

Health Needs of patients with
Learning Disabilities.

Benefits of Health Screening

- Thanks for information from:-
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- 3. RCGP/LD group.

SCREENING

- Need at risk group
- High sensitivity
- Cost effective
- Positive predictive value such as high prevalence in an at risk group.
- “Health screening programmes are more likely to be effective if delivered in a population-based, pro-active, co-ordinated way rather than relying on the individual to initiate the arrangements for the health check. The programme should screen those needs which occur most commonly in at risk populations and which interventions and supports can be made available.” Scottish Health Needs Assessment report.

ICD 10 DEFINITION

- Mental retardation [LD] is a condition of arrested or incomplete development of the mind, characterised by impairment of skills manifested during the developmental period, which contribute to the overall level of intelligence, i.e. cognitive, language, motor and social abilities. Also IQ of less than 70
- 4 types. Mild, moderate, severe and profound.
- Incidence 0.6% - 2.5% of population.

CO-MORBIDITY OF LEARNING DISABILITY.

- EPILEPSY ranging from 1 in 100 in mild LD to 1 in 2 in profound.[Around 25%]
- AUTISM [Children 2 per 10,000 with LD]
- ATTENTION DEFICIT HYPERACTIVITY DISORDER[ADHD]Prevalence rate of ADHD in LD is up to 10x higher than general population[Seager and O'Brien 2003]
- MOTOR PROBLEMS ie Cerebral Palsy.Motor problems increase with age[29% Over 55 rising to 58% over 75]
- HEARING DIFFICULTIES[From ear wax to severe sensory neural deafness,glue ear in Down's syndrome]Reported prevalence = 12.3% - 47%

CO-MORBIDITY 2

- VISUAL DEFECTS[From occipital blindness,squints,visual field defects,cataracts,refractive errors uncorrected]Prevalence reported 19% - 63%
- DYSPEPSIA[Helicobacter,hiatus hernia,oesophagitis]People with LD have a higher incidence of Reflux disease ie GORD.Thought to be 48%.High incidence of Helicobacter particularly in group living.
- ASPIRATION[Pneumonias,Asthma]
- SPINAL PROBLEMS[Scoliosis,Kyphosis,early Osteoporosis in Rett's syndrome,Osteoporosis with increased fracture risk associated with psychotropics,anti-epileptics,poor positioning in profound LD]This leads to
- OSTEOARTHRITIS [Dysplastic hips,ankles].
- MEDICATION[Psychotropics,anti-convulsants]20-50% of people with LD are prescribed anti-psychotics depending on the population studied.Often for behaviour disorders rather than psychosis.Many experience S/E such as weight gain,EPS and sedation.

CO-MORBIDITY 3

- **CANCER.** Common but different pattern of malignancies from the General population. Increase risk of tumours of oesophagus, stomach and gall-bladder. ?associated with high incidence of reflux disease. Reduced rates of prostate, lung and urinary tract abnormalities. High risk of leukaemia in Down's syndrome.
- **ENDOCRINE DISORDERS.** Hypothyroidism with Down's syndrome. Diabetes with Prader-Willi, Turner's syndrome.
- **OBESITY** Also effect of overeating/Choice for individuals with LD and subsequent obesity and Diabetic risk. Prevalence of obesity reported as higher in LD population varying from 10-50%, higher in women rather than men.

