North West
School of Psychiatry

Intellectual Disability Module Handbook

MRCPsych Course
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A Psychiatry Medical Education Collaborative between Mental Health Trusts and Health Education North West

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Session 1: History Taking and Communication in Patients with an Intellectual Disability

Learning Objectives

- Awareness of the difficulties encountered in assessing patients with an intellectual disability
- Use of other forms of communication rather than just verbal
- The importance and role of the developmental history
- To develop an understanding of how patients with an intellectual disability can present with conditions such as a mental disorder

Curriculum Links

13.3 Clinical

13.3.1 Assessment and communication with people with intellectual disability.

13.3.2 The presentation and diagnosis of psychiatric illness and behavioral disorder in people with intellectual disability, including the concept of diagnostic overshadowing

13.2.2 Aetiology. The influence of psychological and social factors on intellectual and emotional development in people with intellectual disability, including the concept of secondary handicap.

Expert Led Session

- Assessment, interviewing & gathering information in adults with Intellectual disability

Case Presentation

- Case presentation of local patient with intellectual disability, identified by tutor or specialist in post. (This does not have to be an inpatient and discussion with the local ID team may be appropriate in advance to identify such a case). Brief discussion on aetiology as applicable to the case in a formulation type summary

Journal Club Presentation

- Assessment of mental health problems in people with autism Xenitidis K., Paliokosta E., Maltezos S. and Pappas V. (2007). Advances in Mental Health and Learning Disabilities 1, 4, 15-22.
- A guide to intellectual disability psychiatry assessments in the community. Advances in psychiatry Treatment November 1, 2013 19:429-436
- Learning disability in the accident and emergency department. Advances in Psychiatric Treatment January 2005 11:45-57

'555' Topics (5 slides on each topic with no more than 5 bullet points)

Please select one of the following:

- Assessment of the agitated patient in the emergency room setting (focus on environment, style of communication, getting informant history etc)
- How to assess for a mental illness in a patient with a Intellectual disability (Focus on depressed mood or psychosis depending on confidence of chair- possible mute patient, signs and how they differ, role of biological symptoms and effect on routine)
- How to perform a full Developmental History (Focus on all aspects of development and issues of schooling, statement of educational needs, support and current functional ability etc)

MCQs

1. With regard to people with intellectual disabilities, which of the following is false:

A. Diagnosis of intellectual disability is dependent on significantly sub-average IQ and associated deficits in adaptive behaviour with onset occurring before 18 years of age

B. The prevalence of intellectual disability in the general population is 3%

C. Mental health problems are more common than in the general population

D. Mental health problems always present as challenging behaviour

E. The philosophy of normalisation supports people with intellectual disabilities accessing generic health services.

2. According to ICD-10, the following is not a degree of mental retardation:

A. Borderline

B. Moderate

C. Profound

D. Severe

E. Mild

3. Disruptive and dissocial behaviour occurs more commonly in which of the following category?

A. Mild intellectual disability

B. Moderate intellectual disability

C. Severe intellectual disability

D. Profound intellectual disability

E. Equally common across all categories

4. The prevalence of epilepsy in the intellectual disability population is approximately:

A. 1-2%

B. 5-10%

C. 10-15%

D. 20-25%

E. 50%

5. The communication style that does not interfere with assessment in the intellectual disability population is:

A. Denial
B. Fabrication
C. Engagement
D. Digression
E. Suggestibility

Additional Resources / Reading Materials

Books

Intellectual Disability Psychiatry: A Practical Handbook. Edited by Angela Hassiotis, Diana Andrea Barron and Ian Hall.(2010) Wiley Publications.

The Psychiatry of Intellectual Disability. Edited by Meera Roy, Ashok Roy & David Clark. 2006 *Radcliffe Publishing Ltd.*

Royal College of Psychiatrists. DC-LD: Diagnostic Criteria for Psychiatric Disorders for Use with Adults with Learning Disabilities/mental Retardation (Occasional paper) http://www.rcpsych.ac.uk/publications/collegereports/op/op48.aspx

E-Learning

http://www.gmc-uk.org/learningdisabilities/

Journal Articles

Cooper, A., Simpson, N. (2006). Assessment and classification of psychiatric disorders in adults with learning disabilities. *Psychiatry,* 5: 306-11.

Cooper, S.-A., van der Speck, R. (2009) Epidemiology of mental ill health in adults with intellectual disabilities. *Current Opinion in Psychiatry*. 22: 431-436.

