

Psychiatric services for children and adolescents with learning disabilities

Council Report CR123
September 2004

Royal College of Psychiatrists
London

Approved by Council: April 2004
Due for review: 2007

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This is a joint report between the Faculty of Child and Adolescent Psychiatry and the Faculty of the Psychiatry of Learning Disability. It replaces Council Report CR70, published in 1999.

Executive summary

Changing circumstances across the UK, with an emphasis on comprehensive child and adolescent mental health services, have led to this revision of an earlier report. It deals with a service that, falling between child and adolescent psychiatry and learning disability psychiatry, has often been forgotten. The report is intended to complement a variety of recent policy initiatives that have occurred in all of the countries of the UK as well as in Ireland.

The report reviews the resources required for a psychiatric service to young people aged under 18 years and their families. Starting with an overview of the psychiatric needs of this population, the nature of its disorders and the variety of forms of intervention, it describes the characteristics of a model service. It provides a draft standard specification that can inform negotiations between service commissioners and the clinicians and managers of mental health services. While it focuses on the psychiatric element it recognises that such a service must be multidisciplinary and multi-agency and therefore must be seen within the wider range of services supporting mental health. These include education, social services, community child health and other agencies, such as Connexions. The report is written for anyone involved in planning or helping to develop a psychiatric service for this population.

Introduction

This report is intended to inform the negotiations between service commissioners and the clinicians and general managers of psychiatric services that provide for children and adolescents with learning disabilities.

Background

The shift in provision from hospital to community care has changed the pattern of service, with a greater emphasis on the young person remaining in the home, often with a restriction on hospital places to those over the age of 18 years. This has not meant an automatic retention of young people in their community: other institutions have developed, particularly children's homes and residential schools. Some of the latter provide care for up to 52 weeks per year, not always with good access to appropriate health care. At times, because responsibilities have been divided between (for example) the home authority and that of the institution, lack of clarity has led to uncertainty and delay in the provision of mental health services for children in their care. There is a shortage of in-patient places, 40% of which are provided by the private sector (O'Herlihy *et al*, 2001).

The United Nations Convention on the Rights of the Child, ratified by the UK in 1991 and by Ireland in 1992, encouraged the development of services that put 'children first' and were integrated with the mainstream. These concepts were consistent with those inherent in the Irish Constitution and in the Children Act 1989 in the UK: the latter identifying children with disabilities as 'children in need'. Its principles were subsequently embodied in the Disability Discrimination Act 1995 across the UK (amended to include education by various Special Education Needs and Disability Acts in 2001) as well as by the Education Acts in the UK (1996) and Ireland (1998). Although these have encouraged a broad and balanced education, they have also made greater demands on the young person. For example, the introduction of a national curriculum for all pupils in England, although broadly welcomed by special schools, imposed additional demands that potentially limit the time and resources available for individual work. Coupled with increased pressure on resources and greater concern about the legality of certain controls (the right to restrain or detain a child) and treatments (e.g. rectal medication), it has become more difficult for schools to retain certain children. The steady progress towards inclusion appears likely to lead to fewer specialised settings, a reduced tolerance for aberrant behaviour and – where there is a shortfall in the necessary level of support – an increased demand on treatment services. Community services that have been based on special schools will need to extend and change their style to provide for a more diffusely scattered population.

Until now there has been little development of the specialised psychiatric services required for young people with learning disabilities (Fraser & Murti Rao, 1991; Scottish Executive, 2000; Public Health Institute of Scotland, 2003). Falling between the services provided by learning disability psychiatry and mainstream child and adolescent psychiatry, many children have been dealt with by the community paediatrician: a recent national survey found an equal service contribution from each of these three specialties (Lindsey & Flynn, 2003).

This report is intended as a draft standard specification to be used as an outline, adapted for local need, by those responsible for developing these crucial local, specialist psychiatric services for young people with learning disabilities and their families. It comes at a time when there is widespread recognition of the importance of the development of a comprehensive child and adolescent mental health service (CAMHS). In England, it has been recognised as one of the priorities set out for commissioners in their expansion of these services over a 3-year period (Department of Health, 2002); in Scotland, it is to be the subject of a Needs Assessment Report. It complements the reports produced for Ireland (Irish College of Psychiatrists, 2004) and Wales (National Assembly for Wales, 2001).

