Supporting mental health issues alongside learning disabilities

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Abstract
Those with a learning disability are as, if not more, likely to develop and experience mental health issues than those without a learning disability. This article will briefly explore the meaning of mental health, the occurrence of mental health issues in those with a learning disability and the various therapies and treatments that are available.

Key words
- Learning disability
- Mental health
- Healthcare assistants
- Therapies and treatments

Many years ago, it was thought, even if anecdotally, that those with a learning disability were unable to develop mental illnesses or mental health problems, as to do so requires a certain level of mental, cognitive and intellectual development, ability and functioning. It was believed that those with a learning disability may not have the intellectual or cognitive level ‘needed’ to experience mental illness (Smiley, 2005). However, anyone who works with those with a learning disability within either a residential or a community setting will be very much aware that those with a learning disability can indeed experience the same mental health issues that are prevalent within the wider society.

This short article will explore what is meant by mental illness and the various forms that mental illness can take, before highlighting the prevalence rates of the various forms of mental illness within people with a learning disability, in comparison with those without a learning disability. The various forms of therapy and treatments that are available for those with mental health problems will be discussed.

Finally, the roles of the healthcare assistant (HCA) in supporting those with a learning disability who are experiencing a mental illness will be highlighted.

What is mental health?
The first thing that must be said is that although learning disabilities arise from a lack of or impaired development of the brain, a learning disability is not the same as having a mental illness or mental health problem. So, what is mental illness? Mental health and mental illness could be argued to have a number of definitions and meanings.

These include:
- Mental disorder—Weller (1997: 365) said that this term was defined by the Mental Health Act 1983 to cover all forms of mental illness and disability, including mental impairment and psychopathic disorder
- Mental illness—a category not defined by the Mental Health Act 1983 and is therefore left open to interpretation. The use of the term ‘mental illness’ is, however, established through common practice and case law (previous legal cases involving the Act which have set precedents) as meaning ‘the opinion of psychiatrists, backed up by the official classification of mental illness’ (Parsons, 2003: 501). However, mental illness could also be described as a term that is used to describe a number of disorders of the mind that affect the emotions, perceptions, reasoning or memory of the individual (Weller, 1997: 365)
- Mental hygiene—‘the science that deals with the development of healthy mental and emotional reactions’ (Weller, 1997: 365). This term has also been used in the past to define or categorise mental illness. It could be suggested that a closer reflection on these basic definitions could reveal a number of questions.

Weller’s (1997) use of the terms ‘mental disorder’ and ‘mental hygiene’ as definition categories suggests that mental health is often seen and couched in negative terms and language. To infer or suggest, for example, that a person’s mental state is somehow ‘unhygienic’ is to suggest the idea of ‘dirtiness’. Put another way, this amounts to a suggestion that those who have a mental illness or experience a mental health condition or issue are dirty and unclean.

Again, the use of certain, often negative, language to define a person’s mental state is to allow the ‘non-mentally ill’ to control and have power over those who experience mental health problems or difficulties. Parsons (2003) suggests that mental illness has no definition as such and its meaning is left open to interpretation. Such a position could imply that mental illness is whatever the psychiatrist, psychologist or mental health nurse says it is.

Forms of mental health issues
Having a learning disability does not automatically mean that the person will experience a mental health problem. However, there are a wide range of mental health problems...
and severity of problems that can be experienced by people with a learning disability.

**Depression**
Depression is defined as 'a morbid and long-lasting sadness or melancholy which may, or may not, be a symptom of an underlying psychiatric problem' (Weller, 1997: 120). Causes of depression are likely to be numerous and symptoms may include:
- Depressed mood for most of the day
- Decreased interest or pleasure in daily activities
- Insomnia, significant weight gain or loss
- Feelings of worthlessness
- Diminished ability to think, concentrate or make decisions
- Thoughts of death, dying, self-harm or suicide.

**Dementia**
Dementia is a gradual but global and progressive atrophy of brain cells leading to a gradual and irreversible decline in all areas of cognitive functioning, including memory, intellect, social judgment, personality, social skills/behaviour and physical skills. While dementia is usually associated with old age, it is not unheard of for symptoms to appear at any age.

**Addictions**
Addiction is a persistent, compulsive dependence on a behaviour or substance. The term has been partially replaced by the word 'dependence' for substance abuse. Addiction has been extended, however, to include mood-altering behaviours or activities (process addiction), for example, gambling, spending, shopping, eating and sexual activity.

