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Learning disabilities and old age

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People with learning disabilities form only a small part of the general population, but because of their many special needs, they require the provision of specialist health services. National statistics on the prevalence of learning disabilities are poor, but it has been estimated that 160 000 people in England and Wales have severe or profound learning disabilities (Audit Commission, 1987).

Elderly people with learning disabilities form only a small subgroup of people with learning disabilities. However, the age structure of the population is changing due to a fall in birth rate and increasing longevity. The population now includes more people aged ≥40 years with learning disabilities than children with learning disabilities. The needs of people with learning disabilities change as they grow older, and prevalence rates of additional psychiatric disorders are high. Psychiatric services must be able to respond to the growing needs of the increasing numbers of elderly people with learning disabilities.

Prevalence of psychiatric disorders

The literature regarding elderly people with learning disabilities has increased in recent years. Several studies have examined this population to determine prevalence rates of dementia and other psychiatric disorders. Many of these studies have been based on individuals living in learning disabilities hospitals. In view of the national policy of closure of these large hospitals, with resettlement of people into community care, it is difficult to know the extent to which these studies are representative of the whole population with learning disabilities. Studies have used differing methodologies, including the age used to define 'elderly' (which has ranged between 40 and 65 years in recent studies), methods of data collection (taking information from case notes, or using interview techniques), and the diagnostic criteria that have been used. This renders comparisons of results between studies difficult. The lack of suitable published rating scales to measure psychopathology among adults with learning disabilities has also hindered research attempts, although two new scales are now available: the Psychiatric Assessment Schedule for Adults with Developmental Disabilities (PAS-ADD; Moss *et al*, 1993) and the Present Psychiatric State for use with Adults with Learning Disabilities (PPS-LD; Cooper, 1997*a*).

Some studies have attempted to measure the prevalence of psychiatric disorders among elderly people with learning disabilities, by assessing individuals who were identified following a period of active case ascertainment (Corbett, 1979; Lund, 1985; Patel *et al*, 1993; Cooper, 1997*a*). In these studies (as far as possible) whole populations or random samples of the population from a defined area were studied. Patel *et al* (1993) used the PAS-ADD and DSM–III–R criteria (American Psychiatric Association, 1987) to assess 105 people aged ≥50 years. Corbett (1979) used ICD–8 criteria (World Health Organization, 1974) to classify psychopathology in his study of 402 adults with learning disabilities, which included 110 aged ≥60 years. Lund (1985) used a checklist and modified DSM–III criteria (American Psychiatric Association, 1980) to assess 302 adults with learning disabilities, 27 of whom were aged ≥65 years. Cooper (1997*a*) used the PPS-LD to assess 134 adults with learning disabilities aged ≥65 years, compared with a random sample of 73 adults with learning disabilities aged 20–64 years. Psychopathology was classified using the Diagnostic

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Criteria for Research of ICD–10 (World Health Organization, 1993), modified where necessary, and Kettering/Leicester criteria for depression (Cooper & Collacott, 1996).

Corbett (1979) did not measure rates of dementia, but the other three population-based studies found similar rates, with dementia occurring in around 22% of those aged ≥65 years (Lund, 1985; Cooper, 1997*a*) and 12% of those aged ≥50 years (Lund, 1985; Patel *et al*, 1993; Cooper, 1997*a*). Rates of dementia increase with age cohorts: 15.6% in those aged 65–74 years; 23.5% aged 75–84 years; and 70.0% aged 85–94 years had dementia (Cooper, 1997*b*). This is considerably higher than the rates found in the general population (Hofman *et al*, 1991). Comparison suggests the rate of dementia to be four times higher in elderly people with learning disabilities than in the elderly general population (Cooper, 1997*b*). These high rates cannot be attributed to people with Down's syndrome, as most do not live to old age. Only five of the 134 people aged ≥65 years in the Leicestershire study had Down's syndrome, three of whom had dementia: 26 of the remaining 129 people with learning disabilities of other aetiologies had dementia (Cooper, 1997*b*). Only nine of the 105 people aged ≥50 years in the Oldham study had Down's syndrome, four of whom had dementia: eight of the remaining 96 people with learning disabilities of other aetiologies had dementia (Moss & Patel, 1993). Psychotic symptoms are found commonly to occur in people with learning disabilities and dementia (Cooper, 1997*c*), as does changed sleep pattern, loss of concentration, worry, reduced speech, change in appetite, and onset of or increase in aggression (Cooper, 1997*c*,*d*; Moss & Patel, 1995; Prasher & Filer, 1995). These symptoms can cause considerable distress to individuals and present a burden (and corresponding stress) to their carers, and so warrant intervention strategies.

