



**The College of Psychiatry of Ireland**  
*Coláiste Síciatrachta na hÉireann*

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# Mental Health Provision for Children with a Learning Disability

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**Position Paper**  
**EAP03/2011**

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Approved by Council

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## Preface

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The Faculty of Learning Disability Psychiatry of the College of Psychiatry of Ireland commissioned a subgroup under the chairmanship of Dr Louise Tansey to provide this report to the Faculty on the current state of child and adolescent psychiatric services in intellectual disability with recommendations for future service development.

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## Acknowledgements

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We would also like to thank those members of the Faculty of Learning Disability Psychiatry and the Faculty of Child and Adolescent Psychiatry who participated in the survey conducted by the authors.

Finally we would like to express our grateful appreciation to Ms Grace Smyth, The College of Psychiatry of Ireland for her invaluable administrative help.

## Executive Summary & Recommendations

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This report was completed by the Faculty of Learning Disability Psychiatry to outline current mental health service provision for children in the moderate to severe/profound range of intellectual disability in Ireland and to make recommendations for future service developments.

The increased prevalence of psychiatric disorders in children with intellectual disability cited in this paper highlights the need for a specialist mental health service.

In response to a recent survey conducted by this subgroup, the number of consultant child psychiatrists working in the area of intellectual disability in Ireland was estimated at 3.61. This falls far short of the number recommended in A Vision for Change (Department of Health 2006). In A Vision for Change, the number of child psychiatrists recommended in this specialty was 1 per 300,000 population. These services are being delivered by a number of consultant psychiatrists with a part-time commitment to children with an intellectual disability.

They are not community based and are being delivered in a fragmented way by consultant child psychiatrists working without the support of mental health teams.

There is no Higher Specialist Training Programme for child psychiatrists who want to train in learning disability. There is no national database for child psychiatric services in learning disability.

In spite of the recommendations in A Vision for Change, no funding has been made available to implement these recommendations (Health Service Executive, 2009).

This group supports the recommendations of A Vision for Change but it would view these as a minimum requirement only. Further recommendations have been made in this report.

### Recommendations

- A model of mental health service for children with an intellectual disability must be funded and developed to closely parallel that already adopted by the child & adolescent mental health services for children of average ability and those with an intellectual disability.
- This must be child centred, community based and separate from the existing disability services.
- This model should prioritise a recovery oriented model of care.
- This service must have catchment area responsibility and a clearly defined referral pathway.
- It must be delivered in partnership with families and other agencies involved in the delivery of care to children with an intellectual disability.
- Structures must be set up to enhance communication with other services to ensure a co-ordinated approach in service delivery.

- It must be delivered by a fully funded multidisciplinary mental health team.
- This team should be trained in mental health to provide a range of services to meet the complex needs of these children.
- Services should include out-patient, domiciliary, day hospital and in-patient services as required.
- Provision must be made for children within the mild range of intellectual disability, approximately one third of whom attend these services.
- Provision must be made for children with a diagnosis of Autism Spectrum Disorder.
- Provision must be made for adolescents (14-18 years) who have an intellectual disability.
- Policies must be established to enable the easy transition of adolescents into adult mental health services.
- A national database needs to be set up for child psychiatric services in intellectual disability.
- The future of child psychiatry for children with intellectual disability would be greatly enhanced by the development of an academic infrastructure to further foster research and training.
- Service developments must proceed as a matter of urgency to permit the development of a higher specialist training programme to train Child Psychiatrists in the Psychiatry of Learning Disability.
- The Faculties of Learning Disability Psychiatry and Child and Adolescent Psychiatry of the College of Psychiatry of Ireland are committed to developing such a training programme but this process will require the support of the HSE.

# Proposed Model for the Delivery of a Mental Health Service for Children with Intellectual Disability

## 1. Introduction

The principle of providing children with quality health care services was enshrined in Article 24 of the United Nations (1989) Convention on the Rights of the Child (ratified by Ireland in 1992). In Article 2, it states that The Convention applied to all children whatever their race, religion or abilities. In Article 4, it states that governments are obliged to take all necessary steps to ensure that the minimum standards set by The Convention in these areas are met.

In spite of this, the development of child mental health services in Ireland and indeed internationally has not been paralleled by those for children with an intellectual disability. The need for such a service has been highlighted in a number of reports where recommendations have also been made regarding a model of service provision. (Irish College of Psychiatrists, 2004 & 2005, Royal College of Psychiatrists, 2010). These children's rights to treatment and recovery are significantly compromised by the lack of appropriate services.