**Anxiety disorders**
Anxiety conditions can be seen as a chronic state of physical and mental tension (Weller, 1997: 30). However, Muir-Cochrane (2003: 213) suggests that anxiety is a normal part of what it is to be human, that it is a normal aspect of human experiences. Certain memories, experiences or anticipated experiences and unwarranted worrying can either cause or trigger anxiety states. Physical and behavioural symptoms of anxiety may include:
- Shortness of breath
- Dizziness
- Choking sensation
- Palpitations
- Sweating and dry mouth
- Elevated blood pressure
- Fear, apprehension, sense of impending doom, terror or dread
- Altered sleep patterns
- Irritability
- Motor tension and exaggerated motor tension
- Panic.

‘Normal’ anxiety, when experienced in the extreme, is sometimes seen as ‘anxiety disorder’ (Muir-Cochrane 2003: 215).

**Borderline personality disorder**
Borderline personality disorder (BPD) is a collection of personality traits that underpin certain groups of behaviours and is a pervasive pattern of instability of interpersonal relationships, self-image, and marked impulsivity. Diagnostic criteria for BPD (Parsons, 2003: 290) can include the following:
- Frantic efforts to avoid real or imagined abandonment
- A pattern of unstable/intense interpersonal relationships
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Table 1. Mental health in those with a learning disability, compared with the mental health of the general population

<table>
<thead>
<tr>
<th>Mental health condition</th>
<th>Those with a learning disability (around 1 000 000)</th>
<th>General population (around 60 000 000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All mental health problems</td>
<td>36%</td>
<td>8%</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Depression</td>
<td>12.5%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Bi-polar</td>
<td>1.5%</td>
<td>1–2%</td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td>16.7%</td>
<td>8–12%</td>
</tr>
<tr>
<td>OCD</td>
<td>2.5–9.4%</td>
<td>1.2%</td>
</tr>
</tbody>
</table>

Sources: Keen (2003) Smiley (2005); Devine et al (2010); Mental Health Foundation (2011a).

- Marked and persistently unstable self-image or sense of self
- Potentially self-damaging impulsivity
- Recurrent suicidal behaviour
- Chronic feelings of emptiness
- Inappropriate, intense anger or inability to control anger
- Short-lived stress-related paranoid thoughts.

Autism has not been included here, as it is a neurological condition rather than a mental illness.

**Learning disability and mental health**

The above mental health conditions are by no means exclusive or as clear cut in terms of presentation or experience. Quite often, the symptoms relating to these various conditions may be subtle and may also indicate the existence or lived experience of more than one mental health care condition.

While anecdotal evidence suggests a link between mental ill-health and learning disabilities, actual prevalence in percentage terms of mental health problems in people with a learning disability can prove to be somewhat elusive. In other words, it is uncertain how many people with a learning disability will also experience a mental health problem. Even Mencap, in response to a personal emailed enquiry from the author, does not hold such data and was thus unaware of prevalence or comparison rates in terms of those without a learning disability.

However, a rather tentative prevalence rate for some mental health problems in those with a learning disability can be suggested (Table 1). However, caution must be exercised here. Table 1 only gives a very small ‘selection’ of mental health problems that could be experienced by those with a learning disability and is, therefore, not inclusive of all mental health problems. Again, ‘there are lies, damned lies and statistics’. Statistics could prove everything, anything or nothing, depending on one’s view. For example, see the different rates for OCD as given by Smiley (2005) and Devine et al (2010), ranging from 2.5% to 9.4% respectively. Devine et al (2010) suggests that a third of a small sample of 96 people with a learning disability also had a mental health problem, while the Mental Health Foundation (2011a) gives an estimated 25–40% compared to around 8% of those who do not have a learning disability. The question here is: does and can such a small sample provide meaningful information and data, bearing in mind that such data could eventually impact on service planning and delivery?

**Treatments and therapies**

There are a number of treatments and therapies that could be used to help those with a learning disability who experience mental health issues; some may be of more use than others.

**Pharmacotherapy**

Alternatively known as ‘drug therapy’. Drugs such as chlorpromazine, haloperidol, benperidol and thioridazine have been used for decades to manage many of the symptoms of schizophrenia and other psychoses. Lithium carbonate has been used as a mood stabilizer in bipolar disorder. Lorazepam, diazepam and nitrazepam have been used to manage and treat anxiety disorders. Fluoxetine, among others, has been used to manage depression.