The studies differ with regard to the prevalence of other psychiatric disorders. The data are summarised in Table 1; however, diagnostic categories are not identical, because of the different diagnostic criteria used. The different age ranges also preclude direct comparison between the studies. In view of the small number aged ≥65 years (n=27) in the study of Lund (1985), the percentages described in his report have been recalculated to present rates for those aged ≥45 years (n=94).

With regard to affective disorders, despite methodological differences, similarities are seen across the studies, with rates between 4.3 and 6.7% (combined rate for depressive episode and manic episode). Anxiety disorders were reported in 5.8% of those aged ≥50 years (Patel *et al*, 1993) and in 15.7% aged ≥65 years (Cooper, 1997*a*). A much lower rate of 1.1% was reported by Lund (1985) for those aged ≥45 years. A separate category for anxiety disorders is not described by Corbett (1979)

Table 1. Prevalence of psychiatric disorders in middle-aged/elderly people with learning disabilities

	Lund (1985) ≥45 years n=94	Patel *et al* (1993) ≥50 years n=105 (PAS-ADD)	Corbett (1979) ≥60 years n=110	Cooper (1997*a*) ≥65 years n=134 (PPS-LD)
Dementia	10.6%[1]	11.4%	–	21.6%
Affective disorders	4.3%	5.7% (depression) 1.0% (mania)	4.5%	6.0% (depression) 0.7% (mania)
Anxiety disorders/ 'neurosis'	1.1%	2.9% (phobic anxiety) 2.9% (generalised anxiety)	–	6.7% (phobic anxiety) 9.0% (generalised anxiety)
Behaviour disorders	7.4%	0%	22.7%[2]	14.9%
Schizophrenia/delusional disorders	3.2%	0%[3]	5.4%	3.0%
Autism	1.1%	0%	3.6%	6.0%
Psychosis (unspecified)	1.1%[4]	–	–	–

1. 22.2% for those aged ≥65 years.
2. Probably includes generalised anxiety disorders.
3. 1.9% had a clinical (as opposed to PAS-ADD) diagnosis of schizophrenia.
4. Likely to be autism.

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and it seems likely from the text that generalised anxiety disorders were grouped together under the heading of personality disorder/behaviour disorder. The differences in these rates may relate to the age groups studied: in the general population, anxiety disorders occur with increased prevalence in old age, especially phobic anxiety disorders. For example, 15.0% of elderly people in Islington have an anxiety disorder of any type (Manela *et al*, 1996), and 13.7% of elderly people in Lewisham and Southwark have an anxiety disorder of any type (Lindesay *et al*, 1989). These rates are similar to that found by Cooper (1997*a*) for the same age group (≥65 years) of elderly people with learning disabilities. The low rate (1.1%) reported by Lund (1985) may in part be due to the age group studied (≥45 years), or may relate to the psychopathology checklist that was used (the number and types of items included on the checklist are not described, but were based on symptoms present in only 38 institutionalised people, so are unlikely to represent a full range of psychopathology). Behaviour disorders were reported to occur in 7.4% of those aged ≥45 years (Lund, 1985), 0% aged ≥50 years (Patel *et al*, 1993), 22.7% aged ≥60 years (Corbett, 1979) and 14.9% aged ≥65 years (Cooper, 1997*a*). Again, differences can in part be accounted for by differing methodologies. It is likely that the figure for behaviour disorders quoted by Corbett (1979) includes generalised anxiety disorders; if this is the case, the rates determined by Corbett (22.7%) and by Cooper (23.9% when combined) are comparable. The 0% reported by Patel *et al* (1993) is out of keeping with other studies, which may relate to behaviour disorders not being measured on the PAS-ADD, or to the diagnostic criteria employed (DSM–III–R, which does not have a category for behaviour disorders). Schizophrenia/delusional disorders are reported to occur in between 0–5.4%. Patel *et al* (1993) do however clarify the difficulty of case detection of schizophrenia using PAS-ADD, and indicate that 1.9% of their sample had a clinical diagnosis of schizophrenia. Autism was reported to be present in between 0 and 6.0%. In the study of Patel *et al* (1993) the text states that no cases of autism (DSM–III–R) were found, but the means of determining this was not described (PAS-ADD does not contain a section for autism). The other studies report rates of 2.2–6.0%, which wide difference can probably be accounted for by the use of different criteria.

