THE PROVISION OF SPECIALIZED PSYCHIATRIC SERVICES FOR PEOPLE WITH LEARNING DISABILITY (MENTAL RETARDATION) IN HONG KONG

HWM Kwok

ABSTRACT

Prevalence studies have indicated that people with learning disability (mental retardation) are at significantly higher risk of developing psychiatric and behavioural disorders. This is one of the main reasons for the failure of community placements. With the promotion of the concept of normalisation and integration, patients' mental health needs are increasingly acknowledged by our community. This paper focuses on the development and provision of specialised psychiatric services for people with the dual diagnosis of learning disability and psychiatric problems. The models of service delivery and resource implications are discussed, with overseas figures quoted for reference. A hospital-based system with multi-disciplinary input and strong community ramifications is recommended for the local setting in Hong Kong.

Keywords: *Community, Learning disability, Psychiatric service*

INTRODUCTION

History tells us that the 'medicalisation' of learning disability (mental retardation) probably started as early as the 17th century, and 'psychiatrisation' by the 19th century.[1] However, most psychiatrists later lost interest in this field and learning disability almost disappeared from the psychiatric scene. This was partly due to the therapeutic pessimism that followed the developments in neuropathology which saw learning disability as an incurable brain disorder and partly due to the domination in psychiatry by psychoanalysis that saw normal intellectual and language abilities as a prerequisite to successful treatment. As a result, the progress in this branch of psychiatry was slow until the past 2 to 3 decades when there was a reactivation of psychiatric enthusiasm in this area.

The resurgence of interest is firstly attributed to the general recognition of the right of people with learning disability to appropriate care in both physical and mental health. Secondly, the concept of normalisation has become widely accepted. People with learning disability are expected to live in the community and to use community facilities. Poor mental state is one of the major reasons for the failure of their integration into the community and this could mean further rejection and social discrimination. At the same time, the role of psychiatrists has also changed dramatically during the past 20 years, from simply making the diagnosis and the administration of residential facilities to more active and direct clinical involvement, including the treatment of psychiatric and behavioural disorders, promotion of mental health, family intervention and contribution to planning and management of services.

RISK FACTORS FOR PSYCHIATRIC PROBLEMS

Individuals with learning disability are at higher risk of developing mental health problems. There are many factors to account for this increased vulnerability, including:

- Brain damage resulting in learning disability may also predispose the individual to mental disorder.
- Some syndromes are known to be associated with behavioural abnormalities and psychopathology. For example, Down's syndrome has been associated with early onset of Alzheimer's disease and Lesch-Nyhan syndrome is associated with self-injurious behaviours.
- Low self-image and chronic frustration caused by repeated failures and multiple disabilities.
- Limited repertoire of coping strategies and defence mechanisms.
- Stigmatisation, rejection, and social isolation.
- Inappropriate expectation, and inconsistent care or overprotection by multiple carers.
- Poor access to community resources resulting in a restricted and disadvantaged lifestyle.

SCALE OF THE PROBLEM: THE POPULATION TO BE SERVED

People with learning disability are growing in number. Children who might have died in infancy now survive to adulthood,

Table 1. Number of mentally handicapped persons by degree of mental retardation (1998).[2]

Mild	Moderate	Severe	Profound	Total
106,528	12,533	4,386	1,880	125,327

and adults are living longer because of better living conditions and more advanced health care. Although early mortality is still a feature of many who are more severely disabled, those who are less impaired have a life expectancy near that of the general population

In Hong Kong, no survey has been conducted to find out the number of people with learning disability in our population so overseas prevalence rates are used to estimate the local incidence. According to government statistics, there were approximately 125,327 persons with learning disability in Hong Kong in 1998 (Table 1).[2]

The prevalence of psychiatric problems according to the studies varies enormously depending on the exact assessment procedure, the sample selection, the definition of mental disorder, and whether severely retarded people were included. Review of the literature found a prevalence rate ranging from 13 to 58% (Table 2). Menolascino used the term 'dual diagnosis' to refer to this group of people with both learning disability and psychiatric disorders.[3]

THE NEED FOR SPECIALISED PSYCHIATRIC SERVICES

It has become increasingly clear that generic psychiatric services cannot satisfactorily meet the complex needs of people with a dual diagnosis.[12,13] These patients do not mix well with other mentally ill patients and are vulnerable and generally disadvantaged in such settings. The pace of ward life is too fast for them and it is difficult to provide therapeutic interventions because of their different level of competence.

