

Queensland psychiatrists' attitudes and perceptions of adults with intellectual disability

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Abstract

Background Quality mental health care for adults with an intellectual disability (ID) depends upon the availability of appropriately trained and experienced psychiatrists. There have been few surveys of psychiatrists working with this population.

Method This Australian study obtained psychiatrists' attitudes to and perceptions of the mental health needs of adults with an ID. Training needs were also sought. The survey instrument used was a purposely designed, 28-item self-administered questionnaire featuring multiple-choice and open-ended questions.

Results The majority of psychiatrists expressed concerns about treatment of this group, describing unmet needs. A total of 75% considered that antipsychotics were overused to control aggression, and 34% of psychiatrists were reluctant to treat adults with an ID. In total, 85% agreed that mental health in ID should be offered as a training option for psychiatric registrars, and that specialized mental health services would provide a high standard of care for this population.

Conclusion Broad concerns are raised regarding pathways to mental health care for adults with an ID in Australia. An Australia-wide training strategy needs to be developed. Partnerships between mental health, disability and community services that serve the mental health needs of this population, should actively seek to engage psychiatrists.

Keywords attitudes, intellectual disability, mental health, psychiatry

Background

Psychiatrists play a critical role in responding to the needs of people with mental health problems. Ideally, clinical practice is not hampered by prejudiced attitudes or by lack of knowledge and skills. However, attitudes and perceptions of patients potentially influence responses. A joint report of the Royal College of Psychiatrists, the Royal College of Physicians of London and the British Medical Association (2001) addressed stigma within the medical profession. This report suggested that despite some positive shifts in attitudes by medical practitioners towards people with mental illness, further changes are required.

Psychiatrists can enhance the success of community care through the reduction of stigma and negative attitudes about intellectual disability (ID) and

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mental illness. Corker (2001), a UK psychiatrist, cautions that while research considers the stigma of mental illness, scant attention has been paid to the effect of clinicians' attitudes on their patients. Psychiatrists should be prepared to identify prejudices and modify attitudes and clinical practice accordingly.

There are few surveys of psychiatrists working with people with an ID. In the UK, three surveys have been recently reported (Alexander *et al.* 2002; Smiley *et al.* 2002; Lindsey & Flynn 2003). Lindsey & Flynn (2003) surveyed the Faculty for the Psychiatry of Learning Disability about their work and experience, finding a range of skills and problems, including lack of inpatient assessment and treatment beds. They argued that community care increased demand for psychiatrists specializing in ID.

Smiley *et al.* (2002) surveyed Scottish psychiatrists working with adults with an ID, eliciting views on the level of psychiatric staffing, the population served and services available. Alexander *et al.* (2002) considered the views of psychiatrists specializing in ID with regards to their job satisfaction, core roles and management. The surveys did not specifically explore psychiatrists' perceptions of adults with an ID.

In Canada, Ouellette-Kuntz *et al.* (2003) surveyed the attitudes of senior trainees in general psychiatric training, towards adults with an ID. The authors concluded that the trainees' attitudes towards this group were inconsistent with community care. In the USA, Bell & Williamson (2002) reviewed articles on special populations published in the journal *Psychiatric Services* between 1950 and 1999. From 578 issues addressing special populations, only seven articles focused on people with an ID (Chaplin 2003).

Kuehn (2003), a psychiatrist working with people with an ID, responded in support of Bell & Williamson's (2002) research (quote) 'there is pathetically little interest in serving this special population, particularly among our leaders – the chairs of departments of psychiatry and psychiatric residency directors in medical schools. I find that many psychiatrists believe that working with this population would be ungratifying and frustrating because of their perception that these individuals are nonverbal, have severe behavioural problems, or are hopeless'.

The views of psychiatrists towards mental health treatment of adults with an ID have ramifications for effective community-based support of this population (Beckwith & Mathews 1995). Attitudes are best

understood as a cognitive state of readiness, organized by experience, exerting a directive or dynamic influence upon an individual's response to related objects or situations (Eagly & Chaiken 1993). The relationship between attitudes, views and perceptions is complex, but judgements are implicated.

Thoughts, aided by belief systems, are used to evaluate particular objects with some degree of favour or disfavour (Eagly & Chaiken 1993). Although striving to adopt an objective, evidence-based approach, clinical tasks undertaken by psychiatrists involve subjective consideration of beliefs, moods, relationships and behaviours. Professional judgement and associated decisions are not isolated from the influence of social, political, economic and scientific systems.

In the 1990s, two Australian studies surveyed attitudes and perceptions of psychiatrists, trainee psychiatrists and medical officers (Lennox & Chaplin 1995, 1996). Both surveys found that respondents held major concerns about the quality of care of people with an ID who had mental health problems. To examine current attitudes of Australian psychiatrists, a survey exploring their attitudes to and perceptions of the mental health of adults with an ID was mailed to all psychiatrists in Queensland. Psychiatrists were questioned about mental health service provision to this group, as well as their related training needs.

