

# Trainees' assessment and management of mental illness in adults with mild learning disabilities

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**Recommended changes in services for adults with mild learning disabilities are likely to have training implications. A case vignette study examined the effect of coexistent mental illness and learning disability on trainees' clinical assessment and management. Mental illness was more likely to be diagnosed in those with a mild learning disability than in a control group who had no learning disability. Despite this, the learning disability group was less likely to receive treatment. Service and training issues are discussed.**

The Joint Working Group of the Sections for Psychiatry of Learning Disability and General Psychiatry recommendations in *Meeting the Mental Health Needs of People with Learning Disabilities* (Royal College of Psychiatrists, 1997) include setting up specialist multi-disciplinary mental health teams which would facilitate the use of generic health services by people with mild learning disabilities and coexistent mental health problems, and the promotion of joint working between learning disability and other specialists to enable the latter to serve people with mild learning disabilities. This study aims to look at trainees' initial assessment and subsequent clinical management of such cases. Limited experience and knowledge about mental illness in those with a learning disability may result in diagnostic difficulties, as well as uncertainty about ways of meeting their mental health needs. There may also be a tendency to attribute their presenting features to the learning disability rather than to the coexistent mental illness. Our hypothesis was that knowledge about the presence of a mild learning disability could result in differences in assessment and management compared to a control group.

## **The study**

A questionnaire was sent to all senior house officers and registrars ( $n=69$ ) in clinical posts in

the Bethlem and Maudsley Trust. For half of the sample this consisted of the following case vignette:

A 35-year-old woman is brought to the emergency clinic by her sister. According to her sister she has not eaten over the last three days and is drinking very little. She has not been involved in her usual activities. The patient had been living with their mother until her sudden death a month ago. Since then she has been staying with her sister. You are told that the patient has a mild learning disability and needs some help with daily living skills.

At interview the patient is unkempt, displays psychomotor retardation and admits that life is not worth living, although she has not harmed herself. She admits to hearing a voice which she recognises as that of her mother, and the voice is telling her that she is bad. The sister says that she can no longer manage her at home.

The remainder of the sample received a similar vignette which did not mention learning disability and her requiring help with daily living skills. Subjects were asked to indicate degree of agreement or disagreement on a five-point Likert scale about: the presence of psychotic depression; level of suicide risk; need for admission; use of the Mental Health Act; use of electroconvulsive therapy (ECT); use of neuroleptic drugs; consideration of psychological treatment once improved; and delaying discharge until alternative accommodation was planned. For each respondent a total 'treatment score' based on the sum of the scores for use of ECT, neuroleptics and psychological treatment was calculated. Independent sample  $t$ -tests were used for statistical analyses.

Since clinical management is based upon assessment opinion, the data were further examined to look at the treatment views of those respondents who agreed that the diagnosis was psychotic depression. Any differences between the two groups would be expected to be directly related to differences in information presented in the vignettes.

## Findings

Fifty-eight questionnaires were returned which gave a response rate of 84%. When compared to the control group, the learning disability case group were more likely to regard the diagnosis as psychotic depression (means=1.07 and 1.56,  $t=2.05$ ,  $d.f.=55$ ,  $P<0.05$ ). There were no other differences between the groups. The total 'treatment score' showed that the learning disability case group were less likely to agree with the suggested treatment approaches (means=4.9 and 4.04,  $t=2.05$ ,  $d.f.=56$ ,  $P<0.05$ ).

### Treatment of psychotic depression

Of those who agreed that the diagnosis was psychotic depression, respondents of the learning disability case were less likely to agree with the use of ECT (means=2.61 and 1.94,  $t=2.33$ ,  $d.f.=38$ ,  $P<0.05$ ). There was no difference in neuroleptic use.

## Comment

Case vignettes are a recognised means of controlling for possible confounding factors in the assessment of clinical management decisions (Lewis & Appleby, 1988). The high response rate means that the findings are likely to reflect trainees' views. Limitations of the study include the availability of limited information in a vignette as compared to a clinical assessment, and that in real-life situations clinicians are likely to consult with a specialist in the psychiatry of learning disabilities.

The difference in the diagnosis of psychotic depression between the two groups is opposite to the finding of Reiss *et al* (1982), who found that psychologists were less likely to diagnose phobia, schizophrenia and personality disorder in mild learning disability groups compared to control groups. They used the term 'diagnostic overshadowing' to explain the process whereby knowledge of the presence of learning disability reduces the likelihood that emotional or behavioural disturbance is appropriately diagnosed. Our case involves aspects of bereavement and other losses (e.g. home). It is possible that the described features were regarded as a grief reaction in the control group, but fit trainees' perception of psychotic depression in the learning disabled. Further evidence may be required to make a diagnosis of psychotic depression in the control group. This difference in diagnostic threshold, as well as differences between the groups in terms of 'total treatment score', may reflect attitudes towards people with learning disabilities. However, there was no other evidence of dismissive or rejecting attitudes,

although the study did not explicitly attempt to elicit such attitudes.

Although respondents in the learning disability group were more likely to diagnose psychotic depression, they were less likely to agree to the use of ECT, perhaps reflecting concern about exacerbating cognitive impairment or uncertainty about its indications. Surprisingly, there was no difference in neuroleptic use given the higher risk of tardive dyskinesia in those with brain pathology.

The comorbidity of mental illness and learning disability is common. Affective disorders can be accurately diagnosed with an adequate informant history and behavioural observation. Gravestock & Bouras (1997) found that clinicians regarded history taking and observation of interview behaviour as the most useful components of the psychiatric assessment of adults with learning disability.

Trainees may feel that they receive insufficient training to manage people with dual disabilities (Lennox & Chaplin, 1995). With recent recommendations that specialised services for people with learning disabilities should be integrated with generic mental health services with access to the latter's in-patient beds, future training will need to take account of this (Menolascino & Fleisher, 1992).

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