

In-patient care for people with a learning disability and a mental illness

The first eight years of a specialist unit

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People with the dual diagnosis of mental illness and mental retardation have proved difficult to resettle from hospital. Yet there is considerable evidence that, if diagnosed correctly, treatment for such patients can be effective (e.g. Matson, 1981; Welch & Sigman, 1980). This paper describes the outcome of treatment at a specialist unit for patients with dual diagnosis.

The study

Service description

The Brunel Unit has 14 in-patient beds for adults with mild mental retardation associated with a psychosis or severely disabling neurosis. It is located at Lea Castle Mental Handicap Hospital in Worcestershire, which at the time of the study had 229 beds serving a catchment area of one million people. The unit comprises three flats, respectively for the assessment of new admissions, for treating patients recovering from acute illness, and for sustained rehabilitation.

Staffing includes 28 nurses, of whom the majority are registered nurses in mental handicap with additional in-house training in mental illness. Medical staffing comprises two sessions each of a consultant psychiatrist and a senior registrar, with ward cover from a registrar. Other staff include a part-time occupational therapist, and sessional inputs from a music therapist and an art therapist. Training has been important in limiting anxiety about the 'dangerousness' of patients, reducing rates of injury among staff and patients, and maintaining team spirit.

Treatment includes drug therapy, individual and group psychotherapy, behavioural programmes, occupational therapy, art therapy, music therapy, relaxation therapy, assertiveness training, health education, computer-assisted learning, and domestic and social skills training. Patients attend treatment facilities elsewhere in the hospital, including further education, remedial teaching, recreation and work skills. ECT is

used infrequently. The unit has sessional time from a neurophysiologist and an EEG technician, who are able to obtain EEG recordings from even the most disturbed patients.

Dr Hurst and Dr Nadarajah separately reviewed case-notes for all 157 first admissions to the unit between May 1983 and February 1991, and assigned diagnoses using DSM-III-R definitions (with agreement on the diagnoses of all but two patients). Outcome at discharge was jointly assessed using a four-point scale: 1. relief of presenting disorder; 2. improvement of presenting disorder; 3. no change in presenting disorder; and 4. worsening of presenting disorder.

The patients

The 157 patients included 97 men and 60 women. Ages on admission ranged between 15 and 63 years, with a mean of 30 years. Two thirds (66%) were assessed as having mild mental retardation using DSM-III-R criteria, with 30% having moderate mental retardation, and 4% with a borderline mental retardation (IQ 70-84). Over a quarter (27%) of patients had epilepsy, and 29% had chromosomal abnormalities or neurological disorders, including 15 with chromosomal abnormalities (nine of the sex chromosomes and six of autosomes), seven with neurological abnormalities from birth (including tuberous sclerosis), six with histories of infection (including encephalitis), eight with motor abnormalities (including hemiplegia and cerebral palsy), four with histories of trauma, and five with associated sensory impairments.

The main psychiatric diagnoses on Axis I are shown in Table 1. The most common were schizophrenia (29%), mood disorders (21%), other psychotic disorders (8%), and sexual disorders (6%). Patients with mood disorders comprised 16% with bipolar affective psychoses, 1% with dysthymia, and 4% with depressive disorder. The group with other psychotic disorders comprised two patients with delusional

Table 1. Diagnoses of main psychiatric disorders (Axis I)

Diagnoses	Number	Percent
Schizophrenia	46	29
Mood disorders	25	16
Bipolar affective disorder		
Depressive disorder NOS	7	4
Dysthymia	2	1
Psychotic disorders nec	12	8
Sexual disorders	10	6
Impulse control disorders	4	3
Adjustment disorder	4	3
Organic mental disorders	3	2
Disorders first evident in infancy, childhood, adolescence	2	1
Anxiety disorders	1	1
Unspecified mental disorder	4	3
Axis II disorder only	37	24
Totals	157	100

