

# **Validating the EssenCES modified for people with learning disabilities in a low-risk secure Forensic setting**

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### Abstract

**Background:** Research has shown that an empowering and nurturing yet challenging work climate is beneficial for people receiving clinical services as it increases patient satisfaction, motivation, engagement, therapeutic alliance and functional improvement. Therefore, for inpatients, monitoring, encouraging and understanding ward climate holds considerable potential for improving forensic mental health services. To date, the most widely employed tool for ward-climate, the EssenCES, has been evidenced as useful in medium and high security hospitals, but little tested with people with learning disabilities or in low security services.

**Aims:** To establish the internal consistency and factor validity of the EssenCES, modified for easier reading, in a low secure hospital unit for people with learning disabilities.

**Method:** Language in the EssenCES was simplified and picture supplements added to facilitate comprehension. Patients completed the scale as part of their clinical routine, supported by NHS employed psychology assistants. The research team, entirely independent of NHS staff, extracted data from the electronic records of purposively sampled residents in a low-secure forensic hospital setting for people with learning disabilities.

**Findings:** 276 records (70% men) were acquired. The EssenCES was shown to have good factor validity and retained the original three factor model including the subscales: *therapeutic hold*, *safety* and *cohesion*. One single-item from the '*therapeutic hold*' subscale was removed to improve the internal consistency ( $p < 0.05$ ).

**Conclusions:** This study adds preliminary support for the use of the EssenCES (with removal of one item) in individuals with learning disabilities within low-risk secure forensic hospital settings.

## Introduction

Social or ward climate has been viewed as an important factor that underpins many social and systemic processes in psychiatric or forensic settings (Dickens, Suesse, Snyman & Picchioni, 2014). It has been explored in psychiatric hospitals generally and also secure forensic hospital settings (Bressington, Stewart, Beer, & MacInnes, 2011; Brunt, 2008; Brunt & Rask, 2007; Goldmeier & Silver, 1988; Kirby, 1997; Long, Anagnostakis, et al., 2011; Nasset, Rossberg, Almvik, & Friis, 2009; Schalast, Redies, Collins, Stacey, & Howells, 2008). Forensic hospital settings aim to provide patients with a safe social climate to facilitate recovery and support them to return and integrate into the wider community (Day, Casey, Vess, & Huisy, 2011) and increase satisfaction while in services (Rossberg & Friis, 2004; Røssberg, Melle, Opjordsmoen, & Friis, 2006). Moreover, it is arguable that creating an effective therapeutic environment is centrally important for motivation/engagement and therapeutic alliance (Johanson & Eklund, 2004; Long, Anagnostakis, *et al.*, 2011), functional improvement (Melle, Friis, Hauff, Island, Lorentzen, & Vaglum, 1996) and recovery and rehabilitation, (Graham, Bernards, Osgood, & Wells, 2006),

Social climate conceptualisation is complex. The term has been used interchangeably with ‘*culture*’ (Day *et al.*, 2011). Organisational ‘*culture*’ is thought, however, to be a distinct concept and can be understood as the overall philosophy of a system or organisation. where key members hold the same attitudes, perceptions and beliefs about behaviour (Day, *et al.*, 2011). ‘Climate’ can be defined as commonly observable and practiced perceptions of the organisation such as the support of new ideas and openness to change (Day *et al.*, 2011). Schalast, Redies, Collins, Stacey and Howell, (2008) proposed three key characteristics of social climate in therapeutic settings; a) perceived environmental safety; b) perceived mutual support; and c) the level of interpersonal tension. Given its importance and dynamic nature, there is a need to monitor and understand ward climates in forensic mental health settings (Lantta, Anttila, Kontio, Adams, & Välimäki, 2016). There are several available tools that have been developed to examine social climate within inpatient settings. The revised Ward Atmosphere Scale (WAS) (Moos & Houts, 1968) is now a 77-item measure that was developed to assess social climate in psychiatric wards. The WAS, however, has limited instrument validation research support and lacks internal consistency (Rossberg & Friis, 2003a; 2003b; Schalast et al, 2008). Schalast, et al, (2008) also noted that specific items were no longer appropriate given the change in health contexts and language over

time and highlighted the logistical challenges presented by the large number of items (Middelboe, Schjodt, & Byrstring 2001). The revised version has also been shown to have poor construct validity and internal consistency (Schalast, *et al*, 2008). To address these concerns, Schalast *et al*, (2008) developed a 15-item instrument - the Essen Climate Evaluation Schema (EssenCES). This measures three climate features, each with five items: (i) '*patient experienced safety*' (i.e. patient perceptions of tension and/or threat of aggression or violence); (ii) '*patient cohesion*' (mutual support: the kind typically seen as characteristic of therapeutic communities) and (iii) '*therapeutic hold*' (the perception that the environment is supportive of therapy and therapeutic change).