Mental health services for children within the mild range of intellectual disability (IQ: 50-70) are mainly provided by the generic child & adolescent mental health teams. However those within the moderate range and below are denied this. This paper explores the mental health needs of children under 18 years of age whose level of ability falls within the moderate, severe or profound range (IQ <50) providing recommendations for a more comprehensive model in the development of a specialist mental health service in this area. This mental health service, whilst professionally led must be child and family centred. This involves a model partnership with the family as well as other key agencies that deliver care. This inclusive approach empowers both the individual and family in the pathway to recovery.

In 2006, a policy document, A Vision for Change was published by the Department of Health and Children outlining a 10 year strategy for mental health service development which included mental health services for children with intellectual disability. Sadly, five years later no progress has been made with any of the recommendations made for children with an intellectual disability.

The need for provision of mental health services in this area is well recognised in a body of literature detailing the increased prevalence of psychiatric disorder in these children. Serious psychopathology affects more than 40% of children and adolescents with intellectual disability. This is a prevalence 2-3 times higher than that in typical children (Emerson E, 2003b). However the different modes of presentation and their increased complexity justify the development of specialist teams separate from the generic community mental health teams.

Traditionally, mental health services were provided to children with intellectual disability by consultant psychiatrists who provided a cradle to grave service for all individuals with intellectual disability including children. These were institutionally based services and

provided by the voluntary organisations. With the growth of generic child and adolescent mental health teams in this country and training programmes for adult psychiatrists in intellectual disability, the need to develop specialist services for children in this category became apparent.

The first appointments in Ireland of child psychiatrists with a special interest in intellectual disability were made in 1991. However, these were located in voluntary organisations which also served an adult population with intellectual disability. This did not provide a suitable infrastructure for the development of psychiatric services for children. Like the adult psychiatric posts in intellectual disability, they were not provided with any ring fenced funding by the Department of Health for the development of specialist mental health teams or inpatient beds.

In A Vision for Change (Department of Health and Children, 2006) a chapter was dedicated to policy regarding mental health services for people with intellectual disability with scant reference to children. It is noteworthy that in these service recommendations, there was no distinction made between adults and children where the same mental health team composition was recommended for both, in spite of their different needs.

In the same policy document, recognition was given to the fact that children with intellectual disability have numerous developmental needs for which they require the input of disability teams in the community. It was recommended that the proposed mental health teams for children with intellectual disability be established parallel to the community disability teams with whom they were to have a key relationship. Though there has been considerable growth in the community disability teams for these children, there has been no development in the community mental health teams.

Recommendations were made for the development of thirteen consultant led mental health teams nationally. In Ireland currently there are less than five whole time equivalent consultant child psychiatrists providing a mental health service to children with intellectual disability and serious mental health problems.

The inadequate numbers of consultant child psychiatrists in intellectual disability has serious implications with regard to training future consultant child psychiatrists who want to specialise in the area. There is currently no higher training programme to meet the obvious man power requirements. This crisis needs to be addressed by the Psychiatric Training Committee as a matter of urgency.

As a priority, those consultant psychiatrists already in post need to be equipped with the recommended mental health team support and infrastructure for the delivery of a mental health service that will also facilitate training. Training programmes will then need to be established that will give trainees the opportunity to work under the supervision of these consultant child psychiatrists both at a junior trainee and a specialist registrar level. This would enable them to be trained in the core competencies and the specialist skills required.

