

MCQs

1 An increase in behavioural problems in a child with a learning disability can be a consequence of:

- a constipation
- b poor seizure control
- c communication problems
- d anti-epileptic medication
- e physical abuse.

2 In children with learning disabilities, attention-deficit hyperactivity disorder:

- a cannot be diagnosed
- b requires different medication from that used for other children
- c should be diagnosed in the context of the child's developmental level
- d medication is more likely have side-effects
- e is often diagnosed.

3 Psychosis in children with learning disabilities:

- a is a common diagnosis
- b often presents as 'self-talk'
- c can be associated with a genetic disorder
- d responds to antipsychotic medication
- e is usually associated with a change in personality.

4 Behavioural problems in children with autism and learning disabilities:

- a are common
- b can be provoked by minor changes in routine
- c are seldom associated with high anxiety levels
- d may be helped by the use of a visual timetable
- e are likely to be the same in all environments.

5 Medication for behavioural problems in learning disability:

- a is widely accepted
- b has been well studied
- c should be used only under specialist supervision
- d may be used to reduce anxiety in autism
- e can be used without a clear diagnosis.

MCQ answers

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

The new developmental psychiatry

INVITED COMMENTARY ON...

MENTAL HEALTH OF CHILDREN WITH LEARNING DISABILITIES

Tom Berney

Abstract Psychiatric services for children and adolescents with learning disabilities have been subject to fashion and aspiration rather than pragmatic planning, at different times being claimed by different specialties. As services have atrophied, it has become clear how distinct are the clinical issues that arise in this group; issues that show developmental psychiatry at its starkest with a combination of organic, dynamic and systemic factors that require community teamwork. As services and specialties regroup, this evolving area is likely to continue defining itself, perhaps taking in adults with developmental disorders, to emerge as a new specialty, developmental psychiatry. It remains to be seen where this will sit within the health service.

Thirty years ago, 'mental handicap' psychiatrists routinely worked across the whole lifespan but much of their time was taken up with patients under

18 years old. Times changed; children were educated in special schools rather than being trained in social service centres and child psychiatry declared its

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remit to be young people irrespective of ability. Many learning disability psychiatrists retreated to an adult-only practice, leaving the newly emergent community paediatrician to fill the gap that had opened between psychiatric aspiration and service reality. This gap has become more pronounced as training programmes in child and adolescent psychiatry have failed to include enough experience of severe learning disability to give their graduates the confidence necessary to include this in their practice. At the same time, much of the experience with children has been lost from learning disability programmes.

Developmental psychiatry is at its most florid and biological in this particular population. The developmental perspective underpins much of psychiatry. Does work with young people with learning disability really differ substantially from mainstream child psychiatry? It certainly differs in emphasis: epilepsy and autism are recurrent themes, and the diagnostic terminology is affected by the patient's motivation. For example, is the violence of someone with a severe learning disability to be categorised as a conduct disorder, lumped in with their autism, or put into the ragbag of challenging behaviour? This disturbance may arise in the context of a family that is adapting to disability and for which 'good-enough parenting' has been baffled and overwhelmed by an adverse behavioural phenotype. Given this porridge of psychopathology, it is unsurprising that targeting a symptom, any symptom, can produce a global improvement as long as the treatment carries conviction; witness the power of the placebo in the treatment of autism with secretin (Sandler, 2005). This meld of biological, behavioural and psychodynamic psychiatry applies to prevention as well as treatment. The psychiatrist is part of a community team for whom treatment is balanced by supportive work as they help families to work through the recurrent crises of adjustment to, as well as the practicalities of, life with a child with a disability (Bicknell, 1983). The resultant multidisciplinary, multi-agency, community-based style of work might be the model for the latest guidance on psychiatric roles (Care Services Improvement Partnership, 2005).

Children first?

Inclusion, the Children's National Service Framework (Department of Health, 2004) and the development of 'children's trusts' (Department for Education and Science, 2005) set out the new agenda – services that are 'children first' rather than lifespan services for people with learning disabilities. Which psychiatrists will practise with this population?

The College developed criteria for those who wished to get dual training towards accreditation in both specialties (Royal College of Psychiatrists, 2006). However, the 5-year programme that equips psychiatrists to work not just across the range of childhood ability, but also with adults with learning disability has failed to become fashionable. Indeed, we have yet to discover how many of these doubly qualified psychiatrists, assuming that they restrict themselves to children and adolescents, will persist with the mind-expanding post that demands that they engage with the widely differing networks, cultures and clinical approaches entailed in an all-ability practice. Here it is worth remembering how difficult it is to remain a psychodynamically oriented neuropsychiatrist: many settle on one side of the therapeutic fence while keeping entry rights for occasional forays to the other.

A new specialty

However, a new group is emerging. Drawn either from child psychiatry or from learning disability psychiatry, developmental psychiatry is emerging as a specialty. In this, psychiatrists are supported by a professional network that has an annual, residential, academic meeting as the focus for a group still small enough to encourage informal contact at other times.¹

How will this translate into a psychiatric service in which recruitment appears still to come predominantly from learning disability psychiatry? Posts in the sub-specialty outnumber candidates. This gives greater weight to those factors that might make a post attractive, high on the list being a professional peer group. A comprehensive child and adolescent mental health service does not necessarily require generic clinicians or clinics. Service developers need to take a moment from the excitement of managerial monopoly to think about retention as well as recruitment. Someone coming from, say, a learning disability programme and accustomed to that faculty's close, tribal network, may not feel at home in the midst of child psychiatrists.

It remains to be seen how developmental psychiatry will evolve as a sub-specialty. Clinicians may, as has happened in other areas of child health, accompany their patients into adulthood. Such a gradual return to the lifespan developmental specialist would accord with the slow recycling of fashion and practice that is humanity's hallmark.

1. Those who wish to know more about this network should contact Dr Chris Speller (chris.speller@kennetandnwilts-pct.nhs.uk).

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