On the other hand, special knowledge and skills are required for the accurate diagnosis of mental illness in people with learning disability because of their different presentations or communication difficulties. The physical environment of the ward should not be the same as the general psychiatric wards and extra facilities for time-out and sensory stimulation are necessary to meet their special needs. Therapeutic processes also require modification to take into account of their intellectual limitation. Staff should be familiar with co-existing physical disabilities and conditions such as epilepsy, which often complicate learning disability. There should be no doubt that specialised services increase staff competence and skills, bring benefits of cumulative experience, accept 'ownership' of the task in hand, and increase the probability of effective and successful treatment.[14] The Royal College of Psychiatrists has strongly emphasised the need for specialist psychiatric services for adults and young people with learning disability.[15] An in depth review of the service needs of people with learning disability by a study team of the Department of Health of the British Government also concluded that there is a long term requirement for specialist mental health provision and doctors specialising in the psychiatry of learning disability.[16]

SERVICE DELIVERY

A specialist psychiatric team should have service provisions for the following clinical groups of people with learning disability living within a defined catchment area:

- Those having super-added mental illness, acute and chronic, including adjustment disorder, neurotic problems, psychotic disorders, and personality problems.
- Those with challenging behaviours: behaviours of such an intensity, frequency, or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit or delay access to and use of ordinary community facilities.[12]
- Those who offend against the law.
- Those with brain damage, epilepsy, or other associated physical handicaps resulting in poor social adaptation, and at risk of developing psychiatric problems

Apart from the full range of formal psychiatric treatment, intervention programmes should also include opportunities for social skills and vocational training, further education, and recreational activities whenever necessary.

How such specialist psychiatric services are best delivered to target patients remains a matter of discussion. Over the

Table 2. Reported prevalence rates for psychiatric disorders in people with learning disability.

Author	Age range (years)	Location	Prevalence of psychiatric disorder (%)
Rutter et al 1976[4]	9-11	Total child population in Isle of Wight	6.6 (control group) 38.9 (brain damaged children)
Primrose 1976[5]	All ages	Hospital (admissions)	58
Ballinger and Reid 1977[6]	Over 16	Hospital Community	52 (31% significant) 41 (13% significant)
Corbett 1979[7]	Under 16 Over 16	Total London district population Total London district population	47 (all severely mentally retarded) 46 (mild and severe mental retardation)
Lund 1985[8]	Adults	Community (Denmark)	27
Day 1985[9]	Over 40	Long-stay hospital residents	30
Iverson and Fox 1989[10]	Adults	Community (Midwest county)	36
Reiss 1990[11]	Adults	Community (Chicago)	39

years, a variety of models have been developed. They can broadly be divided into hospital- and community-based services. The former[17] emphasises the need for specialist inpatient facilities whereas the latter[18] utilises beds in generic psychiatric units for inpatient treatment and focuses more on home-based intervention in the community.

Advantages of a hospital-based service include ability to provide close observation, thorough assessment, intensive therapeutic programmes, and an ability to cope with a high level of disturbed and violent behaviours. Resources and facilities can be used more efficiently and may be tailored to match patient needs, e.g. time-out rooms and durable furniture. Staff training, support, and supervision can all be made easier within this framework.

On the other hand, a community-based service will no doubt invest more time on people living in the community. Proponents of this model argue that patients should be treated in their own homes as far as possible. They work closely with the carers, social services, and voluntary organisations to ensure that the mental health needs of patients are met at the community level and keep the necessity for admission to hospital to a minimum.

In Hong Kong, the mental hospitals and psychiatric units are accommodating a considerable number of people with learning disability. Most of these patients have a dual diagnosis, including some serious mental illnesses and severe challenging behaviours. Our community is not yet ready to accept all of them due to inadequate social infrastructure and lack of experienced front line staff. Therefore, initially. it is appropriate and logical for our services to be based at the hospital while community work should play an increasingly important role as our society matures.

RESOURCES AND MANPOWER

TREATMENT BEDS

In general, thresholds for admission tend to be lower than in general psychiatry because of the complex nature of this group of patients. Besides, a longer duration of stay is usually necessary because more time is needed for a comprehensive assessment and to establish a firm diagnosis. The demand for respite care beds is also expected to be higher.