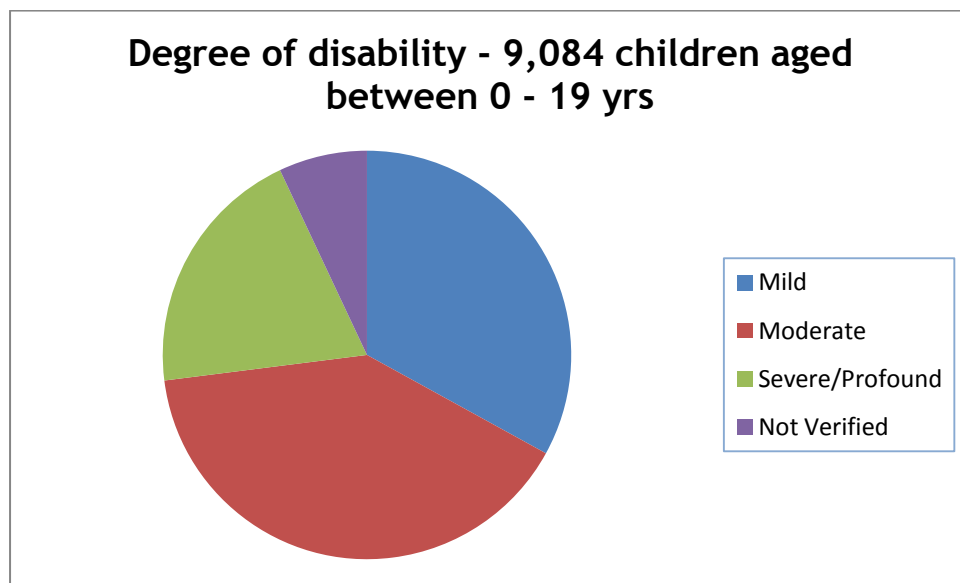


## 2. The need for a dedicated mental health service for children with an intellectual disability

Figures from the National Database of Intellectual Disability 2009, Ireland, show that there are 9,084 children aged between 0 and 19 yrs. registered as having an intellectual disability.

Table 1.1 shows the degrees of disability which have been identified in this population.

Table 1.1 Extrapolated from figures of the National Database of Intellectual Disability 2009



Mild 33%, Moderate 40%, Severe/Profound 20%, Not Verified 7%

Using the database figures, the total prevalence for all levels of intellectual disability is 3.2%. Of these, 1.2% fall within the mild range of intellectual disability, 1.3% fall within the moderate /severe/profound range and 0.7% are unverified. The prevalence rates are based on the census population 2006 figures.

However it is important to note that this is not an accurate representation of the actual numbers of people with mild intellectual disability in the general population. The National Database gives information about the people receiving a service or in need of it. Many children functioning within the mild range of intellectual disability are mainstreamed in education and health and are in less need of an intellectual disability service. If we take the prevalence of mild intellectual disability however, as defined by IQ criteria, it affects 2% (20 per 1,000) of the general population. This would be expected if IQ is normally distributed.

The incidence of children with severe intellectual disability alone is expected to rise 1% year on year for the next 15 years with at least as high a rise in incidence of children with

mild and moderate intellectual disability, due to multiple causes, primarily medical advances e.g.

- Increased survival and life expectancy, especially of people with Down Syndrome
- Increased survival of low birth weight babies (50% of whom show later cognitive impairments) (Full Parliamentary Hearings and Services for disabled children, 2006. London)

It is well recognised that children with an intellectual disability have a higher incidence of mental health disorders. Nearly 40% will suffer from a significant psychiatric disorder, compared to less than 10% of those with normal ability (Emerson E, 2003b; Emerson and Hatton 2007). Other studies also confirm this high prevalence (Dykens EM, 2000; Tonge B and Einfeld S, 2000; Rutter M, Tizard J, and Yule W et al 1976).

Additional factors of social disadvantage often seen in children with intellectual disability such as economic deprivation, inadequate housing, and family distress increase the likelihood of the development of psychiatric disorders. (Emerson E and Hatton C 2007). Comorbid disorders such as epilepsy, cerebral palsy, sensory impairments, behavioural phenotypes and autism increase the need for psychiatric intervention (Dykens EM, 2000).

Despite the clear need for mental health services for children with intellectual disability, they are not universally available and when present are significantly under resourced.

### **Clinical Need**

Children with intellectual disability can suffer the full range of psychiatric disorders experienced by children of average intelligence. The standard approaches to classification such as the DSM-IV (American Psychiatric Association, 1994) and ICD-10 (World Health Organisation, 1992) can be used to define and classify many of the psychiatric disorders that present in these children. However these classification systems have not yet been validated for use in this group and can be difficult to apply.

Anxiety Disorder, Depression, Bipolar Affective Disorder, Schizophrenia and Psychotic Disorders have all been described in children with intellectual disabilities. They can however have a different clinical presentation often in the form of problem behaviour such as aggression and self-injury.

More commonly encountered problems include Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder, Tourette's syndrome and behavioural phenotypes (Lesch-Nyhan Syndrome, Prader-Willi Syndrome amongst others.) Due to medical advances, an increased length of time is spent by many preterm or very sick babies in intensive care with an increased risk of attachment disorder.