The EssenCES was originally validated in Germany with staff and patients from 20 medium-secure and high-secure forensic mental health hospitals. 333 staff completed the questionnaire (143 women) and 327 patients (315 men). Schalast *et al*, (2008) used factor analyses (principal components analysis) followed by a varimax rotation. The Corrected Item Total Correlation (CITC) coefficient for EssenCES ranged from adequate 0.49 to good 0.75, suggesting it is a reliable measure of social climate (Helmstader, 1964). Internal consistency using Cronbach's alpha was 0.73 to 0.87 (0.70 > is deemed as high internal consistency - Helmstader, 1964; Rossberg & Friis, 2003a). Schalast *et al*, (2008) concluded that the German version of the EssenCES is a valid measurement of social climate.

The EssenCES has since been translated into English and three studies have validated the tool in forensic hospitals in England (Milsom *et al*, 2014; Tonkin *et al*, 2012; Howells *et al*, 2009). Howells *et al*, (2009) recruited 324 staff and patient participants from three high secure hospitals to assess factor validity and internal consistency, finding that the internal consistency ratings of the EssenCES ranged from 0.72 to 0.82 and CITC was 0.18 - 0.69. One item from '*patient cohesion*' (most patients don't care about their fellow patient's problems) was found to fall below the CITC threshold (0.48). Removal of this item increased the internal consistency for the subscale from 0.48 to 0.76. This implies the item only impacts on '*patient cohesion*' subscale and not on the overall internal consistency of the EssenCES (Howells *et al*, 2009). Furthermore, Howells *et al*, (2009) found, within the patient group, '*experienced safety*' had the highest internal consistency (0.82), followed by '*therapeutic hold*' (0.79) and '*patient cohesion*' (0.72).

Tonkin *et al.*, (2012) examined the psychometric properties of this revised EssenCES (changing the problematic item in *patient cohesion*) and found support for its reliability and factor structure in both medium secure criminal justice and clinical settings. Cronbach's alpha co-efficient(s) demonstrated satisfactory internal consistency across all subscales. However, in contrast to Howells *et al.*, (2009) findings, '*patient cohesion*' had the highest internal consistency (0.92) followed by '*experienced safety*' (0.80) and '*therapeutic hold*' (0.79) (Helmstadter, 1964). Thus, both Tonkin *et al.*, (2019) and Howells *et al.*, (2009) found support for the three-factor structure for the EssenCES proposed by Schalast *et al.* (2008). The differences between the Howells and Tonkin studies may be explained by the increased heterogeneity in sample characteristics and context (low, medium and high secure settings). Milsom *et al.*, (2014) reassessed the validity of the EssenCES and looked to provide normative data in the UK for medium secure hospitals. They collated data from staff and patients across 12 medium secure mental health wards and found CITC values of 0.37-0.74 and support for the three-factor model; internal consistency amongst patients was highest for '*patient cohesion*' ( $\alpha$  0.86), followed by '*therapeutic hold*' ( $\alpha$  0.75) and '*experienced safety*' ( $\alpha$  0.66). In contrast to previous studies (Tonkin *et al.*, 2012; Howells *et al.*, 2009 and Schalast *et al.*, 2008), they also found two items in the subscale '*experience safety*' ('really threatening situation can occur here' and 'some patients are so excitable that one deals very cautiously with them') had unsatisfactory CITC. They concluded, however, that removing either or both items would not have a significant impact on the consistency of the '*experienced safety*' subscale.

An important development from Milsom *et al.*, (2012) was the inclusion of patients diagnosed with a learning disability, as the EssenCES was not originally developed for this population, but Milsom *et al.*, (2014) did not comment specifically on the results from the learning disability participants, perhaps because this subsample was too small. Quinn *et al.*, (2012) investigated the validity of the EssenCES in a sample of people of both sexes and a mean tested IQ of 63.21. The '*therapeutic hold*' subscale required transformation as this did not meet the parametric assumptions. Specifically, item 13 ('often staff seem not to care if patient succeed or fail treatment') gave a CITC value of 0.19. Once this item was removed, the internal consistency achieved an acceptable level. Cronbach's alpha revealed high internal consistency for '*experienced*

*safety*' (0.82), followed by '*therapeutic hold*' (0.79) and '*patient cohesion*' (0.72). Given that there are only these two small studies and none of people with learning disabilities in low security services, analysis of the EssenCES in such a sample would be beneficial. Our aim, therefore, was to assess the psychometric properties of the EssenCES in a specialist low security services for people with learning disabilities.