Although there are differences in the study findings, some generalisations can be made. Psychiatric disorders occur more commonly in elderly people with learning disabilities than they do in the elderly general population. This is due to higher rates of dementia, schizophrenia, behaviour disorders and autism, although there are similar rates of anxiety disorders in the two groups, and depressive episodes are less prevalent among elderly people with learning disabilities than in the elderly general population. Psychiatric disorders also occur more commonly in elderly than in younger adults with learning disabilities: a direct comparison of such rates was made in the study of Cooper (1997*a*), which showed the higher rate to be mainly due to dementia and anxiety disorders. In contrast, although rates of individual disorders varied across the age groups studied, the overall prevalence for an additional psychiatric disorder remained constant in the study of Lund (1985). However, very few of these adults were in the old age group. Due to lack of data on dementia, a comparison of overall rate cannot be made from Corbett (1979). Patel *et al* (1993) did not include a younger group for comparison in their study.

Adults with Down's syndrome

The studies quoted above refer to middle aged/elderly people with learning disabilities of all aetiologies. However, certain causes of learning disabilities are associated with particular behaviour phenotypes. An example of this is Down's syndrome, which occurs in about 20% of the current cohort of adults with moderate to profound learning disabilities. Life expectancy is increasing for everyone with learning disabilities, but the greatest life expectancies are among those who are female, have less-severe learning disabilities, are ambulatory, do not have Down's syndrome and who have remained living in the community (Jacobson *et al*, 1985). Consequently, the proportion of people with Down's syndrome out of the total of those with learning disabilities decreases with increasing age cohorts. People with Down's syndrome do not usually survive into old age. However, it is well recognised that middle-aged people with Down's syndrome have a considerable psychiatric morbidity, due to high rates of dementia (Oliver & Holland, 1986; Holland & Oliver, 1995). Neuropathological studies indicate that by the age of 40 years, almost all adults with Down's syndrome have Alzheimer's disease (Mann, 1988). Clinical studies have shown dementia to be prevalent, by using the different approaches of repeated measures of adaptive behaviour, psychometric assessment, psychiatric assessment or neurological assessment. Because of these different methodologies, reported rates of

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dementia among adults with Down's syndrome differ, and direct comparison between studies may not be valid. However, ICD–10 dementia has been found to occur in 2.0% of those aged 30–39 years, 9.4% aged 40–49 years, 36.1% aged 50–59 years, and 54.5% aged 60–69 (Prasher, 1995). As an increasing number of people with Down's syndrome live into middle age, and in the future may survive into old age, the high prevalence of dementia in this group is likely to have a substantial impact on psychiatric and social services (as well as affecting the lives of individuals and their families and carers).

The exact cause of the high rates of dementia among people with Down's syndrome is unknown, although theories include the implication of genetic material coded on chromosome 21, including superoxide dismutase and amyloid precursor protein which may be contributory to dementia. It has also been suggested that the different distribution of apolipoprotein E in people with Down's syndrome compared with the general population may be relevant.