This needs to be seen within the wider range of services supporting mental health, which include education, social services and other agencies such as the employment support group Connexions as well as Tier 1 services (Committee of Inquiry into Meeting the Mental Health Needs of Young People with Learning Disabilities, 2002). In England, this is reflected in (and can be complicated by) a reorganisation that should eventually result in integrated social and health services (the Care Trust) and child-centred services (the Children's Trust) as well as an increasing emphasis on child protection (Home Office, 2003).

Terminology

Learning disability

The Departments of Health of the UK adopted 'learning disability' as the term to identify the condition of 'mental retardation', the term used in ICD-10 (World Health Organization, 1992) and categorised as F70-F73. In Ireland, the Department of Health suggested the use of the terms 'intellectual disability' for people with a moderate or more severe mental retardation and 'learning difficulty' for people with mild mental retardation (Department of Health, 1990). At about the same time, across the UK, Departments of Education adopted the term 'learning difficulties' (Education Act 1993). The similarity of the terms has led to confusion. The educational category of 'moderate learning difficulties' largely corresponds to the health categories of 'mild' or 'borderline' learning disabilities. This confusion is compounded as job descriptions, service specifications and academic publications use the terms 'learning disabilities' and 'learning difficulties' virtually synonymously. However, it is important to recognise that the need for special educational provision reflects not just the individual's cognitive ability but also

social and emotional competence. Others have introduced the term ‘developmental disability’ to include a wider population who do not necessarily have mental retardation.

In line with the title of the statutory body of the Royal College of Psychiatrists, we have used the term ‘learning disability’ in this report without intending it to have any theoretical or clinical significance. Those using this document may wish to adapt it to their own terminology.

Children and adolescents

In some services, ‘children and adolescents’ are defined by age, a cut-off of 19 years often being used in line with education practice, or of 18 years in line with the UN Convention on the Rights of the Child. Other services for young people use leaving school as a defining factor, an event that may occur as early as age 16 years, although there is the potential for further education. It is important both that the cut-off points between various services are clearly defined and that they should overlap to allow a degree of flexibility in provision. It is essential that there is no gap in provision, particularly where services are not coterminous, and that all referring agencies are aware of the nature of provision and the referral procedures, including those in emergencies. People should have access to those services best able to meet their needs, rather than being subject to an arbitrary allocation based on an ‘exact’ IQ score or the date of their birthday.

Children and adolescents of all ages and levels of disability have very different needs that are best addressed from a developmental perspective. In this report we use the term ‘young people’, while recognising that this includes a wide range of age, nature and degree of disability and, consequently, of psychiatric disorder.

Psychiatric service

The psychiatric service is delivered by a multidisciplinary (and sometimes multi-agency) team dealing with the assessment and management of psychiatric disorder – a term that includes a wide range of disturbance that may arise from mental illness, emotional problems or learned maladaptive behaviour that may be considered to be ‘challenging behaviour’. The boundaries of the service are likely to depend on local agreements rather than any (national) concepts. Although the service would normally include a psychiatrist, the latter might not be involved with many of the children and carers that the service deals with.

The service is only one of a range of other services involved in the promotion of mental health (Committee of Inquiry into Meeting the Mental Health Needs of Young People with Learning Disabilities, 2002) and it is essential that it is well integrated; a pattern that Children’s Trusts are intended to promote.

Aims of services

Prevention

The prevention of learning disability itself is mainly the remit of other clinicians and scientists, including obstetricians, paediatricians and genetic counsellors. Psychiatric services have an important collaborative and supportive part to play in such work. More central to the role of the psychiatrist is the prevention and amelioration of the mental health problems associated with learning disability, and this requires work both with children and with their families, as well as with other professionals involved in their care and education. Much will depend on the extent to which supportive services such as specialised teaching and training (in areas such as communication, relationships and the skills needed to lead a more independent and satisfying life, all of especial significance in young people of diverse backgrounds) are accessible and appropriately funded.