Session 2: Mental Disorders in Intellectual Disability

Learning Objectives

- Recognising and identifying how the presentation of mental disorders differs in ID population
- Importance of collateral information from various sources
- Role of medication/ doses/side effects

Curriculum Links

13.1 Services

13.1.2 The provision of specialist psychiatric services for people with intellectual disability

13.2.1 The factors which might account for the observed high rates of psychiatric behavioral disorders in this group.

13.3.2 The presentation and diagnosis of psychiatric illness and behavioral disorder in people with intellectual disability, including the concept of diagnostic overshadowing

13.3.4 The application of psychiatric methods of treatment in intellectual disability including drug treatments. The application of a multidisciplinary approach to the management of mental health problems in people with intellectual disability

Expert Led Session

- Dr Patel's presentation - Mental disorders

Case Presentation

- Case presentation of a local patient with intellectual disability, identified by tutor or specialist in post. If there is neither a specialist consultant nor tutor in post **discussion with the local ID team** may be appropriate in advance to identify such a case. Brief discussion on aetiology as applicable to the case in a formulation type summary

Journal Club Presentation

Please select one of the following papers:

- Cooper S.A., Smiley E., Morrison J., Williamson A. and Allan L. (2007) Mental ill-health in adults with intellectual disabilities: prevalence and associated factors. British Journal of Psychiatry 190, 1, 27-35.

- Hurley A.D. (2006) Mood disorders in intellectual disability. Current Opinion in Psychiatry 19, 5, 465-469.

- Cooper S.A. Melville C.A. and Enfield S.L. (2003) Psychiatric diagnosis, intellectual disabilities and Diagnostic Criteria for Psychiatric Disorders for Use with Adults with Learning Disabilities/Mental Retardation (DC-LD). Journal of Intellectual Disability Research 47, supplement one, 3-15.

'555' Topics (5 slides on each topic with no more than 5 bullet points)

Please select one of the following:

- Assessment of the Psychotic patient in the community setting (focus on environment, style of communication, getting informant history etc.)

- Perform a risk assessment in a patient with a moderate Learning disability who is presenting with self-injurious behaviour (Focus on nature of behaviours, communication ability of the patient, issues of any change.)

- What are the roles of a community ID nurse, speech and Language therapist and an Occupational therapist in the ID team?(You can discuss this with your local ID team to guide with the task)

MCQs

1. In individuals with severe learning disability, self-injurious behaviour has a peak occurrence between the ages of:

A. 10-15 yrs
B. 15-20
C. 20-25
D. 25-30
E. 35-40

2. Self-injurious behaviour is common in which of the following:

A. Cri du chat syndrome
B. Angelman syndrome
C. Downs Syndrome
D. Cornelia de Lange syndrome
E. Lesch Nyhan syndrome

3. Prevalence of depression in ID is around:

A. 1%

B. 2-4%

C. 5-15%

D. 16-25%

E. 26 -35%

4. Which of the following apply to the PAS-ADD:

A. Was developed from the SCID

B. Focuses exclusively to Axis II Disorders

C. Designed for completion by carers with knowledge of psychopathology

D. Each item is rated on a 6 point scale

E. It comprises a life events and a problems section

5. In patients with ID and schizophrenia compared with patients with ID alone, the following were noted:

A. Impaired mobility

B. High birth weight

C. Gestation beyond 38 weeks

D. Impaired hearing

E. Low rates of obstetric complications

Additional Resources / Reading Materials

Books

Seminars in the psychiatry of learning disabilities – second edition (2003), The Royal college of Psychiatrists, Gaskell

Psychiatric and behavioural disorders in developmental disabilities and mental retardation (2001), Edited by Nick Bouras, Cambridge University Press, 1999. Reprinted 2001.

Practice guidelines for the assessment and diagnosis of mental health problems in adults with intellectual disability (2001) Deb, S., Matthews, T., Holt, G., & Bouras, N. published by Pavillion for the European Association for mental Health in Mental Retardation.

Sturmey, P. (1995) DSM-III-R and persons with dual diagnoses: conceptual issues and strategies for future research, *Journal of intellectual Disability Research*, 39, 357-364

Corbett, J. A. (1979) Psychiatric morbidity and mental retardation. In: F. E. James and R. P. Snaith (Eds.) *Psychiatric illness and Mental Handicap*, London: Gaskell.

Lund, J. (1985) The prevalence of psychiatric morbidity in mentally retarded adults, *Acta Psychiatrica Scandinavica*, **72**, 563-570

Reiss, S. (1988) *The Reiss Screen for Maladaptive Behaviour*. Ohio: IDS Publishing Corporation.

Matson JL and Bamburg J (1998) Reliability of the assessment of dual diagnosis (ADD), research in Developmental Disabilities 20, 89-95

Moss S (2002) The mini PAS-ADD interview pack, Brighton: Pavilion Publishing

Roy A, Matthew H, Martin D and fowler V (2002) HoNOS-LD: Health of the Nation Outcome scale for people with Learning Disabilities, Kidderminster: British Institute of Learning Disabilities

Journal Articles

Bouras, N. and Drummond, C. (1992) Behaviour and psychiatric disorders of people with mental handicaps living in the community. *Journal of Intellectual Disability Research*, **36**, 349-357.