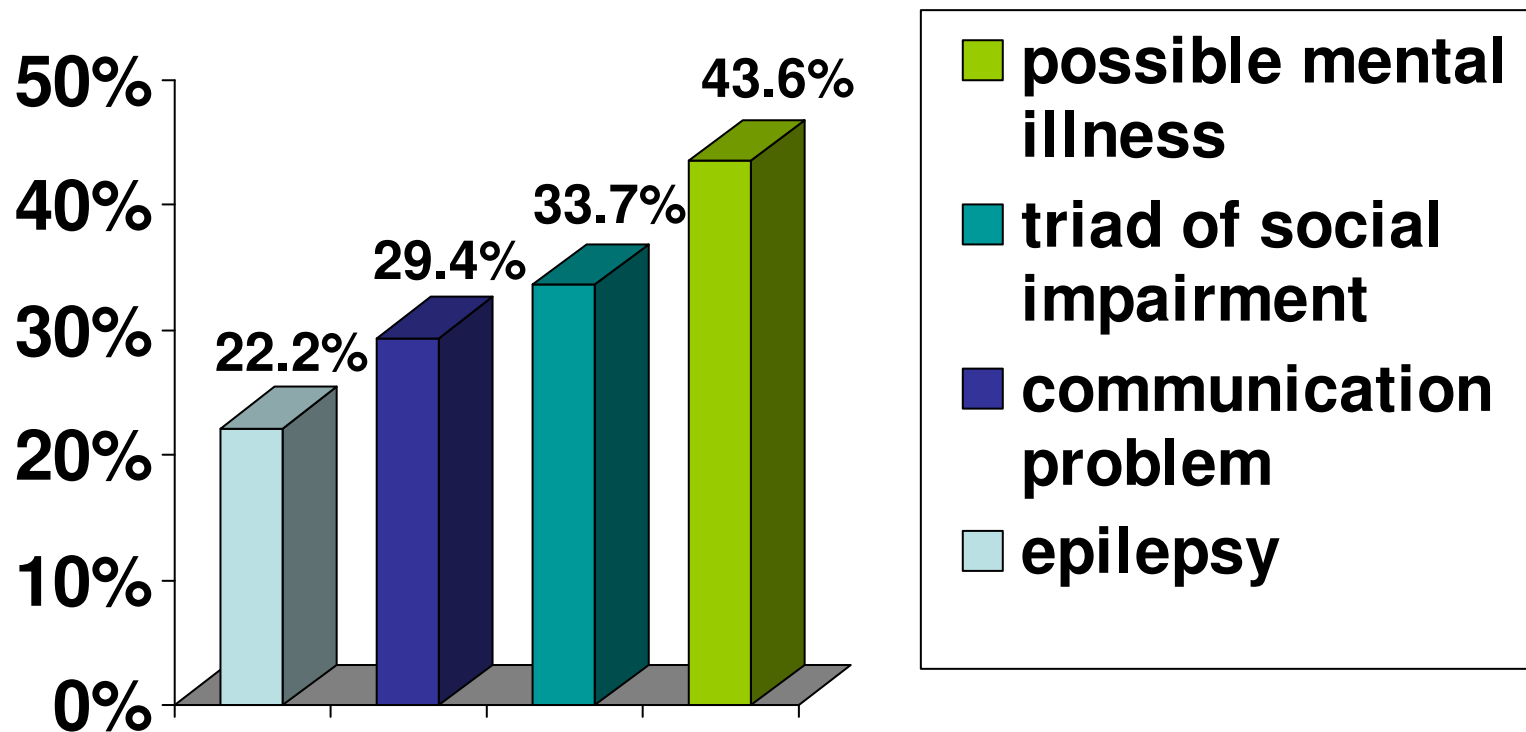
CO-MORBIDITY 4

- **CARDIOVASCULAR DISEASE.** Congenital heart disease is common and genetically determined. ie Down's syndrome, Velo-cardio-facial syndrome. However as people with LD are living longer, increased risk of CV disease.
- **ACCIDENTS.** High rate of accidents and injury. Particularly from falls ie 2ND. neurological impairments, epilepsy, psychopathology,
- medication, sensory impairments, balance difficulties and also behavioural problems such as self injury and destructive behaviours. Adequate risk assessments could diminish these.

MENTAL HEALTH DIFFICULTIES.

- DEPRESSION/ADJUSTMENT DISORDERS
- BI-POLAR DISORDER
- ANXIETY such as POST-TRAUMATIC STRESS DISORDER, SOCIAL PHOBIA, GENERALISED ANXIETY DISORDERS.
- SELF INJURIOUS BEHAVIOURS
- CHALLENGING BEHAVIOUR
- OBSESSIVE COMPULSIVE DISORDER
- SCHIZOPHRENIA/FUNCTIONAL PSYCHOSIS
- DEMENTIA[Down's syndrome can develop Dementia in there 30's]
- Quote from "COUNT US IN" 2003 "At one point in time 40% of young people with LD will be experiencing significant mental health problems. Figure is 10% for young people without LD."

High prevalence serious illness/ disability



DEATH RATES – SCOTLAND

Sally-Ann Cooper

University of Glasgow

- 16-44y Gen pop./1000 = 1.0
- 16-44y LD/1000 = 11.6 [SMR = 1160%]
- 45-59y Gen. pop/1000 = 6.6
- 45-59y LD/1000 = 25.3 [SMR = 383%]
- 60-74y Gen.pop/1000 = 22.1
- 60-74y LD/1000 = 41.2 [SMR = 186%]
- 75y+ Gen.pop/1000 = 93.4
- 75y+ LD/1000 = 100 [SMR = 107]
- **TOTAL GEN.POP = 11.3/LD = 21.9/[SMR = 193]**
- **SOLUTION = PRIMARY CARE HEALTH CHECKS.**

Decreased determinants of ill health: Lifestyle

	ID Population	General population
Hypertension ¹	22%	30.6%
Smoking	6.8%	25.5%
Excessive Alcohol Use ²	1.1%	38.5%

¹ systolic blood pressure 140 and or diastolic blood pressure 90 or above

² 14+ units/week for women, 20+ units/week for men)

Increased determinants of ill health: Weight/obesity

	ID population	General population
Underweight (body mass index < 18.5)	4.0% (3.9% M) (4.0% F)	N/A
Overweight or obese (body mass index ≥ 25)	65.9% (57.1%M) (72.7%F)	60.5% (65%M) (56%F)
Obese (body mass index ≥ 30)	35.2% (28.6%M) (40.4%F)	22.6% (22%M) (23%F)
Diabetes	9.0%	3.9%

The key paper

Beange, McElduff and Baker. Medical Disorders of Adults with Mental retardation: a population study. *AJMR* 1995, Vol, 99. No 6, 595 -604.