Management

At present, many of the mental health problems of young people with learning disabilities follow a pattern of chronicity or frequent relapse, particularly at times of transition, for example on changing school or service. In many instances this means a long-term involvement of the psychiatric services with the young people and their families, both directly and by liaison with the wider, generic health, education and social services networks, to provide a multi-agency, integrated service. For some, it involves working in collaboration with a variety of residential facilities, including schools, children's homes and specialist units. Such service networks need to be comprehensive, catering for young people of all ages with all degrees and forms of disability.

The method of service delivery will vary from place to place and will depend on local resources and other service initiatives. This report aims to outline the important constituents that need to be available somewhere within the local service network. Service commissioners may need to approach both child psychiatrists and learning disability psychiatrists to ensure such a comprehensive delivery, and there should be clearly defined care pathways. Where a particular service is not available locally, commissioners should identify a clear mechanism by which it can be accessed, for example by contract with a neighbouring trust.

Services need to be both accessible and acceptable to families, who should always be consulted about – and preferably involved in – treatment, which will often depend on their active participation. Some parents will need high levels of personal or material support to participate, and this may not always be available or sufficient. All families need to have their social and cultural backgrounds taken into account, and the service needs to take account of language and culture

as well as the effects of discrimination. These factors will add extra complexity, particularly with the involvement of others, such as interpreters, clerics, community workers and local leaders, and compound issues such as the maintenance of confidentiality.

The care group and its needs

Various research studies and service development projects have estimated that at least one in 1000 of the general population in Great Britain has a learning disability to such a degree that they will need highly specialist health services at some point in their childhood. Within this group, approximately 40% will suffer from significant psychiatric disorder (Hoare *et al*, 1998; Linna *et al*, 1999; Dykens, 2000; Stromme & Diseth, 2000; Emerson, 2003). Putting it another way, in an average health district of 300 000 people, at any one time there will be in the region of 120 young people with learning disabilities who have substantial psychiatric problems. Of these, about 30 children will show some form of challenging behaviour which presents a serious management problem in the absence of special measures to contain it (Kiernan & Qureshi, 1993). This is a minimum figure: various factors will lead both to higher prevalence and, in certain areas, to difficulties in service provision (Richardson *et al*, 1986; Slatter & Black, 1986; Emerson, 2003). Such factors include:

- socio-economic deprivation
- a remote rural population
- a lack of local residential projects
- poor educational provision
- inadequate supportive services.

Common clinical problems

Problems of young people

The full range of psychiatric disorders is seen in young people with learning disabilities. The problems are frequently long-term and the response to treatment idiosyncratic because of the underlying neurological disorder. There are a number of other disabilities and disorders that frequently occur in association with learning disability, including epilepsy, cerebral palsy and sensory impairments, as well as characteristics peculiar to the underlying medical disorder (Dykens, 2000), and the potential impact of these needs to be understood. There is a need for coordinated work with specialised health and educational services, voluntary agencies and local parent groups.

In addition, certain problems of such young people may require more specialised treatment. These include the conditions listed below.

- (a) Autistic spectrum and other pervasive developmental disorders are particularly frequent and pose a special challenge to the services. Given the nature, severity and impact of autism and its related disorders upon young people, their families and carers, it is necessary that specialist

expertise and support be available locally in order to facilitate the early diagnosis, development and integration of these young people. Here the service response should be determined by individual need and the suitability of local provision, rather than being based simply on an arbitrary measure of ability level (Department of Health, 2001*b*; Le Couteur & Baird, 2003).