Psychiatric disorders in these children are complex and best lend themselves to the use of a biopsychosocial model in assessment and treatment. In this group of children because of their multiple needs, assessment and diagnosis is multi-faceted and multi-disciplinary. There is an increased risk of medical conditions due to the greater instance of congenital abnormalities.

Assessments are lengthier and involve a high level of interagency collaboration. Close liaison with primary care, paediatrics, child and adolescent mental health services, adult

mental health services for people with intellectual disabilities, disability services and schools is required. Assessment tools are often necessary but many have not been validated for children with intellectual disabilities. The developmental behavioural checklist (Einfeld S & Tonge B, 1995) and the Nisonger Child behaviour rating form (Aman et al, 1996) are two carer completed rating scales designed for use with young people with intellectual disabilities. These can be used to screen populations and are of use in the diagnosis and assessment of response to psychopathology in this group.

### **Treatment Approaches**

The child psychiatrist with the family has a key function in the coordination of treatment interventions which need to be adapted to the ability level of the child. The more common range of treatments used include psychoeducation (of the wider family and supporting community), behavioural therapy, family therapy, pharmacological therapy, social skills training and other specialised individual therapy specific to children with intellectual disability.

### **Pharmacological Therapy**

Drug treatments are valuable in targeting the symptoms of the psychiatric disorders listed above. Whilst they can help to alleviate challenging behaviours, they should always be used in conjunction with rather than as a substitute for multi-disciplinary team assessment and other treatment approaches.

Children with intellectual disability often have idiosyncratic responses to medication so this must be closely monitored as side effects can go unreported. A high level of investigation is also recommended prior to commencement. Due to other co-morbidities such as Epilepsy, the potential for drug interactions must also be considered.

## **3. Current service provision**

Traditionally, disability services for children and adolescents with intellectual disability were delivered by voluntary bodies. These services were frequently not child centred or community based. Whilst a number of services still adopt an institutional model of care, the past decade has shown a growth in community based early intervention and school aged teams. These have developed in partnership with the Health Service Executive.

Services are provided based on the disability related needs of the child and include the provision of respite, rather than residential care. Mainstreaming is strongly advocated. Multidisciplinary teams of professionals have been established including Physiotherapists, Speech and Language Therapists, Occupational Therapists, Psychologists, Early Intervention Specialists and Clinical Nurse Specialists. However, no provision has been made for the potentially serious mental health needs of these children. As a result, there are a significant number of children with a dual diagnosis who are undiagnosed and / or untreated.

### **Consultant Numbers**

For the purpose of this paper, a survey in May 2010 by the Faculty of Learning Disability of the College of Psychiatry of Ireland was carried out to ascertain the actual number of consultant child and adolescent psychiatrists working in this area in Ireland in May 2010.

Results show that there were 4.6 whole time equivalent (W.T.E.) posts, provided by approximately 11 child psychiatrists throughout the country, all on a part time basis. We acknowledge that this may be an underestimation as it is based on the numbers who responded to the questionnaire but on a rough estimate the total number of WTE's would not exceed 5 in the country.

Table 2.1 Number of consultant child psychiatrists working in intellectual disability, May 2010

HSE	WTE's
Dublin North East	1.8
Dublin Mid Leinster	1
South	1.54
West	0.27
Total	4.61

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**Addendum**

***As of March 1<sup>st</sup> 2012, there will be a further reduction in consultant numbers in these posts of at least 1.63 WTE, due to retirement.***

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### Service Provision

These psychiatrists treat children and adolescents in the moderate to profound range of intellectual disability, and some who are functioning in the mild range. There is no standard model of care.

None of these psychiatrists have been provided with staffed and funded mental health teams. Some work in professional isolation with little peer support due to the dearth of child psychiatrists in this specialty.

There is no out of hour's emergency mental health service for children with intellectual disability. These children have no access to in-patient beds. Currently, children in crisis are being placed in private beds in Ireland or in out of state placements. This is done at great expense to the state and inconvenience to both the children and their families.

This level of mental health service provision falls far short of the recommended 1/300,000 population which equates to approximately 13 fully staffed mental health teams recommended by A Vision for Change.

## 4. Recommendations for service development

### Location of service

This service is catchment area based and should be located in the community. This would be a positive move from an institutional based service to a mainstream setting. This could be in conjunction with the generic child and adolescent mental health service, as part of a comprehensive service. It is vital that separate funding be made available for the initiatives and developments of this service.

