Journal discussion- Patients with personality disorders and intellectual disability – closer to personality disorders or intellectual disability? A three-way comparison by Alexander et al.

By Dr Priyanka Tharian, Consultant general adult psychiatrist,

Newham, East London Foundation Trust.

Introduction

- GA with special interest in patients with intellectual “disadvantage.”
- past research projects in field
- Research based risk assessments vs real life risk assx.
- Patients with ID and PD fall between services
- So how to provide a service & manage risk?

Aims of Talk & the study.

- Scope of talk- summary of paper, discussion & my reflections.
- compare patients with co-morbid PD and ID with patients with either diagnosis as a standalone.
- service evaluation cohort study
- 3 arms- (PD and ID), PD alone, ID alone.

Background.

- diagnostic overshadowing, comorbid diagnoses mislabelled as “behavioural problems”.
- Overlap in presenting symptoms between some PD and ID.

- Diagnosis is important:

– patients with mild ID need access to general adult care when they’re not accepted into LD services.

- For treatment.
- For risk assessments

- National guidance- ID patients need greater access to “mainstream”/GA services.

Retrospective Cohort Study

- Database of over 1000 secure uk hospital inpatient discharges,
- 362 patients selected (inclusion criteria met)
- Timeframe: between 1992 and 2001
- Diagnoses- ICD-10, by consultant
- 3 arms – ID, PD, ID with PD
- Compared for pre and post treatment variables.

- Main finding- more similarities than differences between the comorbid group and ID alone group.

PD only group characteristics.

- **Pre-treatment variables-HIGHER** number of :
- **previous hospital admissions**
- **previous convictions & younger age at 1st conviction**
- **previous offences and also of violent convictions.**

- **Post-treatment variables- HIGHER number of:**
- Post release convictions
- Re-offending at 1, 2 and 5 years
- Serious/Violent re-offending at two years.

ID-PD group characteristics.

- Pre-treatment variables:

- More compulsory detention under criminal sections and restriction orders.

- Longest length of stay in hospital

- Older patients on d/c

- Lower number of previous convictions & later age at first conviction.

(most closer to ID group)

- Higher scores on the HCR-20 and the PCL:SV

- Post treatment variables-

- Lower rates of future offending than PD only group.

- ?Diverted away from the criminal justice system

My Reflections.

- forensic settings, the total prevalence of PD was 39.3% mostly Antisocial PD.
- Growing PD caseload in GA services.

- Forensic ID services- mostly mild ID,
- GA services- mainly PDs also ?mild ID

- When ID undiagnosed, risk undetected/underestimated.
- Assess baseline & change in function.
- Collaborate with families & wider MDT.
- Medium/low secure forensic settings- rates of Antisocial PD & EUPD ~50%. May come to GA first- liaison forensic cons ELFT.

Risk factors in assessment- (formulations)

- Risk factors for PD more common in socio-economically deprived inner city London pops.

- Lack of access to educational assx.

- Present late to GA services, barriers to accessing care.

Conclusions.

- Boundary disputes for patients with ID and PD.
- Patient distress.
- Difficult adapting to different teams & lack of continuity.
- In devising specialist units, consider equality of outcomes (as well as access)
- Need specialised psychology for those with ID.

- In GA our SPS services were suspended,
- Less F2F sessions, would impact on those with ID and PD.
- For ID patients, risk info from non verbal aspect of assessment may be lost.
- Need to adapt services around patients.

Take home message…

- LD & PD co-morbid group can sometimes be more risky than the PD group in terms of risk variables.
- LD & PD group closer to the LD group in terms of treatment outcomes.
- Need access to LD services/units & risk management approaches.

Any questions?

Thank you for listening ☺ !

priyanka.tharian@nhs.net