- (b) Serious mental illnesses (including schizophrenia and affective disorders) do occur in young people with learning disabilities; however, the assessment and diagnostic process can be difficult owing to the complexities in the presentation and interpretation of symptoms caused by impaired communication skills. Application of standard diagnostic criteria can be problematic if the communication system used cannot describe specific experiences and feelings.
- (c) Attention-deficit hyperactivity disorder is a diagnosis that has to be made with regard to the child's developmental level; the response to treatment is likely to differ from that of the normal population.
- (d) Behavioural disorder; this may be associated with epilepsy as well as with anti-epileptic drugs.
- (e) Emotional disorders are often overlooked as they frequently present in conjunction with a behavioural disorder, especially in services that historically have not been funded and staffed to meet such needs.
- (f) Aggressive behaviour frequently is the presenting symptom for disorders of physical health as well as of mental health. There is often doubt about the permissibility of particular forms of treatment, restraint or detention in the management of the physical challenges during assessment and treatment (Lyon, 1995).
- (g) Self-injurious behaviour; as (f).
- (h) Disorders of sleep, eating and elimination are particularly common among young people with learning disabilities, and are often of a type not commonly found in other children (for example, pica).
- (i) Child abuse, including neglect, emotional and sexual abuse – children with learning disabilities are at greater risk than others of certain kinds of abuse (Chamberlain *et al*, 1984).
- (j) Offending and forensic psychiatric problems occur particularly in adolescence, and may also be secondary to any of the above.
- (k) Drug and alcohol misuse problems may coexist with each other and are often wrongly considered merely to be a manifestation of learning disability.

Problems of families

The impact of disability on families is variable but can be great, substantially affecting family function (Dupont, 1986; Quine & Pahl, 1989). Difficulties in coming to terms with the diagnosis and in finding appropriate strategies make the child's

disturbance worse. Insecure attachment patterns may persist from infancy and adversely affect the development of personality. Therefore, complex relationship and adjustment problems are frequent. Failure to take into account differences in cultural attitude to disability will compound problems further.

Diagnosis of learning disability

The need for early diagnosis of learning disability has been emphasised (Department of Health, 2001a; Committee of Inquiry into Meeting the Mental Health Needs of Young People with Learning Disabilities, 2002). The impact of disability is both immediate and long-term. It is such that there should be a link with services from the time the disability is identified, rather than waiting until one or more of the problems listed above develop. Such work is most appropriately done at Tier 1, but there should be ready involvement of higher tiers as occasion demands for an individual and their family.

Meeting health needs

Psychiatric disturbance should be prevented as well as treated (Committee of Inquiry into Meeting the Mental Health Needs of Young People with Learning Disabilities, 2002), and this needs adequate CAMHS services at Tier 1. The full range of conventional psychiatric intervention strategies is required, and must also take account of particular needs such as those of young people from minority ethnic backgrounds. However, in addition, particular expertise is required for the following.

Diagnosis

Assessment should include the child's general level of function and the social context, particularly the family and the school. Diagnosis of the learning disability and its consequences requires close involvement with other services, including developmental and community paediatrics, paediatric neurology, clinical genetics and educational psychology. Speech and language therapy is of importance because delayed language development is a frequent and particular problem, so that assessment requires particular expertise and resources, as well as caution in the interpretation of non-verbal behaviour. This could be a significant challenge where the services and assessments are in languages foreign to the family and child, the norms being those of the majority.

Adjustment counselling

In addition to a range of multi-agency support, usually at Tier 1 level, a family will often require specific counselling. Although initially this will be about the diagnosis and the outlook, further work is likely to be necessary from time to

time, throughout the family's life, as new hurdles expose fresh issues for the family to cope with, particularly at times of transition (Bicknell, 1983). The nature of the disability also means that young people will be particularly vulnerable to adjustment problems as they come to recognise their limitations, particularly in contrast to their peers and siblings. Again, this work has to be closely linked to that of other services and includes both direct clinical work and liaison.

Other family work

Psychiatric work often involves helping families understand their children's behaviour, facilitating the development of parenting skills, enhancing family coping mechanisms and promoting appropriate play, occupation and communication. It requires strong multidisciplinary and multi-agency working relationships to ensure that psychiatric input is coordinated effectively with other ongoing work, notably that by social and educational services.

Specialised individual therapies

Certain forms of psychological therapy are of established use for young people with learning disabilities; these include a variety of behavioural and psychodynamic approaches and other focused forms of treatment. Although the evidence base for mental health work with young people of normal ability can be assumed to be applicable to young people with learning disabilities unless there is specific evidence to the contrary, adaptations will be necessary, for example because of communication and conceptual difficulties.