### Referral procedure

We would endorse the referral procedure recommended in A Vision for Change, 2006 with a single point of entry for referral through the general practitioner.

### Team composition

This service should be provided by a multidisciplinary mental health team with clinicians who are experienced and trained to offer a support and treatment plan for the child's needs. Parents should have a key role in formulating and implementing both treatment and recovery plans. Families and/or carers should also receive appropriate supports and therapies within this service.

A Vision for Change 2006 recommends the provision of a fully staffed multi-disciplinary mental health team to cover a catchment area of 300,000 populations. It stipulates that child and adolescent mental health teams in intellectual disability should be community based with domiciliary, day hospital and outpatient treatment. The inpatient bed requirement is not estimated. Whereas these recommendations are welcomed, they are not sufficiently child centred and fall short of the actual requirements

We would recommend the mental health team composition presented in Table 3.1 below. Children with intellectual disability may also require additional specialised individual therapy e.g. play therapy, art therapy and music therapy which can sometimes be accessed through the disability teams or other community services.

Table 3.1 Recommended minimum staffing requirements of a CAMHS ID Team

#### Recommended Minimum Staffing Requirements

1 Consultant Child Psychiatrist of Intellectual Disability

2 Psychologists:

1 senior grade

1 basic grade

2 Social Workers:

1 senior grade

1 basic grade

## **2 Community Mental Health Nurses:**

**1 community psychiatric nurse (grade CNM 111)**

**1 clinical nurse specialist dually trained in child psychiatry and learning disability**

## **1 Speech & Language Therapist**

**1 Senior Occupational Therapist**

## **2 Non Consultant Hospital Doctors:**

**1 Senior Registrar**

**1 Registrar**

## **2 Administrative Staff:**

**1 Grade III**

**1 Grade IV**

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### **Structuring of consultant posts**

Based on the recommendations of A Vision for Change 2006, there will be thirteen WTE child and adolescent consultant psychiatrists with a special interest in intellectual disability appointed in Ireland. This is a minimum requirement. We propose that all new consultant appointments be delivered as joint appointments with a commitment to both generic and intellectual disability services. This would help to minimize professional isolation which can occur with those consultant groups that are in a minority. It would also lend itself to cross fertilisation of skills between the generic, child and adolescent mental health services and the intellectual disability child and adolescent mental health services. It would facilitate joint training of child psychiatrists with a special interest in intellectual disability.

### **Components of Service**

#### **Outpatient Clinics**

Outpatient clinics should be located in child friendly premises with easy access to other members of the multi-disciplinary team. This model of service facilitates the more able children who can accompany parents to the clinic for assessment, diagnosis and treatment. This is a suitable venue for parent supports group, family therapy, social skills groups and adolescent groups.

#### **Community and outreach services**

Meaningful connections and community involvement for a child with an intellectual disability are difficult to establish and maintain. These children require even greater supports to access the community and social networks which foster their self esteem and sense of inclusion. Outreach and community services are therefore the preferred model of service delivery for these children.

This is often the most frequently used model of service adopted by child psychiatrists in intellectual disability. The nature of the problems with which these children present demands a lot of outreach work. The level of the child's disability or the degree of challenging behaviour often necessitates visiting the child in the home or school. Attendance at network meetings with other agencies involved in the child's care is the

norm. The child psychiatrist has a key role in providing support to teachers in both mainstream and special needs schools. Support is also given to residential placements which again is largely community based.

### **Out of hour's service and inpatient bed facility**

Like their peers with normal intellectual ability, all children with intellectual disability and mental health problems have a right to a 24 hour on-call service. This should be provided by members of the multi-disciplinary team trained in mental health. In the event that the child requires an admission, (s)he should have the right of access to an in-patient bed.

In A Vision for Change, no specific recommendations were made for inpatient beds. This is a serious omission given the high prevalence of psychiatric disorders in these children.

There is less published guidance on in-patient bed requirements for children with intellectual disability and mental health problems. Based on figures from UK, (Royal College of Psychiatrists, 2010) we envisage 3 beds per 500 000 population would be sufficient. In light of the planning of the national forensic unit for children in the eastern region, it is essential to have access to at least 3 beds for children and adolescents with intellectual disability.