However, caution must be exercised as most, if not all, of these drugs will have serious side-effects such as dry mouth, ‘Parkinson’s’-like tremors, hypothermia, apathy, drowsiness and convulsions. Some of these drugs may no longer be used quite as extensively as they have been in the past, having been superseded by newer drugs with fewer unwanted side effects. Again, while some of these may be transient, some may be long-lasting. While there are drugs such as procyclidine that deal with some of these unwanted side effects, they too will have their own side effects. Again, it is not that unusual to hear that people with a learning disability had been prescribed these powerful drugs years and even decades previously and were still taking them, although the original reason for such drugs were no longer evident.

**Talking therapies**

Talking therapies involve talking to someone who is trained to help you deal with your negative feelings—and
talking therapies give people the chance to explore their thoughts and feelings and the effect they have on their behaviour and mood (Mental Health Foundation, 2011b).

These include cognitive behavioural therapies (CBT), dialectic behaviour therapy (DBT), psychodynamic therapies, humanistic therapies, other kinds of talking therapy and support and information. For more on ‘talking therapies’ for those with mental health problems, please see the Mental Health Foundation website (2011b).

As some of these therapies may not have been tried successfully with those with a learning disability, caution must be exercised when thinking about using them.

**Complementary therapies**
These will include hypnotherapy, reiki, meditation, acupressure, acupuncture and prayer or other spiritual exercises. Although many of these forms of therapy in the treatment of physical and even mental health problems have been used effectively for centuries in China, Japan and India and are becoming more popular elsewhere, their use with those with a learning disability may be untested or ‘under-tested’. Their value may not be apparent and their use unsafe. Having said that, many of these forms of therapy rely to a large extent on holistic human connectedness and compassion; these can rarely be unsafe.

**The roles of the HCA**
The roles of the HCA when working with people who have a dual diagnosis of learning disability and mental health are varied and numerous. In a way, these roles can be summed up in the word ‘COAT’:

- **Communicate**
- **Observe**
- **Awareness**
- **Training**.

**Communicate**
The first of the key roles of the HCA is to get to know and talk to the service user. Bear in mind that, no matter how bizarre the person’s behaviour, speech and thought processes may be, mental illness is not catching.

To connect psychologically and emotionally with other people through communication is a fundamental human need and thus not to communicate, not to connect, is a denial of this fundamental need.

**Observe**
The second of the key roles is to observe the service user. This can be done within a formal context, with the HCA ticking a chart to say that he or she has seen the service user; many HCAs who work within a secure setting will be familiar with this type of observation.

Observation of the person’s mental state is also vital, as subtle mental state changes could be picked up. Again, such mental state observations may indicate whether or not the person’s therapeutic programme is effective and is working. Through observing the behaviour of the

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**Skillful counsellors can help patients deal with negative feelings**

service user, any unwanted side effects of the therapeutic programme, particularly of medication, will be noticed and reported back.

**Awareness**
The third key role, awareness of the diagnosis and needs of the service user, can be achieved through thoroughly reading the service user’s care plans and observing and communicating with the service user and colleagues and then implementing these care plans.

**Training**
The fourth key role, professional training and development, is vital in order to implement safe, evidenced-based and inclusive practice. There are a number of ways to engage in such training. The first is to participate in any ‘in-house’ training opportunities, such as staff meetings.

Participation in training courses and workshops

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**Group therapy is another approach to tackling depression.**
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Key Points

- Those with a learning disability are as, if not more, likely to experience mental health problems than those without a learning disability
- Mental illness could be described as a number of disorders of the mind that affect the emotions, perceptions, reasoning, behaviour or memory of the individual
- Pharmacotherapy, the talking therapies and complementary therapies all have a role in the treatment and management of many of the symptoms of mental illness
- The role of the HCA is to ‘wear the coat’ of communication, awareness, observation and training

arranged by your employer is also vital. The reading of nursing and health care journals is also a useful way to acquire new knowledge, as is networking with other nursing, health care and social care colleagues. Indeed, such networking during training workshops and courses can often be more important and fruitful than the course or workshop contents itself.

Finally, the Royal College of Nursing contains a number of mental health and learning disability forums which could be of real use when searching for information regarding mental health and learning disabilities.

Conclusion

Those with a learning disability are just as likely, if not more so, to develop and experience a mental health problem, such as depression, anxiety disorders and schizophrenia, at some point in their lives. As such, many HCAs working within learning disabilities or mental health services will encounter and work with these service users.

It is being suggested here that before starting work each day, HCAs should remember to put on the ‘COAT’; communicate, observe and monitor the service user, be aware of the service user’s needs and engage in training opportunities whenever possible. Remember, one can never have too many coats!