The epidemiology of other psychiatric disorders in adults with Down's syndrome also appears to differ from that in adults with learning disabilities of other causes (Myers & Pueschel, 1991; Collacott *et al*, 1992; Prasher, 1995). Dementia and depressive episodes appear to occur more commonly in adults with Down's syndrome, whereas behaviour disorders and schizophrenia appear to be less common. Some attempts have been made to explain the differential rates of affective disorders on the basis of the relative serotonin deficiency which is found in people with Down's syndrome (Cooper & Collacott, 1993). It is unclear at this stage how the profile of psychiatric disorders among people with Down's syndrome will affect overall prevalence rates for the whole population of people with learning disabilities as the population continues to age.

Aetiology of psychiatric disorders

It is not surprising that elderly people with learning disabilities have high rates of psychiatric disorders. They are subject to the same risk factors that affect the whole population, such as genetic factors (family history), physical factors (illness; drug side-effects), psychological factors (adverse events in childhood which have shaped personality development), and social factors (social deprivation; limited social networks; life events). Additionally, they are at risk of psychiatric disorders because of factors that are associated with learning disabilities, including physical factors (multiple physical disabilities and pain; epilepsy; behaviour phenotypes), psychological factors (admission into institutions and multiple moves within and between institutions; lack of consistent parental figures in childhood; vulnerability to and therefore probable increased rates of neglect, exploitation and abuse), social factors (stigma; limited social networks; lack of confidant; limited opportunities and choices; society's demands exceeding an individual's abilities and coping mechanisms; lack of occupation and recreation), developmental factors (developmental stages of headbanging and 'tantrums'; lack of communication skills to make needs known). Also, they are subject to the risk factors for psychiatric illness which affect elderly people, such as increased physical ill health and frailty; social isolation; bereavement and loss.

Older people with learning disabilities will have different life histories when compared with children and young adults of today. Many of these older adults will have been raised in institutions for people with learning disabilities, at a time when such disabilities were highly stigmatised. Younger adults are more likely to have been raised within caring families in the wider community, with better lifestyles and access to treatments and educational opportunities that may have been denied their seniors. Whether this will have an effect upon the vulnerability to psychiatric disorders for future generations of elderly people with learning disabilities is yet to be determined.

The high rate of dementia in people with learning disabilities requires special comment. Certain associations with dementia have been found to be similar in people with learning disabilities and the general population. This includes increased rates of dementia in people who are older, female, with more poorly controlled epilepsy, a larger number of additional physical disorders, and less likely to be smokers (Cooper, 1997*b*). As previously discussed, certain groups (e.g. people with Down's syndrome) are particularly at risk. However, rates are considerably higher for people with learning disabilities of all aetiologies than for the general population. The reasons for this are not clear. Perhaps it relates to underlying 'brain damage', with a similar mechanism to that by which head injury predisposes to dementia in later life in the general population. Perhaps genetic factors are relevant. It seems unlikely that dementia presents at an earlier stage in people with learning disabilities compared with the general population; particularly in view of the recognised difficulty in diagnosing dementia at an early stage in people

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with Down's syndrome, who have been studied more often. Higher educational achievement is protective against dementia in the elderly general population; whether this is relevant to people with learning disabilities is yet to be determined.

Management of psychiatric disorders

The management (assessment and treatment) of psychiatric disorders among elderly people with learning disabilities follows the same general principles that are used when working with the general adult population or with younger adults with learning disabilities, but with emphasis in different areas, depending upon the person's individual needs. Some factors are usually different between the assessment of a person with learning disabilities compared with that of a person of average ability.

Differences in the assessment process

Importance of an informant history

It is always good practice to take a collateral history; however, the importance of this increases with individuals with more severe learning disabilities. For those with profound learning disabilities, and for many of those with severe learning disabilities, the history from the person's carer will be the only history obtainable. People with moderate learning disabilities may well experience some difficulties with concepts such as passage of time, sequencing and detailed memory of past events, and so the history from the main carer remains important, taken together with the history from the person with learning disabilities.