### **Groups with Special Needs**

#### **Adolescent (14-18 year olds)**

Due to the different needs of this group, they are at risk of being marginalised in the future service development. Alternative treatment models may need to be used, and access to day hospital places would be recommended. Transition to the adult services can be a challenge for them. This must be done sensitively and in close liaison with our colleagues in adult psychiatry intellectual disability services.

#### **Children with Autism Spectrum Disorders**

About 70% of children with autism have non verbal IQ's of below 70 and about 50% below 50. (Turk J 2006). Autism and Autism Spectrum Disorder are also associated with high rates of psychiatric co-morbidity, Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Conduct Disorder, Anxiety Disorder, Depressive Disorder (3<sup>rd</sup> Sverd J 2003).

As all of these children also attend the disability services, close liaison with these services is required to ensure a coordinated approach to their management. Many of these children are the most challenging in treatment. In this area in particular the psychiatrist can work effectively in a consultative capacity to other disciplines in the field. Some child psychiatrists take a special interest in the area and liaise with disability services around the assessment and diagnosis of these children where the use of standardised diagnostic techniques such as The Autism Diagnostic Interview schedule is recommended.(Lord M., Rutter M. and Le Couteur A (1994).

## **Children and Adolescents with Forensic Needs**

### **Children in the mild range of intellectual disability**

The majority of these children will access the generic child and adolescent mental health services. However approximately one third of this group will attend the child and adolescent mental health services of intellectual disability. These children have complex needs. It is important that their needs are addressed and appropriate interventions are put in place to meet them.

### **5. The role of the child psychiatrist in intellectual disability**

The role of the Child Psychiatrist in Intellectual Disability has been recently outlined (Royal College of Psychiatrists 2011).

This can be varied, incorporating their skills as clinicians, managers, teachers, expert witnesses, advocates and researchers.

#### **Clinical role**

Consultant child psychiatrists in intellectual disability assume responsibility for taking referrals to the service. They have a primary role in the assessment, diagnosis and treatment of children with psychiatric disorders. They have a responsibility to educate and inform the parents and child about the diagnosis and support them in their treatment choices.

They must be capable of assuming leadership in the multi-disciplinary team and coordinating the interventions recommended. Within the multi-disciplinary team, they have a duty to support other members and offer supervision around case management.

Child Psychiatrists with a special interest in psychiatry of learning disability often work with multiple agencies in relation to a single case. They have an advisory and support role to general practitioners and other specialists in delivering healthcare to patients with intellectual disability. They also have a consultative role to the generic child and adolescent mental health services, regarding children with mild intellectual disability and complex needs.

#### **Responsibility for service delivery and policy**

The consultant child psychiatrists advise managers on the model of service delivery that best meets the patients and family's needs. This model should prioritise a recovery oriented system of care. It must also be inclusive moving away from the previously employed segregated settings. (Philadelphia Department of Behavioural Health and Intellectual Disability Service Recovery Advisory Committee 2006).

Consultant child psychiatrists will also assume managerial responsibilities ensuring that this service is developed appropriately. They will be involved in policy development to promote the health and welfare of children with intellectual disability either at a local or national level. The child psychiatrist has a responsibility to work in partnership with the



Mental Health Commission to raise to the best international standards the quality of mental health services provided in Ireland.

### **Research and Audit**

The development of a quality mental health service informed by an evidence base requires a good information technology system. A national database is required which would help to define the mental health needs of the population and to estimate the prevalence of psychiatric disorders.

Classification systems need to be validated for use in this population. This would facilitate the development of standardised diagnostic tools and questionnaires for the diagnosis of mental health problems in children with intellectual disability. It would also help in the evaluation of treatment outcomes.

### **Training and Education**

Child and adolescent mental health teams for children with intellectual disability under the leadership of a consultant child psychiatrist have a central role in providing education for medical undergraduates, general practitioners and other health care professionals working with children with intellectual disability. Parents, teachers and other care groups should also be able to avail of such education.

### **Responsibilities for training child psychiatrists in psychiatry of learning disability**

The consultant psychiatrist may be approved by the College of Psychiatry of Ireland as educational supervisors for basic specialist training or as trainers for higher specialist training.

A competency based curriculum is required as a foundation to a good specialist training programme. Due to the shortage in child psychiatrists in intellectual disabilities and a lack of an infrastructure for postgraduate training, there is no higher training programme for child psychiatrists who want to train in this area. This is a critical situation with the growing need for child and adolescent consultant psychiatrists in intellectual disability. Without a national training programme it will be impossible to implement the recommendations of A Vision for Change with 13 consultant led teams for the country.

