Geriatric Psychiatry

Mental Health Issues of Older People with Intellectual Disabilities

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Abstract: The number of people with intellectual disabilities (ID) who live into old age is growing, which presents physical and mental health-care challenges. Certain disorders such as dementia are more common in ID, particularly in Down syndrome (DS). Additional physical and mental comorbidities make diagnosis and management more difficult, and the productive collaboration between the aging and the ID care systems could enhance service delivery. Although the body of knowledge in this area is growing, there is still a lack of formal educational opportunity for trainees in psychiatry or for established clinicians in Canada to increase their skills.

Key Words: intellectual disability, elderly, mental health

Mental health care of the intellectually disabled (especially the elderly) is in its infancy in Canada. Although organizations advocating for the humane treatment of those with intellectual disabilities (ID) have achieved successes in many areas of the community, psychiatric specialist academic training and service provision have lagged far behind, as documented by Lunsky, Bradley and Leichner (1,2). Unlike some countries such as the United Kingdom, no specialist training stream exists for ID in Canada, and there are few psychiatrists with special expertise in ID. The teaching and exposure to ID within psychiatric residencies tends to be fragmented, optional and, if present at all, confined to child psychiatry rotations.

Prevalence

Published prevalence figures for ID throughout the world vary considerably (one to three per cent) (3), because of varying criteria, samples surveyed and risk factors. Bradley and others have published the most recent Canadian prevalence data that found an overall prevalence for ID of 7.18/1000 and 3.54/1000 for severe ID among teenagers living in the Niagara region of Ontario (4). The life expectancy of adults with ID has increased, resulting in an increase of adults and seniors with ID (5). Specific subgroups of these will have particularly high mental health needs. For example, adults with Down syndrome (DS), who have increased their life expectancy to about age 59 years (6), are particularly likely to develop Alzheimer’s disease (AD) at an early age (7). In all adults with ID, cognitive changes and other physical aging-related changes add to preexisting medical, psychiatric and behavioural problems, which are already more prevalent and challenging in this population.

Physical Health Issues

Mental health issues in older people cannot be separated from medical issues that affect clinical presentation and treatment options. Evenhuis and others reviewed medical issues of older adults with ID (8). Although some health risks are reduced in those with ID (motor vehicle accidents, substance abuse and sexually transmitted diseases), other health risks increase and reflect both biological predispositions (dementia in ID) and environmental factors (institutional placement with resultant increased prevalence of Helicobacter pylori infections), as well as lack of physical activity with resultant obesity. In particular, those with cerebral palsy (CP) are likely to develop arthropses secondary to long-term abnormalities in muscle tone, recurrent reflex esophagitis, decubitus ulcers, constipation and bladder dysfunction. Epilepsy, which is much more frequent in ID, can result in increased falls and injuries, as well as sudden death and secondary effects of anticonvulsant medications, such as bone demineralization. Persons with DS are already more likely to have visual, auditory, cardiac, gastrointestinal, endocrine, dermatologic and immunologic impairments, thus making further aging changes (including dementia) more problematic.

Mental Health Issues

Thorpe and others have reviewed biobehavioural issues of older adults with ID (9). In general, behavioural problems are more common in those with ID and more common than are core psychiatric disorders, such as depressive illness or schizophrenia. Some behaviours may not only...
Directly relate to brain abnormalities (impulse control, attentional difficulties and poor understanding) but may also be due to impaired learning of socially appropriate behaviour or to learning of abnormal behaviours from others, especially in institutional settings. Additional stressors that are common to old age, such as bereavement or change of residential status, add a greater burden to an individual with ID, who has reduced cognitive and emotional coping skills and decreased or reduced social support networks (that is, no adult children to buffer the losses).

Major mental illness occurs in about 10 per cent of older people with ID, with dementia playing a prominent role (10). Psychotic disorders increase with age, although anxiety and mood disorders continue to be more prevalent throughout the lifespan. Certain disorders, such as DS, may increase the likelihood of mood and anxiety disorders as well as dementia. Collacott (11), for example, found that depression was three times as common in DS than in ID without DS, and Charlot and others (12), among others, have published articles about the possible association of DS and obsessive slowness. Irritability, a symptom that presents frequently in ID, can be a marker for various organic and mental illnesses (13).

Diagnostic Issues
The comorbidities of aging and preexisting ID, superimposed on a lifetime of restricted social roles and experiences, make baseline symptomatology more difficult to differentiate from de novo mental illness. This is a particular problem for clinicians who are unfamiliar with ID and for those who have little information on the patient’s premorbid cognitive-emotional functioning. The time required to obtain an adequate history can be considerable. Instruments designed in the general population to detect and to measure symptoms, such as the Mini-Mental State Examination (MMSE) (14), are generally limited by a “floor effect” and are therefore unhelpful for those with low preexisting intellectual functioning. Further, because of the wide range of intellectual abilities in ID, there is no one battery of tests that clinicians can administer to establish and to measure dementia, although consensus conferences on this topic have been held, and general suggestions have been published in the literature (15). Instruments to measure noncognitive mental health symptoms in ID have been developed (16) but require training and are not widely used outside the ID community.

Interventions
Advocates for the humane care of persons with ID have made great strides over the last century in decreasing institutionalization, in increasing their access to community care, and in strengthening their potential for independent and personally rewarding lives. Ironically, the move to deinstitutionalization itself may have worsened psychiatric care for adults with ID, because localized pockets of knowledgeable professionals, who were based in the institutions, dispersed. As a result, challenging disabled patients were spread across the regions to be cared for by inexperienced community service providers. Inpatient psychiatric units that are used in periods of crisis are often aware of their inability to provide developmentally appropriate care, especially in the case of long-standing conduct disorders.

Seniors with ID who develop dementia become increasingly difficult to care for in open ID units, which are designed to maximize autonomous functioning, and may eventually require transfer to a dedicated dementia unit where staff are unfamiliar with ID. The transfer can be stressful for the patient, and copatients on the dementia unit who have non-ID dementia may further reject these patients because of unusual behaviours (personal experience). Reciprocal educational sessions between staff at the initiating ID facility and the receiving dementia unit will help to maintain people with ID in their home as long as possible and then to care for them as well as possible in the dementia unit, once this move becomes necessary. Despite the known increased risk, only one study has been published with a large-scale, double-blind, placebo-controlled trial of a cognitive enhancer (donepezil) in patients with DS and AD (17). This study demonstrated a nonsignificant tendency for donepezil to improve function and cognition but showed that some behavioural measures worsened. Other ongoing trials of donepezil in DS may further clarify the usefulness of this intervention.

Conclusion
It is a challenge to diagnose and care for the increasing numbers of older people with ID and mental health problems. Increased interaction between aging and ID services is essential to best maintain the quality of life for these multiply impaired seniors. The role of cognitive enhancers in DS and AD has yet to be determined.

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