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S55. Mental health in mental retardation
(European Association for Mental Health and Mental Retardation)

TRAINING IN THE PSYCHIATRY OF MENTAL HANDICAP IN THE UNITED KINGDOM

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It is essential that professionals working in psychiatric services for mentally handicapped people are properly trained. Mental handicap has been a recognised psychiatric specialty in the United Kingdom for 150 years and there are well established specialist services and specialist training programmes for doctors and nurses which could serve as a model for other countries.

Currently, doctors wishing to specialise in the Psychiatry of Mental Handicap must satisfactorily complete a period of general psychiatric training followed by a period of specialist training in schemes approved by the Royal College of Psychiatrists an the Joint Committee on Higher Psychiatric Training. General psychiatric training lasts 3-4 years and includes a clinical placement and academic lectures on mental handicap. The specialist qualifying examination taken on completion of general training includes both questions and a clinical examination in the subject. Specialist training takes another 3-4 years full time in an approved scheme with prescribed academic and clinical components. Total duration of specialist training is shortly to be halved but the components will remain the same.

Currently there are 200 Consultant Psychiatrists in Mental Handicap in the UK and 90 training posts. The first Chair in the Psychiatry of Mental Handicap was established in 1980 and there are now seven Chairs with academic posts at Senior Lecturer level in all University Departments. Medical students receive an average of eleven hours lectures and "hands on" experience in mental handicap and the subject is being increasingly covered in the continuing education of General Practitioners.

Nurses have received specialist training leading to specialist qualification since 1919. In recent years there has been a shift in emphasis from medical and psychiatric aspects to social care but this trend is now reversing and nurses working in the service are increasingly obtained more appropriate training. Nurse training generally is also moving towards the model of general training followed by specialist training.

Social workers and clinical psychologist receive some academic lectures and a practical placement in mental handicap during training.

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The emphasis of enabling people with chronic disabilities to remain in their local community, even if they have additional complex needs, including psychiatric disorders, has drastically influenced the delivery of mental health services over the last 25 years. With the resettlement of people with mental retardation in the community, the response from psychiatrists has been creative, flexible and promising. The development of expertise by psychiatrists such as community based therapeutic interventions, psychotherapy, behaviour and cognitive techniques and special services for people who offend, have all enhanced the clinical and treatment methods. There is a presumption, that the psychiatric services will be available locally to meet the individuals' varied needs. Within a geographical area, however, a service response will need to have an overall vision, with a role for co-ordination of care based on individual planning. The criteria for determining the size of the population in need of specialist services, including mental health, should be based on the individuals' ability to cope with everyday life.

DIAGNOSIS AND ASSESSMENT OF PSYCHIATRIC DISTURBANCES IN MENTALLY RETARDED SUBJECTS

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Because mentally retarded subjects often do not provide reliable information to clinicians, diagnosing psychiatric disorders can be a difficult process. Comprehensive clinical assessment of psychiatric disorders in subjects with mental retardation therefore should be based on multiple sources of information, like case records, behavioral observations in everyday environments, client and staff and/or parents interviews and use of medical tests. Subjects with mental retardation suffer from the full range of psychopathology. But the presentation of psychiatric disorders, e.g. affective disorders, is influenced by the level of cognitive function. Furthermore, behaviour problems like aggressive or self-injurious behaviour may be associated with a psychiatric disorder. Especially in subjects with severe and profound mental retardation the application of unmodified ICD or DSM criteria or the use of psychopathology inventories constructed for persons with normal intelligence therefore does not make sense. Future research should focus on the reliability and validity of modified criteria for psychiatric disorders with this population.

PSYCHOPHARMACOLOGICAL TREATMENT STRATEGIES IN MENTALLY RETARDED

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There is a growing awareness of the existence of psychopathological syndromes in the mentally retarded. Epidemiological studies differ however considerably in the estimated prevalence of the classical psychiatric disorders in these patients. Coexisting brain disease affects the way in which psychiatric disorders are presented. Besides that there is also a tendency to be aware of the specific association of etiological syndromes and forms of psychopathology, not currently classified in the existing diagnostic systems. These factors make a rational psychopharmacological treatment strategy difficult. The situation is even more complicated because of the fact that there is almost no systematic evaluation of efficacy of psychotropic drugs in the different etiological subgroups of mentally retarded patients. However, this state of affairs more or less parallels the situation in clinical psychiatry where a causal treatment of the underlying pathological substrate is currently not feasible and target symptom directed polypharmacy is the most modern strategy.
Guidelines will be presented for psychopharmacological treatment of specific psychopathological symptoms, occurring in different etiological syndromes.

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