The General Medical Council advised by the postgraduate medical training bodies requires a four year training programme for all mental health specialties before they can receive their Certificate for Higher Specialist Training. They also now require that consultants maintain their competence through a process of life-long learning by enrolling in the Professional Competence Scheme (Medical Practitioners Act 2007).

Eligibility for the division of Psychiatry of Learning Disability currently requires 2 years training in learning disability psychiatry. Members of the Faculty of Learning Disability Psychiatry are currently working with the Faculty of Child Psychiatry to develop a blueprint for dual training in Child Psychiatry and Learning Disability Psychiatry. This will include the detail of how a dual scheme will be operationalized. This can only occur with the development of a comprehensive service for children with a learning disability.

## Appendix 1 Definitions

### Intellectual Disability

The definition of Intellectual Disability used in this paper is synonymous with that of Mental Retardation in the ICD-10 and DSM-IV, Classification of mental and behavioural disorders.

It is a condition of arrested or incomplete development of the mind which is especially characterised by impairment of skills manifested during the developmental period. Adaptive behaviour is always impaired. The degree of cognitive impairment is measured by an IQ test. Individuals are grouped according to their intellectual level.

### Levels of Intellectual Disability

Data received from ICD-10 and DSM-4

	IQ Range	Approximate Mental Age in adulthood
Mild	50- 70	9-12 years
Moderate	33-49	6-9 years
Severe	20-34	3-6 years
Profound	<20	<31months

Individuals that lie within the mild range of intellectual disability have minimal impairments in adaptive functioning. The majority of this group do not require specialist mental health services in Intellectual disability.

### Psychiatric Disorder

The presence of abnormalities of behaviour, emotions or relationships which are developmentally inappropriate and of sufficient severity and duration as to cause persistent suffering or hardship in the child, or distress or disturbance in the family or community (Rutter et al,1970).

### Mental Health Problems

The presence of abnormalities of behaviour, emotions or relationships of sufficient severity to require professional intervention which may not be a psychiatrist.