Method

Queensland psychiatrists were posted a 28-item self-administered questionnaire featuring multiple-choice and open-ended questions. Questions probed the perceptions of psychiatrists across their spectrum of responsibilities. Information sought included the number of adults with an ID seen by the psychiatrists within the last 6 months; responses to 16 statements of opinion regarding the management of adults with an ID (scored using five-point bipolar response-formatted Likert scales); and details regarding training and education needs, including preferred presentation mode and venue. Responses to the statements of opinions are presented in agree/disagree format.

The questionnaire, accompanied by an explanatory letter and reply-paid envelope, was sent to psychiatrists ($n = 306$) and psychiatric registrars ($n = 104$) residing in Queensland by the Royal

Australian and New Zealand Council of Psychiatrists (RANZCP Queensland). In effort to increase the response rate, the survey was mailed out on two separate occasions, approximately 6 weeks apart, during 2001. Data were coded, verified and entered into Microsoft Access, and then analysed using the Statistical Package of Social Sciences (SPSS) 10.0 for Windows. Responses to open-ended questions underwent content and thematic analyses.

The survey used was a revised version of an earlier questionnaire that probed Australian psychiatrists, psychiatric trainees and psychiatric medical officers about the mental health care of adults with an ID (Lennox & Chaplin 1995; 1996). Changes included modified language and additional questions regarding training and education preferences.

Results

There were 175 completed questionnaires, a response rate of 43% from the total mail out ($n = 410$). There were 141 responses (47%) from consultant psychiatrists ($n = 306$), and 31 (30%) of psychiatric registrars responded ($n = 104$). Only 2% of respondents ($n = 3$) did not indicate their appointment status. The majority of respondents were male ($n = 96$), and there were 73 female respondents. Six respondents did not indicate their gender. Results combine responses from consultant psychiatrists and registrars, referring to them as 'psychiatrists'. The majority of respondents were consultant psychiatrists (81% or $n = 141$), with 18% of the sample comprised of psychiatric registrars ($n = 31$). Responses were combined as separate analysis demonstrated significant similarity.

Clinical contact with adults with an intellectual disability

The majority of psychiatrists were actively involved in treatment of adults with an ID and were familiar with issues that the survey addressed. In total, 56% ($n = 98$) of psychiatrists had seen 1–5 adults with an ID within the last 6 months, and 20% ($n = 35$) of the respondents had seen 6–15 patients with an ID within this period. Few respondents ($n = 7$, 4%) had seen more than 15 patients with an ID. The minority of respondents ($n = 30$, 17%) had seen no adults with an ID within the last 6 months.

Consultation setting

The majority of psychiatrists saw adults with an ID within a public sector setting, either as inpatients ($n = 19$, 11%) or as outpatients ($n = 66$, 38%). However, 50 psychiatrists (29%) saw adults with an ID privately, and 4 psychiatrists (2%) saw this group as inpatients in a private setting.

Most common diagnoses

Respondents were asked to rank the three most common diagnoses given to adults with an ID they had seen within the last 6 months. Diagnoses were listed in detail and were drawn from the Diagnostic and Statistical Manual of Mental Disorder-IV (American Psychiatric Association 2000). Table 1 details the most common diagnoses.

Psychoses were the most frequent diagnosis. Mood disorders emerged as the second most common diagnosis, with 25% of respondents ($n = 44$) making this choice. The third most common diagnoses were psychoses and mood disorders. Thirteen per cent of psychiatrists ($n = 23$) indicated psychoses, with 13% ($n = 23$) choosing moods disorders.

Table 1 Most common diagnoses

Diagnosis	Most common N = 175 n (%)	Second most common N = 175 n (%)	Third most common N = 175 n (%)
No response	28 (16)	31 (18)	38 (22)
Childhood*	24 (14)	1	11 (6)
Delirium/dementia	8 (5)	8 (5)	6 (3)
Medical condition	1	7 (4)	6 (3)
Substance related	3 (2)	5 (3)	6 (3)
Psychoses	44 (25)	25 (14)	23 (13)
Mood	19 (11)	44 (25)	23 (13)
Sexual/gender identity	1	2 (1)	3 (2)
Anxiety	6 (3)	6 (3)	13 (7)
Impulse control	8 (5)	9 (5)	10 (6)
Adjustment	8 (5)	14 (8)	14 (8)
Personality	2 (1)	5 (3)	5 (3)
Clinical conditions	2 (1)	4 (2)	1
ID	20 (11)	8 (5)	8 (5)
Other	1	6	9 (5)

*Disorders usually first diagnoses in infancy, childhood or adolescence including autism spectrum disorder. ID, intellectual disability.

