Rose & Gerson, 2009). Furthermore, reduced psychological resources and cognitive abilities may render individuals with ID less able to adequately cope with adverse life events (van den Hout, Arntz, & Merckelbach, 2000). Individuals with mild ID may be particularly vulnerable due to awareness of their plight. These vulnerabilities provide a strong rationale for the early identification and treatment of those individuals at risk (McGillivray & McCabe, 2007).

There is some debate as to the treatment of choice for depression among people with ID. Treatment is commonly pharmacological, although there is relatively little research into the efficacy of antidepressant use in people with ID (Antonacci & Attiah, 2008; Sturmey, 2004) and findings remain equivocal. In a review of the treatment of mood disorders in adults with developmental disabilities, Antonacci and Attiah (2008) concluded that there is little evidence to support the use of antidepressants in the treatment of mood disorders among this population. However, a recent retrospective case-note analysis of 221 people with ID prescribed antidepressants for depression, generalised anxiety disorder, and obsessive compulsive disorder found that approximately half of the sample demonstrated clinical improvement (Rai & Kerr, 2010). Given the ongoing debate around pharmacological efficacy in this population, it is prudent to consider other treatment approaches.

There is a growing body of literature indicating that people with ID and depression may benefit from cognitive behavioural (CB) strategies (Dagnan & Chadwick, 1997; Ghafoori, Ratanasiripong, & Holladay, 2010; Lindsay, Howells, & Pitcaithly, 1993; Rose, West, & Clifford, 2000). While there is less research concerning the efficacy of CB strategies among people with ID in comparison to the general population (Beail, 2003; Hatton, 2002; Willner, 2005), when appropriately adapted, CB interventions appear helpful for people with mild ID experiencing a range of mental health problems (Hatton, 2002). In this population, we have demonstrated a reduction in depressive symptoms following participation in CB group treatment programmes and these positive effects were sustained over time (McCabe, McGillivray, & Newton, 2006; McGillivray & McCabe, 2007; McGillivray, McCabe, & Kershaw, 2008). The findings of a more recent study by Ghafoori et al. (2010) provide further support for a structured CB group treatment approach for individuals with mild-borderline ID who have depression. In this study, levels of depression in participants significantly decreased post-treatment, although improvements were not maintained at 4-month follow-up. There is also initial evidence that staff in disability agencies can be trained to effectively deliver CB group programmes to individuals with symptoms of depression (McGillivray et al., 2008). Although these findings are promising, there remains a need for further examination of interventions and particularly how best to facilitate access to depression treatment for this population.

In the Australian context, primary mental health care is provided by General Practitioners (GPs) who may refer their patients to mental health specialists, such as psychologists or psychiatrists. There are indications, however, that many individuals with ID who exhibit symptoms of depression are not diagnosed by their GP and do not receive appropriate mental health services (McGillivray & McCabe, 2007). It appears that access to general health care by people with ID is poorer than their non-disabled counterparts (Krahn, Hammond, & Turner, 2006; Ruddick, 2005; Webb & Rogers, 2002). A number of barriers have been identified, such as the absence of reliable and valid measures to explore health in people with ID, the potential for communication difficulties between the GP and the patient (Ruddick, 2005), as well as their lack of knowledge and experience with people with ID (Millar, Chorlton, & Lennox, 2004; Phillips, Morrison, & Davis, 2004). These barriers also apply to mental health care (Phillips et al., 2004), with the addition of barriers related to a lack of understanding of mental health risks, presentations and treatment options for people with ID (Deb et al., 2001). As such, there is a strong need for more effective methods of detecting depression and more efficient pathways of care for this population.

Disability support staff are well-placed to identify and assist individuals with mild ID who are experiencing depressive symptoms and may play a key role in either facilitating access to mental health care, or directly providing intervention strategies. In previous research, we have investigated the views of key stakeholders (including support workers, caregivers, and health professionals) about the perceived risk factors and characteristics of depression among people with mild ID, as well as the intervention needs of this population (McGillivray & McCabe, 2010). A key obstacle identified was the lack of staff trained to undertake screening and assessment of depression and to provide support and basic prevention/intervention programmes to individuals with ID.

Screening of people with ID who may be at-risk of depression is essential in order to ascertain individuals in need of referral or intervention. Screening does not require specific expertise and can be undertaken by minimally trained support staff (Hermans & Evenhuis, 2010). The benefits of clinicians working collaboratively with support staff in order to gather accurate diagnostic information about individuals with ID has been emphasised (Hurley, 2008). However, barriers to this process have also been identified. These include lack of knowledge about mental health concerns among caregivers (Borthwick-Duffy & Eyman, 1990), inadequate provision of mental health training for professional caregivers, and negative attitudes held by caregivers towards mental health services for individuals with mental health concerns (Edelstein & Glenwick, 2001). However, knowledge and attitudes of support staff may be enhanced through training (Costello, Hardy, Tsakanikos, & McCarthy, 2010).

The primary aim of the current study was to compare the impact (immediate and follow-up) of three intervention options: (i) staff administered group CB intervention strategies with referral to a GP; (ii) staff administered CB group intervention strategies only; and (iii) staff initiated referral to a GP only, on symptoms of depression among people with mild ID. A secondary aim was to evaluate the extent to which staffs were able to identify and screen individuals at risk for, or demonstrating symptoms of depression.

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