Patel, P., Goldberg, D., and Moss, S. (1993) Psychiatric Morbidity in older people with moderate and severe learning disability: The Prevalence Study, *British Journal of Psychiatry*, **163**, 481-491.

Diagnostic Criteria for Psychiatric Disorders for adults with learning disabilities (DC-LD) (2003) *Journal of Intellectual Disability Research*, 47, supplement 1.

Session 3: Behavioural Issues in Intellectual Disability

Learning Objectives

- Understanding challenging behaviour and awareness of methods of recording/ assessing
- Aetiology of challenging behaviours
- Management options

Curriculum Links

13.1 Services

13.1.2 The provision of specialist psychiatric services for people with intellectual disability

13.2.1 The factors which might account to the observed high rates of psychiatric behavioural disorders in this group

13.3.2 The presentation and diagnosis of psychiatric illness and behavioural disorder in people with intellectual disability, including the concept of diagnostic overshadowing

Expert Led Session

- Challenging Behaviour Talk

Case Presentation

- Case presentation of local patient with intellectual disability presenting with behavioural problems, identified by tutor or specialist in post (this does not have to be an inpatient and discussion with the local ID team may be appropriate in advance to identify such a case). Brief discussion on aetiology as applicable to the case in a formulation type summary

Journal Club Presentation

Please select one of the following papers:

Unwin G.L. and Deb S. (2008) A multi-centre audit of the use of medication for the management of behavioural problems in adults with intellectual disabilities. British Journal of Learning Disabilities, 36, 2, 140-143

- Cooper S.A. Melville C.A. and Enfield S.L. (2003) Psychiatric diagnosis, intellectual disabilities and Diagnostic Criteria for Psychiatric Disorders for Use with Adults with Learning Disabilities/Mental Retardation (DC-LD). Journal of Intellectual Disability Research 47, supplement one, 3-15.

- Group-based cognitive-behavioural anger management for people with mild to moderate intellectual disabilities: cluster randomised controlled trial BJP October 2013 203:288-296;

'555' Topics (5 slides on each topic with no more than 5 bullet points)

Please select one of the following:

- Review of Frith Guidelines on management of Patients with ID that present with Aggressive or Self Injurious behaviours. (Read the Guidelines in particular the flow charts)

- Describe challenging behaviour and the various phases of the cycle of challenging behaviour (Focus on nature of behaviours, communication ability of the patient, issues of any change.)

- Formal Assessment of a behavioural problem with a view to intervention. (You can discuss this with your local ID team to guide with the task). Steps involved, would include ABC charts or functional assessments and basic behavioural interventions

MCQs

1. Causes of challenging behaviour in a person with learning disability:

A. Pain
B. Overstimulation
C. Under stimulation
D. Wanting attention
E. All of the above

2. The following statements are true of factors increasing challenging behaviours in a person with learning disability except which option?

A. Undetected physical illness
B. Communication problems
C. Underlying mental illness
D. Environmental issues
E. Problem solving ability

3. Inappropriate behaviours may be maintained by re-enforcement from others. Which of the following is a process that helps to identify factors maintaining that behaviour?

A. Functional analysis
B. Statistical analysis
C. Procedural analysis
D. Behavioural analysis

EMI Questions

Match each of the following psychological strategies to their possible effects**:**

A. Proactive Strategies
B. Positive Programming
C. Focused Support
D. Reactive Strategies

1. Systematic instructions given for greater skills and competence development which improves social integration

2. To produce rapid results and reduce reactive strategies

3. Designed to manage the behaviours at the time they occur

4. To produce change over time

Additional Resources / Reading Materials

E-Learning

www.LD-Medication.bham.ac.uk

British Psychological Society and Royal College of Psychiatrists (BPS & RCPsych, 2006). Challenging behaviour: a unified approach. Available:

http://www.rcpsych.ac.uk/pdf/23%2009%202011%20LD%20PSYCH%20READING%20LIST.pdf

Session 4: Offenders in Intellectual Disability

Learning Objectives

- Awareness of differences in offending behaviours in ID population
- Outcome following Offence
- Treatment options for offenders with ID

Curriculum Links

13.1 Services

13.1.2 The provision of specialist psychiatric services for people with intellectual disability *Forensic ID

13.2.1 The factors which might account to the observed high rates of psychiatric behavioural disorders in this group.

13.2.2 The influence of psychological and social factors on intellectual and emotional development in people with intellectual disability, including the