Mental health in intellectual disability training needs

In total, 153 psychiatrists (88%) had received no training relating to the mental health needs of adults with an ID within the past 12 months. Sixteen respondents (9%) had attended training, and 104 respondents (59%) indicated interest in attending further training.

Statements of opinion

Psychiatrists were asked to respond to 16 statements about the management of adults with a concurrent ID and mental disorder. A total of 85% of psychiatrists agreed that dual diagnosis (coexisting ID and mental illness) should be offered as a training option for psychiatric registrars, and that specialized mental health services would provide a high standard of care for this population. A total of 75% agreed that antipsychotics were overused to control aggression, and that Disability Services Queensland was not easy to liaise with or refer to. Table 2 details all responses.

Education and training needs

When asked whether psychiatrists received sufficient training to manage the mental health needs of adults with an ID, 132 (75%) suggested no. Twenty-five psychiatrists thought sufficient training was provided. The survey concluded with open-ended questions designed to draw out education and training needs associated with mental illness in adults with an ID, including preferred presentation mode and venue. Responses were analysed with regard to content and themes, then prioritized into the following five categories.

Diagnostics

Training and education in the assessment and diagnosis of mental illness in adults with an ID emerged as a clear priority. Specific requests were made for training that assisted with the recognition of depression, psychosis and mood disorders. Psychiatrists commented on problems associated with the atypical presentation of mental illness in this population.

Table 2 Attitudes and perceptions of Queensland psychiatrists

Statement of opinion	Agree N = 175 n (%)	Disagree N = 175 n (%)
1. 'There is seldom the need to investigate psychiatric symptoms in the more severely intellectually disabled'	8 (5)	158 (90)
2. 'Adults with dual diagnosis receive a relatively poor standard of psychiatric care'	119 (68)	44 (25)
3. 'Psychiatric treatment of these adults is usually symptomatic, rather than diagnosis based'	122 (70)	41 (23)
4. 'Adults with dual diagnosis commonly stay too long in psychiatric beds'	117 (67)	44 (25)
5. 'The acute admission ward is adequately suited to the needs of adults with dual diagnosis'	34 (19)	129 (74)
6. 'Adults with dual diagnosis are exploited by other patients during inpatient admission'	141 (81)	21 (12)
7. 'Individual supportive psychotherapy is a useful treatment'	136 (78)	30 (17)
8. 'Antipsychotic drugs are overused to control of aggressive behaviour'	131 (75)	32 (18)
9. 'Inadequacy of community support services often makes the prescription of antipsychotic drugs necessary'	136 (78)	30 (17)
10. 'It is easy to refer to and liaise with Disability Services Queensland (DSQ)'	25 (14)	132 (75)
11. 'Specialised psychiatric units for adults with dual diagnosis would provide a higher standard of care'	149 (85)	15 (9)
12. 'Rehabilitation beds in psychiatric hospitals should be available for their management'	118 (67)	44 (25)
13. 'Psychiatrists receive sufficient training in behavioural management of adults with dual diagnoses'	35 (20)	131 (78)
14. 'A sub-specialty of psychiatry should be responsible for the treatment of adults with an ID'	103 (59)	60 (34)
15. 'The Psychiatry of dual diagnosis should be offered as a training option for all psychiatric registrants'	148 (85)	18 (10)
16. 'I would prefer not to treat adults with an ID'	102 (58)	60 (34)

Behaviour management and treatment

Although psychiatrists thought that their skills and techniques were suitable for the management of problem behaviours in the general population, they require assistance with responding to the complex behavioural needs of adults with an ID. Access to additional clinical strategies that reduced challenging behaviour was needed, as well as advice regarding tailoring techniques used in the general population. Information that could be provided to paid carers and family members was also required.

Pharmacotherapy/psychopharmacology

Psychiatrists wanted access to evidence-based prescribing guidelines or best practice recommendations that specifically addressed the needs of adults with an ID. Indications for psychotropic drug use when managing challenging behaviour were also requested.

Information in 'general'

Psychiatrists sought evidence-based information and advice regarding service options for adults with an ID. They wanted to know not only what services existed, but also how to access these services. Many advised of their interest in knowing about current innovations in the ID field. Others asked for opportunities to interact with clinicians who held expertise. Many psychiatrists advised that they needed to understand how to collaborate with existing service delivery systems, and some suggested that they needed to interact more with disability and other services but lacked opportunities to do so.

Training format preferences

Psychiatrists were questioned about preferences for training and education opportunities. The majority chose seminar ($n = 68$) and 1-day or less workshop ($n = 53$) formats.