ID Sample compared with National Heart foundation data

Define and measure:

Major/Minor health impairments
Mortality data
Demographic factors
Risk factors: smoking/drink/obesity

Findings:

Never married increased
Married decreased
Obesity increased
Exercise decreased
Smoke/drink decreased
Associated physical &
medical problems increased
42% undetected medical illness
Increased hospitalisation

EFFECTS OF HEALTH NEEDS

- Evidence from different health systems that people with LD experience a disparity in health compared with the general population. This leads to reduced life expectancy, high morbidity, reduced participation in health promotion activities, and an increase of healthcare utilisation [eg. Poorly controlled epilepsy and visits to A&E]

EFFECTS cont.

- Reasons underlying this disparity are complex and seem to relate to:
- 1.characteristics of individuals such as genetic disposition.
- 2.Difficulties in communicating health needs and
- 3.defecits in service provision
- *From “Previously unidentified mordidity in patients with intellectual disability.”*
- *Baxter,Felce,Kerr et.al.BJGP Feb.2006*

PEARL

- PRIMARY CARE AUDIT AND RESEARCH IN LEARNING DISABILITY.
- PRACTICES IN WALES AUDITING CARDIFF HEALTH CHECK
- 374 ADULTS RECRUITED
- 318 HAD BASELINE DATA COLLECTED
- 190 RECEIVED HEALTH CHECKS
- 181 POST HEALTH CHECK, 3-4 MONTHS LATER
- 128 DID NOT PARTICIPATE FOR A VARIETY OF REASONS.
- IDENTIFIED NEW DISEASE FINDINGS IN A PRIMARY CARE POPULATION

The impact of health checks

- Ninety-three of 181 individuals (51%) had health needs newly identified as a result of the initial PEARL 1 health check: of whom 59 (63%) had one health need identified, 23 (25%) two and 11 (12%) more than two

The impact of health checks

- There were 148 health needs identified in total: 43 (29%) arose from health promotion activities, such as a need for cervical cytology, 56 (38%) related to sensory impairment, 24 (16%) were found during the systems enquiry or physical examination and 25 (17%) fell into the remaining areas of the health check. 38 of the 148 needs identified arose through formal measurement such as mammography or blood and urine testing

The impact of health checks

- The identified problems may be deemed serious for 16 patients (8% of those audited, 17% of those with newly identified health needs). These include one each with breast cancer, suspected dementia, asthma or post menopausal bleeding, two each with diabetes or hypothyroidism, and four each with high blood pressure or haematuria

What is disparity

Whitehead* 1990

- Recognised that disadvantage in health was linked to a broad range of measures
- Recognised that the concept had both moral and ethical dimensions
- Recognised 7 (overleaf) determinants of health differences

*Whitehead M. (1990) The concepts and principles of equity and health. WHO. Copenhagen.

What is disparity

Whitehead* 1990

- Natural biological variation
- Health damaging behaviour if freely chosen (sports)
- Treatment advantage to one group if they are first to adopt health promoting behaviour
- Health damaging behaviour where lifestyle choice restricted
- Exposure to unhealthy, stressful living and working conditions
- Inadequate access to essential health and other public services
- Natural selection or health related social mobility

The key words (1995)

- Indifference
- Apathy
- Preferential access to certain health services
- Health promotion targeted to this group
- Regular physical examinations are needed
- Problem not due to a lack of sources of help
- Health can make people reach their potential

WHAT ARE THE DIFFICULTIES AROUND HEALTH CHECKS?

- COMMUNICATION BARRIERS
- CARERS PERSPECTIVE
- DIFFICULTY IN EXAMINATIONS[AUTISM/CONSENT]
- AFFECT OF STIMULATION AND SOCIALISATION IN INSTITUTIONAL ENVIRONMENTS
- DIAGNOSTIC OVERSHADOWING – EFFECT OF DIAGNOSIS OF LEARNING DISABILITY UNDERESTIMATING IMPORTANCE OF EMOTIONAL BEHAVIOUR.
- UNDER DIAGNOSIS OF DEPRESSION
- DIFFICULTY IDENTIFYING PSYCHOSIS
- EFFECT OF EPILEPSY/CHRONIC MEDICAL CONDITIONS.
- INTERPRETATION OF CHALLENGING BEHAVIOUR IGNORING PHYSICAL CAUSES.

COMMUNICATION STRATEGIES TO HELP IN HEALTH CHECKS.

- Remember you're a GP. You have been trained in communication.
- Try to assess level of communication and level of LD. ie Mod.LD. will have poor communication skills.
- Do not rush the consultation
- If problems, consider a house call next time. ie familiar surroundings.
- Speak to the patient not the carer
- Use carer for information you cannot get from the patient or confirmation of facts. Value opinion particularly if parent.
- Remember LD difficulties such as time frames. Perhaps use markers such as times of "soaps.
- Good eye contact
- Keep language simple/not too many adjectives
- Closed questions and limit choice of subject. One thing at a time.
- Assess capacity and consider AWIA if treating.