Avoiding compliant answers

People with learning disabilities are more likely to give compliant answers, or to repeat the last item when given a choice (e.g. the same person may respond "yes" to both questions "are you happy?" and "are you sad?". If asked "are you happy or sad?" the answer is more likely to be "sad", whereas if asked "are you sad or happy?" the answer is more likely to be "happy"). Hence it is important that questions are asked in an open way, and confirmed with further detail from the individual and their main carer. A person with learning disabilities may also be unable to describe different emotional states.

Asking about an appropriate range of psychopathology

Psychiatric disorders can present differently in people with learning disabilities compared with people of average ability. Depression, for example, is more likely to present with irritability, labile mood, social withdrawal, loss of speech, loss of adaptive behaviour skills, increase in aggression or other maladaptive behaviours, sleeplessness and loss of appetite. This is in contrast to the misery, hopelessness, suicidal ideation, guilt, feelings of worthlessness, sleeplessness and loss of appetite seen in depressed adults of average ability. Such differences become increasingly apparent the more severe the person's learning disabilities (e.g. a person with profound or severe learning disabilities does not have the developmental ability to experience suicidal ideation but can become depressed). Consequently, it is essential that the psychopathology checklist in the 'presenting complaint' part of the history includes relevant symptoms, and not just those that are found in psychiatric illness in the general population. This requires a different knowledge base to that used in general psychiatry.

Measuring change from baseline functioning

Many adults with learning disabilities have long-standing personality/behaviour traits that would be considered abnormal in an average person. Consequently, when recording symptoms of psychiatric illness, it is important to distinguish between state and trait items. For example, an elderly person previously of average ability who scores less than 24 on the Mini-Mental State Examination (Folstein *et al*, 1975) is likely to have either a dementia or an acute confusional state. If a person with learning disabilities scores less than 24 on the same instrument, this could indicate a gain, loss or no change in ability compared with their usual functional level. Similarly, if a person of average ability reports poor appetite, poor concentration, mid-insomnia and early morning wakening, these are likely to be symptoms of depression. However, the same report in a person with learning disabilities may represent symptoms of depression, or may be long-standing behavioural traits which are normal for that person. Consequently, the history taken must be detailed, and must distinguish between trait and state items, by recording whether a change has occurred from the usual pattern.

Completing a developmental history

This is necessary in all psychiatric assessments of adults with learning disabilities. A developmental

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history includes assessment of the aetiology of the person's learning disabilities (and hence gaining important information that can be compared against the known behaviour phenotype), and their current level of adaptive behaviour. Knowledge of adaptive behaviour skills is important as this will modify the way in which psychiatric disorders present, and additionally is a necessary component to enable developmentally appropriate treatment plans to be devised. Information regarding the way that the person developed in early childhood can also be relevant both to psychiatric diagnosis (e.g. autism) and to an understanding of the way that an individual and their family have come to terms with disabilities and what coping mechanisms have been employed.

Mental state examination

Psychiatric symptoms in adults with learning disabilities can be 'labile'; for example, a person with depression may well be able to laugh and smile at a joke, and so their affect may not appear depressed during a short interview. However, failure to maintain a euthymic mood over a longer period of time is more suggestive of depression (e.g. episodes of irritability or misery occurring during the day, rather than being constantly miserable). People with learning disabilities can be suggestible depending upon their immediate environment. Hence, being able to jolly someone along does not equate with them having a euthymic mood. Mental state examinations have to be based over a longer time-scale (preferably including periods of observation), rather than just a brief snapshot.