## **Method**

### **Ethics**

On 22<sup>nd</sup> January 2016, ethical approval was obtained from an National Health Service (NHS) Ethics Committee with expertise in assessing projects relating to learning disability.

### **Design**

A cross-sectional research design was used. Purposive sampling was employed to recruit 276 individuals (determined by *a priori* power analysis) likely to be representative of people with confirmed learning disability in low secure services in a National Health Service (NHS) setting.

### **Measures**

All participants completed the Essen Climate Evaluation Schema (EssenCES), English version. In the standard version there are 15 valid items, plus two positively worded items (an icebreaker and positively worded concluding item). Items are assessed on a 5-point Likert scale (0) I disagree, (1) I agree a little bit, (2) I agree a little bit more, (3) I agree quite a lot and (4) I agree very much. Six items were reversed scored, five of which were from the *safety* questions and one question for *therapeutic hold*. The questionnaire was adapted and included pictures and bullet point information to aid the participant understanding (Please see Appendix A for an example). The adapted version was developed by the lead consultant clinical psychologist in the learning disability forensic service in order that the measure was responsive to learning disability

service users to understand and give their responses. This was developed through a focus group and with speech and language therapy input.

All data were collected by NHS employees. Every six months the higher assistant psychologists (trained and experienced in administering and scoring the EssenCES) provided patients with the opportunity to complete the EssenCES. The questions were read by the psychologist, additional, neutral prompts offered if necessary and images pointed to in order to complement understanding.

## **Procedure**

All information was collated from the computerised staff records system (Patient records information system), with no direct contact between patients and researchers. To collate the data for this research, the staff sharing system (patient records information system, PaRIS) was accessed via a health service computer and all relevant information was gathered from the patient's records (date of birth, date the assessment was started (not inputted), sex, and EssenCES data).

## **Data Analysis:**

We replicated the analyses conducted in the original study of EssenCES (Shalast *et al*, 2008). In brief, therefore, we conducted a principal components analysis using varimax rotation, followed by tests of the reliability and internal consistency of the questionnaire. Preliminary data analysis using IBM SPSS v. 29 found no outliers but that select sub-scales were negatively skewed. Schalast et al. (2008) suggested that the latter is typical in criminal justice or clinical populations. Moreover, given the large sample size and robustness of PCA, the statistical analysis was conducted.

## Results

### General characteristics of the sample

276 patients were recruited. Their average age of the participant was 39 years (SD = 1.42). The majority of the patients were men (193, 70%).

### Principal Components Analysis (PCA) using Varimax Rotation

The tests for suitability of the data for factor analysis confirmed its appropriateness in this respect (KMO; Kaiser-Meyer-Olkin Measure of Sampling Adequacy and Bartlett's Test values  $>0.50$  (0.85),  $p=0.001$ ). Three components (factors) explained 60% of the total variance. The rotated component matrix confirmed a three factor solution for this participant sample. Single question items (that were assigned to the subfactor that made most intuitive sense) attained a loading of at least 0.60 (up to 0.81) on the 'right' factor. One item did not reach a loading of 0.40 (*therapeutic hold-4* (Q13)) and did not fall into any other factors. This item was therefore removed, along with questions 1 and 17, which are the two dummy items.

The principal components analysis using varimax rotation was re-run, with *therapeutic hold-4* removed. Appropriateness was reconfirmed (KMO and Bartlett's Test  $>0.50$  (0.83),  $p=0.001$ ). Three components (factors) still explained 60% of the total variance. Items assigned to the subscale also loaded onto one factor: all items now attained a loading of at least 0.65 (up to 0.81) on the 'right' factor (see Table 1).

Table 1 about here

### Corrected Item Total Correlation (CITC) and internal consistency

The CITC and internal consistency were measured across the three factors (*patient experienced safety, cohesion, therapeutic hold*). *Therapeutic hold-4* initially remained as this item did not significantly impact on the results within the PCA.

A CITC above 0.50 is considered as high (Helmstadter, 1964) and Rossberg and Friis (2003a). The CITC for this sample ranged from -0.22 to 0.70, therefore; only the item *therapeutic*

*hold-4* (-0.22) was removed. Once removed, all items appeared to be adequate indicators of the aspect they are assigned to and the CITC range was 0.51 to 0.70. See table 2.

## Discussion

The EssenCES, with its presentation adapted for people with learning disabilities, and used in a low security hospital unit, showed a similar three-factor structure as the parent scale has done in all other settings tested – *patient experienced safety, cohesion and therapeutic hold*, although removal of one of the therapeutic hold questions improved the reliability and validity of the adapted EssenCES increases this sample with learning disability.