Discussion

Queensland psychiatrists are involved in the provision of mental health services to adults with an ID, despite anecdotal evidence from some disability service providers suggesting difficulties in engaging these specialists. The majority of psychiatrists had

seen this group within the last 6 months. Many were of the opinion that adults with an ID receive a poor standard of psychiatric care. The majority also believed that this group did not benefit from acute admission, and there was potential for exploitation during inpatient admission to generic mental health units.

There was majority agreement that specialist in mental health services, including inpatient services, should exist for this group because existing mental health services have limited utility for adults with an ID. Psychiatrists advised that their approach to treatment of this population was symptom based as opposed to diagnosis driven. The majority thought psychotropic drugs were overused in their management of aggression. Additionally, many believed that the inadequacy of community services influenced the over prescription of psychotropic drugs.

There was general consensus among psychiatrists that they need more knowledge and expertise in treating and managing mental health problems in this population. Few disagreed that psychiatrists require training and education, particularly in regard to the diagnostic and assessment challenges associated with atypical presentations of mental illness, and the treatment of challenging behaviour. Access to evidence-based psychotropic prescribing guidelines was requested. Although some saw value in the development of a subspecialty in psychiatry, there was wider agreement regarding training options for psychiatric registrars.

Most were interested in redressing their perceived lack of skills, with a preference for expert presentations in a 1-day or less, seminar format. In the USA, Reinblatt *et al.* (2004) used an anonymous questionnaire to examine the perceptions of general psychiatry residents about the utility of specialized training that they received while working on an inpatient unit for patients with an ID and mental illness. This questionnaire was sent to 58 former and current residents, with 43 questionnaires returned. A total of 98% of respondents strongly agreed or agreed that training was useful, and 56% of respondents rated the training as sufficient preparation to treat patients with an ID. The majority (84%) reported that the training should be required during psychiatric residencies. Our survey reveals similar results, as did Lennox & Chaplin (1995, 1996) in their earlier survey of Australian psychiatrists.

The low response rate of 43% suggests caution in generalizing findings. The response rate may have been influenced by the accuracy of the address list provided by the RANZCP. Another possible reason for the response rate may relate to failure by adolescent and child psychiatrists to respond. They may have considered a response inappropriate in light of the survey being targeted at psychiatric treatment of 'adults' with an ID. Anecdotal evidence suggests that adolescent and child psychiatrists could remain involved in the treatment of patients who move from childhood to adulthood because of limited alternatives for referral. Alternatively, interest in the topic, relevance of the topic to their practices and general problems associated with survey completion and return, may have had an impact upon response numbers.

Conclusion

Psychiatrists' perceptions of adults with an ID have the potential to influence clinical decisions and shape therapeutic outcomes. There has been some exploration of views of psychiatrists about adults with an ID within Australia (Lennox & Chaplin 1995, 1996). Other surveys of psychiatrists working with this population have been conducted in the UK (Alexander *et al.* 2002; Smiley *et al.* 2002; Lindsey & Flynn 2003), the USA (Reinblatt *et al.* 2004) and Canada (Ouellette-Kuntz *et al.* 2003), although there is a dearth of research focusing upon attitudes and perceptions of this population.

This study suggests that negative perceptions about people with an ID held in the broader community may also be held by some Queensland psychiatrists. While the majority of Queensland psychiatrists are actively treating adults with an ID, 43% were reluctant to treat this population. This finding is similar to Lennox and Chaplin's (1996) earlier Australian survey that reported 39% agreed with 'I prefer not to treat adults with an ID'. Inadequate training opportunities provide another explanation of reticence to treat.

The lack of psychiatrists with expertise in this population has been internationally recognized and is not unique to Australia (O'Dwyer 2000). However, there are few psychiatrists in Australia with specialist interest in adults with an ID, and only one Queensland psychiatrist that we are aware of, with a practice

solely dedicated to this group. While mental health in ID training initiatives targeted at psychiatrists holds potential to improve the situation, multiple strategies are required. There is increasing evidence that specialist service responses are required if the mental health needs of this group are to be realized (Bouras & Holt 2004).

Service responses to the mental health needs of adults with an ID across Australia, as in most Western nations, are patchy, ad hoc and lack strategic direction (Molony 1993; Lennox & Chaplin 1995; Parmenter 1998; Beange *et al.* 2000; Bigby & Ozanne 2001). Partnerships between mental health, disability and community services that are responsive to the mental health of this population should actively seek to engage psychiatrists. This collaboration is necessary, as solo clinicians or agencies are unable to provide effective responses (Mohr *et al.* 2002a,b; Lindsey & Flynn 2003). However, at present Australian psychiatrists are poorly equipped to contribute because they lack the required knowledge and skills to effectively assess and treat adults with an ID. Part of the solution lies in the development of a special interest group within the RANZCP. An Australia-wide training strategy needs to be developed and implemented by the commonwealth and state governments, in conjunction with the RANZCP.

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