Summary

Psychiatric assessment therefore consists of taking a full history (presenting complaint including psychopathology checklist, past psychiatric and medical history, drugs, family history, developmental history, personal history, social history, forensic history), mental state examination, physical examination as well as psychiatric and physical investigations. In a person with no verbal skills, physical illness can mimic psychiatric illness, and hence its elimination is important. Certain physical illnesses occur commonly in people with learning disabilities (e.g. hypothyroidism occurs commonly in people with Down's syndrome). There can also be an overlap between psychiatric symptoms and epilepsy and anti-epileptic drug side-effects, which may require special attention in the assessment. Where a diagnostic formulation is uncertain it may be necessary to continue the assessment by undertaking a period of observation. The special investigations required are dependent upon the person's presentation; however, a review of case notes, information from other informants and professionals who know the individual and blood tests (i.e. full blood count, urea and electrolytes, liver function test and thyroid function tests) are indicated in all cases, particularly when the person does not have verbal skills. Other investigations should be undertaken as indicated by the initial assessment. When the presentation is one of dementia, a full dementia screen should be undertaken to eliminate reversible/treatable causes. In people presenting with dementia, a computed tomographic or magnetic resonance imaging head scan may be indicated to exclude other organic lesions, such as space-occupying lesions (if the individual has symptoms of raised intracranial pressure, or focal neurological signs) or hydrocephalus (which occurs at an increased rate in people with tuberous sclerosis). An abnormal scan finding cannot be used to confirm a diagnosis of dementia, as scan findings are often abnormal premorbidly and a premorbid scan is rarely available for comparison.

Differences in treatments

Psychiatric treatments for elderly people with learning disabilities are very similar to those used among the elderly general population and younger adults with learning disabilities. These include using physical (drugs and ECT), psychological, social and developmental treatments, usually in combination. There are, however, some differences in treatments used for people with learning disabilities and the general population.

Agreeing care plans with the person's main carer as well as with the individual with learning disabilities

Even simple treatments such as the use of psychotropic drugs requires the carers to understand the reason for using the drug, potential benefits and potential side-effects, because for people with moderate to profound learning disabilities it is likely that the carer will administer the drug, record any changes that occur, and alert the doctor if any side-effects or adverse effects occur (particularly for people who do not have verbal skills). If the person with learning disabilities spends time in many different settings (which is often the case – e.g. two different day centres, nights spent at a residential care home, and weekends with family), this can require liaison with many different carers. For more

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complex management plans the time spent initially coordinating and setting up the care plans and educating carers in order to seek their cooperation can be one of the important factors that determines whether the plan succeeds or fails. In many cases, it is the carers who actually implement the plan, and record its outcome, and so their cooperation can be crucial.

Epilepsy and psychiatric disorders

About 25% of people with learning disabilities have epilepsy. Antipsychotic and antidepressant drugs affect seizure control and interact with anti-epileptic drugs, and so when used in the treatment of psychiatric disorders careful assessment and treatment of the person's seizure disorder is additionally required.

Developmental approaches

There are many developmental approaches that can be beneficial in the treatment of psychiatric disorders. These include simple education about health, psychiatric symptoms and treatments (undertaken in a way that is appropriate to the person's developmental level). Skill development programmes can be beneficial in enhancing confidence and self-esteem, as well as increasing a person's functional level and independence. Such programmes can also be used as a basis from which a one-to-one confiding relationship can be developed for those people who find formal counselling methods threatening. Skills work may also be used as a method of distraction from distressing psychiatric symptoms.

Psychological approaches

Psychological treatment strategies are based on standard principles, but require modification to be developmentally appropriate. For example, an anxious person with profound learning disabilities will not be able to use a cognitive model of anxiety, or progressive muscular relaxation, but may benefit from semi-hypnotic relaxation methods, soft music, bubble baths, foot spas, aromatherapy, massage and Snoezelen rooms (sensory stimulation rooms). A person with learning disabilities and dementia may benefit from reality orientation, but this will not include writing the day and date on the wall if she/he cannot read. More useful approaches include putting pictures on doors to identify rooms (e.g. a picture of a toilet or a bed); using a pictorial planner to identify the day's events (e.g. a picture of a plate and cutlery to represent meal times, a piano to represent music sessions), and ticking off when each event has been completed. Reminiscence groups may be therapeutic and enjoyable for those with verbal skills (although memories are likely to be of the old institutions), but for those who do not have verbal skills a scrapbook can be useful to keep pictures of important people, places and events, which a carer can look through together with the person with learning disabilities. When behavioural techniques are employed (e.g. to change maladaptive behaviours), the care plans are often implemented by carers rather than the person with learning disabilities setting their own targets and keeping their own diary/records (although involvement of the person with learning disabilities is encouraged whenever possible, and includes keeping pictorial records/plans and colouring wall charts to reinforce achievements).