13.3.2 The presentation and diagnosis of psychiatric illness and behavioural disorder in people with intellectual disability, including the concept of diagnostic overshadowing

13.2.1 The factors which might account to the observed high rates of psychiatric behavioural disorders in this group

13.3.7 The assessment, management and treatment of offenders with intellectual disability

Expert Led Session

Dr. Razzaque Lecture (and Dr Burke and Dr Gupta) + optional case vignettes

Case Presentation

Case presentation of local patient with intellectual disability presenting with offending behaviour problems. , identified by tutor or specialist in post (this does not have to be an inpatient and discussion with the local ID team may be appropriate in advance to identify such a case). Brief discussion on aetiology as applicable to the case in a formulation type chair to pose question if patient has an IQ of 55 how will this alter i.e. pathway/management.

Journal Club Presentation

Please select one of the following papers:

- Mentally disordered detainees in the police station: the role of the psychiatrist APT March 2010 16:115-123; doi:10.1192/apt.bp.107.004507
- Ian Hall Young offenders with a learning disability APT July 2000 6:278-285; doi:10.1192/apt.6.4.278
- S. Halstead Forensic Psychiatry for People with Learning Disability APT March 1996 2:76-85; doi:10.1192/apt.2.2.76

'555' Topics (5 slides on each topic with no more than 5 bullet points)

Please select one of the following:

- Describe the pathway of a person with intellectual disability following a recent fire setting incident
- Describe Disability Discrimination Act and its impact on patients and clinicians. (Focus on nature of behaviours, communication ability of the patient, issues of any change.)
- Safe Guarding Formal Assessment of a behavioural problem with a view to intervention. (You can discuss this with your local ID team to guide with the task)

MCQs

1. Offenders with ID compared to other offenders:

A. Start offending at a later age
B. Frequently are convicted of single offences
C. Arson offences are over represented
D. More in severe and profound disability
E. Less likely to be convicted

2. Mentally ill offenders with ID were found to be:

A. Younger at first conviction
B. Had less admissions to psychiatric hospitals
C. Showed a high frequency of violence
D. Tended to be females
E. Committed more serious offences during the follow-up period

3. In patients with ID referred for evaluation for a report, the percentage felt not competent to stand trial is (approximately):

A. Up to 10%
B. 11 - 20%
C. 21 - 30%
D. 31 - 40%
E. 41 - 50%

4. In offenders with ID the following is the most commonly used form of psychological input/ therapy:

A. Psychodynamic Psychotherapy
B. Gestalt Therapy
C. Cognitive Behavioural Therapy
D. Response and stimulus prevention
E. Dialectical Behavioural Therapy

5. Regarding the PCL-R;

A. Low scores are related to recidivism
B. Relate to Cluster A personality disorders
C. Those in medium security have higher scores than those in high security
D. Scoring patterns in ID population are significantly different compared to the general population
E. High scores relate to aggression

Additional Resources / Reading Materials

- **William Fraser & Michael Kerr (eds) Seminars in the psychiatry of learning disability Gaskell Press 2003 ISBN 1-901242-93-5
  Chapter 16: Forensic psychiatry and learning disability by Susan Johnston
- Wm Lindsay et al (Eds) Offenders with developmental disabilities 2004. Willey ISBN: 0-471-48635-3
- Ian Hall Young offenders with a learning disability APT July 2000 6:278-285; doi:10.1192/apt.6.4.278
- S. Halstead Forensic Psychiatry for People with Learning Disability APT March 1996 2:76-85; doi:10.1192/apt.2.2.76
- Mentally disordered detainees in the police station: the role of the psychiatrist APT March 2010 16:115-123; doi:10.1192/apt.bp.107.004507
- Kalpana Dein and Marc Woodbury-Smith Asperger syndrome and criminal behaviour APT January 2010 16:37-43; doi:10.1192/apt.bp.107.005082
- David Murphy Understanding offenders with autism-spectrum disorders: what can forensic services do?: commentary on... asperger syndrome and criminal behaviour APT January 2010

16:44-46; doi:10.1192/apt.bp.109.006775

- Michael A. Ventress, Keith J. B. Rix, and John H. Kent: Keeping PACE: fitness to be interviewed by the police APT September 2008 14:369-381; doi:10.1192/apt.bp.107.004093

Legal aspects in Psychiatry of Learning Disability:

This module does not currently include a specific lecture on legal aspects. You should be familiar with the Mental Health Act 1983 and Mental Capacity Act 2005 from other modules on this course. Some supplementary reading is included here:

- Asit B. Biswas and Avinash Hiremath: Mental capacity assessment and 'best interests' decision-making in clinical practice: a case illustration APT November 2010 16:440-447; doi:10.1192/apt.bp.108.006494