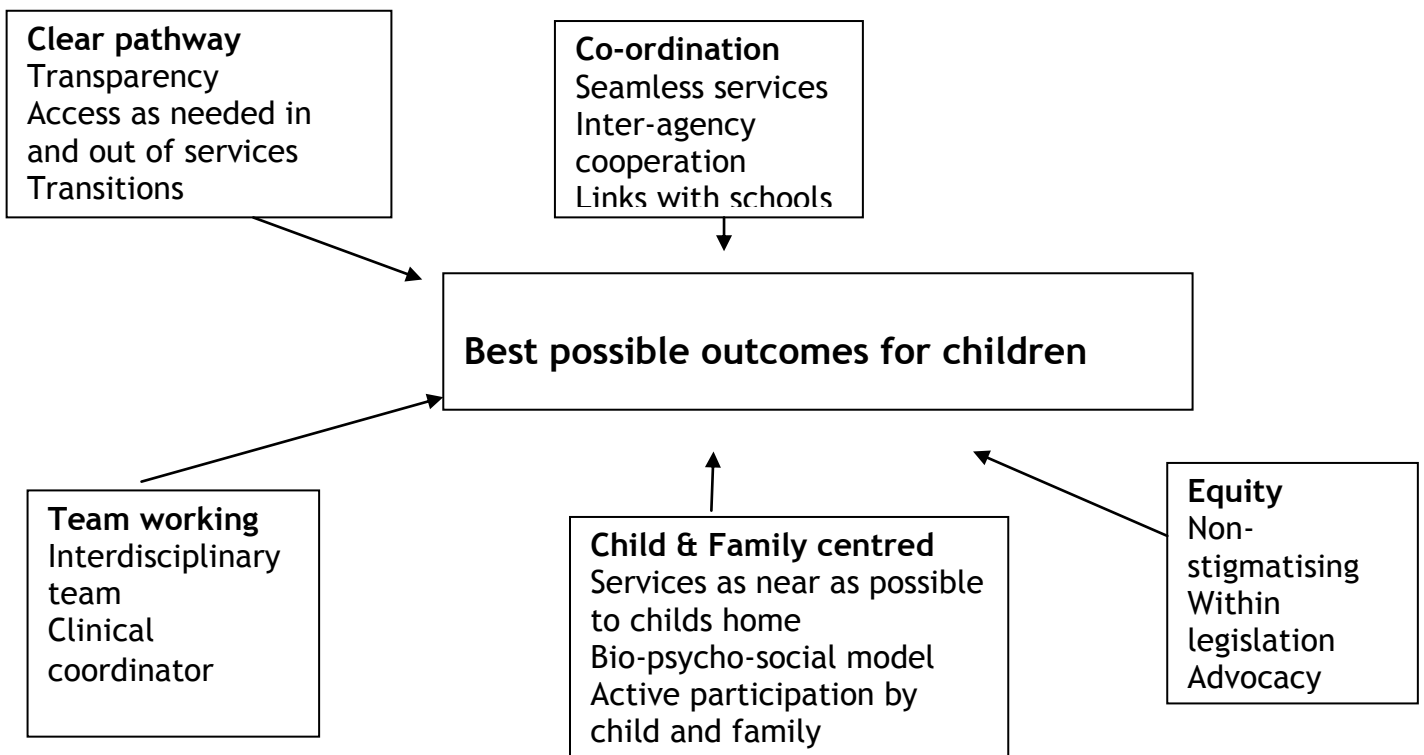
### Behavioural Phenotypes

The behavioural phenotype is a characteristic pattern of motor, cognitive, linguistic and social abnormalities which is consistently associated with a biological disorder. In some cases, the behavioural phenotype may constitute a psychiatric disorder; in others, behaviours which are not usually regarded as symptoms of psychiatric disorders may occur. (Flint and Yule, 1994)

## Appendix 2 Common psychiatric disorders and clinical presentations in children with intellectual disability

- Autism
- Attention deficit Disorders
- Antisocial and Oppositional Defiant Disorder
- Anxiety Disorder
- Behavioural Phenotypes
- Mood disorder
- Pica
- Rumination Disorder
- Stereotypic Movement Disorder
- Self injurious behaviour
- Schizophrenia
- Tic Disorders
- Tourettes Syndrome

Appendix 3 Guiding principles for delivery of services for children



Bio-Psycho-Social Model

The medical model implies that the cause of disability is the impairment that the individual has, and is best managed by helping the individual reduce or make allowances for the impairment. The social model implies that disability is due to the physical and/or social environment and is best managed by altering or making allowances for the environment. Environmental problems arise from social attitudes which require change. The bio-psycho-social model indicates that both impairments and the environment can contribute to disability. Therefore both need to be assessed in the context of the individual and relevant carers to identify what is the best approach to managing the

disability. In a client centred needs led approach to managing disability the bio-psycho-social model is probably the most practical.  
Scottish Society for Rehabilitation

Appendix 4 List of Core Competencies Required for Child Psychiatrists training in Learning Disability

- Knowledge of the cultural, social and family influence on the genesis, maintenance and management of child psychiatric disorders.
- Knowledge of the psychopathology in intellectual disability with an emphasis on children and adolescents.
- Knowledge of the use of the biopsychosocial model in treatment.
- Knowledge of genetic conditions presenting with intellectual disability and associated behavioural phenotypes.
- Recognition of factors leading to disturbed behaviours e.g. abuse and inadequate care.
- Understanding of epilepsy, the behavioural presentations, pharmacological management and associated side effects.
- Ability to communicate effectively with children with intellectual disability and their families and care givers.
- Ability to work effectively as part of a multidisciplinary team.
- Ability to carry out a comprehensive clinical assessment of the child and adolescent with particular emphasis on developmental and medical history.
- Ability to assess and manage children with autistic spectrum disorder and moderate and severe intellectual disability.
- Familiarisation with the current models of classification of mental health disorders.
- Competency in the application of a variety of therapeutic models in treatment including individual, behavioural, group and family therapy.
- Competence in the psychopharmacological management and understanding of the effects of psychotropic medication in children and adolescents with an intellectual disability.
- Understanding of appropriate legal issues pertaining to children and adolescents with intellectual disability.

Knowledge of the Mental Health Act, 2001.  
Knowledge of the Disability Act 2005 and the Assessment of Need Process

- Understanding of Child Protection Policies and Procedures pertaining to children and adolescents with intellectual disability

Knowledge of the Child Care Act 2006

- Ability to write Court reports and give evidence in Court
- Ability to maintain a risk management system including assessment of dangerousness, risk of deliberate self harm, self neglect and abuse. Ability to write clinical management reports.
- Competence in the use of information technology in clinical practice and service organisation.

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