The one difference between values relating to the *therapeutic hold* scale between the original studies and this work with people with learning disability is interesting, and perhaps an indirect validation. In our sample, the *therapeutic hold* scale had the lowest internal consistency in but it had the highest in Schalast *et al*, (2008) original work. The critical question 13 - item 4 of *therapeutic hold* requires the participant to engage in perspective taking and this may be impaired in people with a learning disability (Swanson, Harris & Graham, 2013). As we did not collect the data directly, we cannot be sure, but it is possible that these patients with learning disability did not have the capacity to complete this item and this may account for the difference found.

Our primary aim had been to test an adapted EssenCES within a low secure forensic learning disability service and thus add to previous research focusing on medium to high secure hospital patients, most of whom had mental illness (Schalast *et al*, 2008; Howells *et al*. 2009; Tonkin *et al*, 2012; Milsom *et al*, 2014). Our findings are consistent with the only prior study to present measurements separately for people with learning disability (Quinn *et al*, 2012), even to finding the same difficulty with the same item (Q 13, *therapeutic hold* item 4). Our larger sample reinforces a proposal that for people with learning disability, this item is best not attempted.

The subscale *safety* also varies in terms of internal consistency scores between different studies. It may be that sense of safety in a secure hospital unit, as a subjective experience, is dependent on the patient's experiences at the time of the questionnaire being completed, rather

than any 'steady state'. Factors such as fluctuations in number of aggressive and self-harming incidents are likely to affect a participant's perceived safety. In addition, patients may feel paradoxically less safe in high security settings because of the presence of more high risk patients and/or more intrusive security features may create an impression of danger (Milsom *et al*, 2014).

### ***Strengths and limitations of the study***

One noteworthy limitation of our study was that we had no details of how the EssenCES had actually been administered in practice. The higher assistant psychologists in this service had guided the participant through the questionnaire, ensuring they understood the questions, but we did not observe this directly and so cannot tell the extent to which they were able to stay truly neutral or the extent to which they may have inadvertently given cues to the patients on direction or strength of ratings. It would be important for future research to standardise administration of psychometric measures in learning disability populations, including training and review of performance of those who administer these measures. Nevertheless, this study is one of the first to highlight the effective use of images that help diverse learning disability populations understand what they are being asked and to respond.

It is unclear whether the period of time over which the EssenCES were completed was a strength or limitation. It is likely that the environment and experience of it changed over a 3 year period. The properties of this scale were measured in that context. As subscale identification as so similar to that in other studies in other circumstances, we suggest that this, in fact, adds weight to evidence for robustness of this tool.

### **Conclusions**

The EssenCES was not originally developed for patients with cognitive impairments, but measurement of ward atmosphere or therapeutic climate is just as important for this groups as others. We found that an adaptation of the tool, which simplified wording of the items and provided accompanying pictorial cues, together with removal of just one item (Q 13 within *therapeutic hold*) resulted in a tool with psychometric properties similar to the original and robust. We recommend its use in future research and practice.

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**Table 1: The EssenCES, with presentation modified for people with learning disability, principal components analysis with varimax rotation**

<b>Subscale and item number</b>	<b>Therapeutic Hold</b>	<b>Safety</b>	<b>Patient Cohesion</b>
<b>Therapeutic Hold 1</b>	0.69	-0.08	0.24
<b>Safety 1</b>	-0.02	0.78	-0.21
<b>Patient Cohesion 1</b>	0.26	-0.23	0.66
<b>Therapeutic Hold 2</b>	<b>0.80</b>	-0.05	0.12
<b>Safety 2</b>	-0.14	0.81	0.00
<b>Patient Cohesion 2</b>	0.30	-0.12	0.74
<b>Therapeutic Hold 3</b>	0.76	0.03	0.11
<b>Safety 3</b>	-0.07	<b>0.80</b>	-0.01
<b>Patient Cohesion 3</b>	-0.01	0.11	0.77
<b>Safety 4</b>	-0.03	0.68	0.06
<b>Patient Cohesion 4</b>	0.16	0.17	<b>0.80</b>
<b>Therapeutic Hold 5</b>	0.70	0.12	0.16
<b>Safety 5</b>	0.13	0.65	0.11
<b>Patient Cohesion 5</b>	0.17	-0.12	<b>0.80</b>

**Table 2: The EssenCES - reliability indices calculated using Cronbach's Alpha and the comparable alphas from earlier literature**

Scale	a Total sample (n = 271)	a Schalast et al (2008) (n = 327)	a Howells (2009)
Therapeutic Hold	0.75	0.87	0.79 (n = 72)
Safety	0.81	0.79	0.82 (n = 72)
Patient Cohesion	0.84	0.80	0.72 (n = 72)