(paranoid) disorders, one with a brief reactive psychosis, and six with atypical psychosis. Small numbers had intermittent explosive disorder (4), adjustment disorder (4), organic personality disorder (3), organic delusional disorder (1), alcohol abuse (1), psychoactive substance abuse (1), Tourette's disease (1), overanxious disorder (1), and obsessive compulsive disorder (1). Three per cent had unspecified mental disorders, and a quarter of the patients (24%) had no diagnosis on Axis I. The latter comprised 11% with a main diagnosis of mental retardation, and 13% with other diagnoses including complex epilepsy, aggressive behaviour requiring assessment, and emergency admissions following a social crisis. There was no association between diagnosis on Axis I and degree of mental retardation, with the exception of bipolar affective disorder which was strongly associated with mild mental retardation.

Nine per cent of patients had diagnoses of personality disorder as their main psychiatric disorder, and a further 22% as a secondary diagnosis. Table 2 shows that the main types of personality disorder were antisocial (14), schizoid (9), and dependent (9). Other disorders on Axis II included 14 patients (9%) with autism, and a further six (4%) with other pervasive development disorders.

Three-quarters (75%) of the patients were admitted directly from the community, with the remainder transferred from other hospitals (18%) or admitted through the courts (7%). Twenty per cent were detained under the Mental Health Act either on admission or during their stay in the unit. Almost a third (31%) of admissions were precipitated by physical aggression to others, or were followed by aggressive episodes during the in-patient stay. Physical aggression was more

common among men, patients with a diagnosis of personality disorder or epilepsy, or with no diagnosis on Axis I. Physical aggression was least evident among patients with schizophrenia and bipolar affective disorders.

Median length of stay was 68 days, and during the eight years covered by the survey, the unit had a total of 34,980 occupied bed-days, equivalent to 12 occupied beds/day (or a total of 14 beds when an allowance is made for occupancy rates).

Outcome

All but two of the patients had been discharged at the time of the survey, with 63% relieved of their presenting disorder, 25% improved, 11% not

Table 2. Diagnoses of personality disorder (Axis II)

Diagnoses	Number	Percent
<i>Cluster A</i>	1	2
Paranoid		
Schizoid	9	19
Schizotypal	1	2
<i>Cluster B</i>	14	29
Antisocial		
Borderline	4	8
Histrionic	1	2
Narcissistic	1	2
<i>Cluster C</i>	9	19
Dependent		
Obsessive compulsive	1	2
Passive aggressive	2	4
Personality disorder NOS	5	10
Totals	48	100

changed, and 1% with a presenting disorder which had worsened. There were no deaths or suicides. Outcome was particularly favourable among patients referred from general psychiatric units, and unfavourable among patients with pervasive developmental disorder, or borderline mental retardation (who tended to resent being placed among people with more pronounced disabilities).

The great majority (94%) were placed in the community, with the remainder returning to the psychiatric or mental handicap hospital which had originally referred them. Over a third (37%) of patients were re-admitted, of whom 62% had one re-admission and the remainder had multiple re-admissions. Re-admission was less frequent among patients with borderline mental retardation and among women, and more frequent among patients with pervasive development disorder or mild mental retardation.

Comment

Recent studies have demonstrated that standardised psychiatric classifications and diagnostic instruments can be used validly for people with a mild or moderate learning disability (Pawlarczyk & Beckwith, 1987; Meadows *et al.*, 1991; Ballinger *et al.*, 1991). Complexity of diagnosis and the distinctive presentation of psychiatric disorders among these patients indicates a need for a specialist service. The experience of operating such a service is that many of its patients who have failed to respond to treatment by general psychiatric services respond well to an environment which is attuned to their distinctive communication skills. Siting a specialised unit of this kind near other specialist services for people with mental retardation provides easy access to specialist treatment, daycare and recreational facilities, but it is essential to maintain good

working relationships with local mental illness services, to share treatment facilities and develop staff skills in work with mentally ill people.

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