Pharmacological therapy

In many of the conditions and situations described above (e.g. psychotic illness, affective disorders and the psychiatric sequelae of epilepsy), drug treatments are of particular value. Children and adolescents with learning disabilities may have idiosyncratic responses to their medication because of the complexity of their condition and there may be difficulties in communication between them and others about side-effects. Specialist psychiatric advice is necessary in the prescription and monitoring of psychotropic medication for children with learning disabilities (British Paediatric Association, 1994). Such psychiatric input into the service should be in close collaboration with other clinicians and agencies.

Treatment setting

Although the above therapies may appropriately be carried out in conventional out-patient facilities, much of the work has to address what is happening in the young person's home and school (Department of Health, 2001a), requiring the time and resources to provide this focus on the community. Some young people,

even with good community support, cannot be managed safely or effectively at home. They require a residential or in-patient setting which can provide thorough assessment and effective treatment of acute mental health problems. This type of care is unusual and requires a tertiary service, representing the fourth tier of provision (Williams & Richardson, 1995). Such services, only available at a regional or multidistrict level, are scarce, and guidance is clear that commissioners should ensure that access to them is secured (Department of Health, 2003a).

Liaison and joint working with other agencies

Partnership with other agencies is now seen as absolutely central to all CAMHS work both at commissioning, service development and clinical levels (Department of Health, 2003b). Liaison work should enable the smooth cooperation of the multiprofessional network so that parents are not faced with negotiating a maze of services but have a virtual front door into a comprehensive child and adolescent mental health service (Department of Health, 2003a). Psychiatric work is delivered as part of a multidisciplinary, sometimes multi-agency, team. This can be a complex arrangement where the team has other roles, including, for example, the provision of support at a primary level or a service to adults – there are still very few community learning disability teams dedicated to young people. The psychiatric service, however provided, must be coordinated closely with all of the following components:

- learning disability services and, in particular, health and local authority teams for children and adolescents with learning disabilities – occupational health and speech and language therapy may be part of one of these or attached to one of the other groups
- other child health services, including generic child psychiatry, paediatrics and community child health (e.g. community paediatricians, school doctors and school nurses)
- educational services, including school staff and educational psychologists
- social services – social workers and care workers, as well as the variety of people who organise special aspects such as out-of-home placement
- employment support agencies, such as Connexions
- services involved with offenders, such as youth offending teams and youth justice teams
- voluntary agencies, including groups such as interpreters, religious groups and community workers, where these are relevant.

It is essential that resources are available for consultation with professionals in other services, facilitating the access of these young people and their families to the generic services. The aim should be for the service to be accessible and useful to all cultural, social and racial groups. Close links may be encouraged by different structures including split posts, allowing one person to bridge two agencies or specialties.

Academic work

Teaching

Staff in the various professional groups involved in the care of young people with learning disabilities and mental health problems require access to appropriate education programmes. Mental health workers (including psychiatrists, clinical psychologists, nurses and other specialist therapists) have a particular role here in order to enhance mutual understanding and ease of cross-referral, and to indicate directions for future research. This remit includes both undergraduate and postgraduate education (Hollins & Bradley, 1987).

Research and audit

Many of the issues concerning the cause, nature and outcome of psychiatric problems in young people with learning disabilities are, as yet, poorly understood. There is a lack of evidence concerning the effectiveness of various treatment strategies in these young people, and little guidance as to which treatment should be used with which child. This needs to be addressed urgently through research and audit and requires an academic infrastructure to be put in place.

Continuing professional development

The service requires consultants with the necessary competencies in a field that bridges both child psychiatry and learning disability psychiatry. Whether or not they have dual accreditation in these two specialties, it is important that the post allows them to continue to acquire the skills, knowledge and experience essential to clinical effectiveness. Opportunities for joint working with other disciplines and agencies are a key element.

Service development and planning

For the most part, the services required to fulfil the mental health needs of young people with learning disabilities are at an early stage in development – an inevitable consequence of the recent changes in health services and in the statutory educational and social services provision for these young people. It follows that the multidisciplinary teams fulfilling this role must be closely involved in service development programmes, both in the National Health Service and in the other key statutory agencies. As with these teams' other activities, this requires sufficient time and resources.