Services for elderly people with learning disabilities

Specialist psychiatric services for people with learning disabilities have less provision for elderly people with learning disabilities than they do for younger adults with learning disabilities (Cooper, 1997*e*). This can be understood in the context of the evolution of such services. Traditionally, they provided for children and young adults, with an emphasis on education, skills acquisition, and helping families to come to terms with disabilities. Old age is a time of loss and coming to terms with such changes and limitations. The family networks of elderly people with learning disabilities tend to be limited to siblings and nieces/nephews, as most do not marry or have children; whereas children and young adults tend to live with parents and through them have contact with family friends and relatives. Due to the considerable increase in life-span of people with learning disabilities in recent years, the population of people with learning disabilities now includes children as a minority, and increasing numbers of middle-aged and elderly people. This presents a challenge for service providers, who have yet to adapt to meet this growing need. In a recent survey, 93.6% of NHS trusts in England and Wales reported caring for elderly people with learning disabilities through specialist learning disabilities health services (Bailey & Cooper, 1997). However, old age psychiatry services also have skills to offer in the provision of care to this group; in particular, with regard to those disorders associated with ageing as opposed to those of developmental origin. The Sections for Psychiatry of Learning Disability and

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for Old Age Psychiatry of the Royal College of Psychiatrists have recently collaborated to produce a document which addresses this issue (Royal College of Psychiatrists, 1997). It is likely that the skills to meet the needs of this group will not be held exclusively in either service. The key to successful provision will lie in collaboration between services and flexible working patterns.

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Multiple choice questions

1. Regarding the prevalence of psychiatric disorders in elderly people with learning disabilities:
   - a dementia is common among people with Down's syndrome
   - b dementia is uncommon in people with learning disabilities of causes other than Down's syndrome
   - c anxiety disorders tend not to occur
   - d depressive disorders occur in about 5%
   - e autism does not occur.

2. Compared with the general population, elderly people with learning disabilities:
   - a have a similar prevalence of dementia
   - b have a similar prevalence of schizophrenia/delusional disorders
   - c have a higher prevalence of behaviour disorders

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d have a higher prevalence of depressive disorders
e have a similar prevalence of anxiety disorders.

3. People with Down's syndrome:
   a have an excess of CNS serotonin compared with other adults
   b appear to have a relative protection from schizophrenia
   c have a different distribution of apolipoprotein E compared with the general population
   d tend to live longer than people with learning disabilities of other causes
   e account for the high rates of dementia found in people with learning disabilities aged 65 years and over.

4. The relative risk of psychiatric disorders in elderly people with learning disabilities is affected in the following ways:
   a early admission to an institution is protective
   b smoking increases the risk for dementia
   c family history of bipolar affective disorder increases the risk for this disorder
   d developmental factors increase the risk for psychiatric disorder
   e female gender increases the risk for dementia.

5. Assessment and treatment of psychiatric disorders in elderly people with learning disabilities involves the following:
   a for a person with moderate learning disabilities it is not always necessary to take a history from an informant
   b dementia can be diagnosed with confidence if the person gains a low score on the Mini-Mental State Examination
   c a developmental history should always be taken
   d a cognitive approach to anxiety management is often useful
   e reality orientation can be useful in people with dementia.

MCQ answers

1	2	3	4	5
a T	a F	a F	a F	a F
b F	b F	b T	b F	b F
c F	c T	c T	c T	c T
d T	d F	d F	d T	d F
e F	e T	e F	e T	e T

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