In an opinion survey of the Consultant Psychiatrists working in Mental Handicap in the UK, Piachaud found that the average recommended bed ratio was 0.19 per 1,000 catchment population.[19] In the USA, Menolascino proposed a similar ratio of 0.15 – 0.19 per 1,000 population based on services developed in an American project.[3] Alternatively, in Day's proposal for a comprehensive national model for the UK (Table 3), he suggested a higher ratio of 0.28 beds per 1,000 population, but this figure includes forensic beds for offenders.[17,20]

STAFFING LEVELS

It is essential that specialist psychiatric services are staffed by properly trained and experienced psychiatrists, nurses, psychologists, occupational therapists, social workers, and other staff. The lack of specialist staff, particularly psychiatrists, is reported to be the major barrier to the development of this subspecialty in many countries.[21]

The ratio of full time consultant psychiatrists in learning disability recommended by the Royal College of Psychiatrists was one per 100,000 population.[15] Their role includes the following:

- provide medical leadership and development of services in the organisation
- function as a clinical specialist in the recognition and treatment of mental illness and challenging behaviours in persons with learning disability
- act as an advisor to the public and various organisations of the mental health issues of people with learning disability.
- act as a trainer for the professional training of staff working in this subspecialty.
- provide a contribution in academic, teaching, and research activities.

Nurses are important because they can help patients mitigate the effect of disability, achieve optimum health, develop personal autonomy, and increase participation in community life. They can also make a key contribution as managers or advisers in the construction of appropriate standards of care and support for this group of patients. They are needed not only in hospitals, but an increasing demand for their expertise will come from day centres, group homes, family homes, and other agencies. It is expected that with further development of community care, community psychiatric nurses will eventually play a major part in supporting people in the domicillary setting. The work of occupational therapists is equally important. Through their broadly based knowledge and expertise, they help their clients to function purposefully in daily life and achieve a balance in personal and domestic care, leisure, and productivity. Similar to other branches of psychiatry, it is obvious that this

Table 3. Recommendation on subregional specialist psychiatric services for the mentally handicapped in the UK.[17,20]

Level	Facility	Role	Number of places
Subregional	Specialist psychiatric unit	Acute mental illness	30 }
		Chronic mental illness	30 }
		Offenders	30 } 140/500,000 population[20]
		Behaviour disorders	40 }
		Rehabilitation	10 }
		Day hospital	30/500,000 population

specialised service is multidisciplinary and all staff should receive appropriate education and training to enable them fulfil their duties and make innovative contributions. High-quality staff make for high-quality services

The staffing figures recommended for the UK and the USA are for reference only and it is unrealistic to suggest that Hong Kong establish a similar number of hospital beds and consultant posts. However, in an era when our government is actively trying to persuade and educate society to stop prejudice against the learning disabled and ex-mentally ill people, the recognition of this subspecialty is timely and justified.

CONCLUSION

Mental health problems are common among people with learning disability. The presence of concomitant severe behavioural or psychiatric disorders is one of the main reasons for the breakdown of their community placements. It is necessary to recognise at all levels of health administration and among the general public that this comorbidity is not merely a collection of special cases. In fact, they represent a sizeable, vulnerable, and notoriously underserved group that requires new initiatives in both service development and service delivery. Proper provision for these people is an essential component of a comprehensive mental health service. Arguments in favour of provision within the general psychiatric services are essentially ideological, a misinterpretation of the normalisation philosophy, and are failing in practice.[13] Specialisation is a legitimate response to special needs and it is the preferred option in many countries

An ideal psychiatric service for people with learning disability should be a comprehensive, coordinated, effective, and efficient service incorporating the principles of normalisation and integration, and delivered in ways which preserve the clients' dignity and value as equal citizens. It should possess the multi-disciplinary skills required for assessment, diagnosis, treatment, care, and rehabilitation. Running such a service will no doubt be a great challenge for professional staff — adequate resources, manpower, and training are needed to make it successful.

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Dr HWM Kwok, MB BS, MRCPSYCH (UK), FHKCPSYCH, FHKAM (Psychiatry), Senior Medical Officer, Psychiatric Unit For Learning Disabilities, Kwai Chung Hospital, Hong Kong, China.

Address for correspondence: Dr HWM Kwok
Senior Medical Officer
Psychiatric Unit For Learning Disabilities
Kwai Chung Hospital
Hong Kong, China.