Characteristics of a model service

Throughout this section it should be noted that the mix of constituents that form a service will vary because of a variety of local factors.

Contracting for service

Commissioners should, through the contracting process, identify the expertise available in provider units in the locality, so that the responsibility for service delivery is appropriately assigned.

Within each district, at least one properly trained psychiatrist should be identified to provide an adequate service to young people with learning disabilities. The service should overlap with psychiatric services for adults, with and without learning disabilities, and those for other young people; there should be no gaps.

Location

Both local district-based services and the larger regional or teaching services may well contribute to such work. The service can be conceived as a series of tiers, using the classification designated by the Health Advisory Service (Williams & Richardson, 1995). In this model, Tiers 1, 2 and 3 would be provided locally, as an integral part of the district's overall services, with contractual access to supra-district Tier 4 services. Although outreach teams and day services might bridge Tiers 3 and 4, access to some in-patient beds is essential. Although psychiatric staff might not be involved at Tier 1, the service needs to be available at all levels.

Personnel

The work requires full, multidisciplinary mental health teamwork and therefore requires psychiatrists, psychologists, nurses, other specialist therapists (e.g. occupational therapists; music, art or play therapists; speech therapists and physiotherapists), adequate secretarial support, and other managerial and back-up staff. Where there is a high density of a particular ethnic minority group the team might include bilingual workers or link workers, or have creative links with local voluntary agencies. All staff should have appropriate training and experience in working with young people whose mental health problems are complicated by learning disabilities (Mental Health Foundation Committee, 1997).

For psychiatry, the College suggests that a service to young people with severe learning disabilities requires a minimum of two sessions of adequately trained

consultant time per 100 000 population. The inclusion of young people with mild learning disabilities requires a further three sessions. This level reflects the demands of the high prevalence of pathological disorders, the community orientation of the work and the substantial amount of time spent in multidisciplinary and multi-agency liaison.

Material resources

The work of the service takes place in a variety of settings. The base premises should include clinic and meeting rooms, and will require appropriate back-up resources including record-keeping, teaching and audiovisual resources. Suitable information technology will be needed for these as well as for the various academic and managerial tasks detailed above.

Frequently, disabilities are multiple and so the accommodation should be appropriate, including, for example, wheelchair access.

Diagnostic facilities

Access is required to genetic investigations, brain imaging, electroencephalography and psychometry, in addition to all routine modern laboratory and investigative facilities.

Community and outreach services

Services should be delivered in the community (Lindsey, 1998). Provision should be sufficient to allow the various out-patient and community activities to proceed along the lines indicated above, including therapy rooms with appropriate audiovisual back-up, etc. Services should have the resources to deliver care or make observations in the young person's home or school where this is appropriate. This should be reflected in the budgeted levels of activity. The development of Tier 3 specialist teams should be encouraged in addition to Tier 2 services (Williams & Richardson, 1995).

Services should reflect the cultural, racial and religious diversity of society, and take account of the different patterns of family life (Mental Health Foundation Committee, 1997).

In-patient facilities

Most of the residential work done by such a service will be in collaboration with existing services: foster homes, children's homes, residential schools and general child and adolescent in-patient services. However, in addition, access is required to specialist in-patient facilities comparable to those available to young people without disabilities (O'Herlihy *et al*, 2001). These will allow the assessment and diagnosis, as well as both short-term and medium-term treatment, of complex,

difficult cases in a setting that provides developmentally appropriate care. The number of beds required will vary depending upon the practice and the resources of the local education authorities, social services, existing health service residential facilities and the availability and use of private establishments (Berney, 2000). For a total population of 1 million, the need is thought to be about 3–4 beds for young people with severe learning disabilities, 2–3 beds for those with mild learning disabilities and 1 bed for those who require low secure provision – the last to include separate provision for those who require security because of the intensity of their disturbance and those who are offenders. There is a separate and national need for medium secure beds.

Services need to ensure that there is access to provision for the full range of young people and their needs. They should provide for both mild and more severe degrees of disability; children and adolescents; emergency as well as planned admissions; formal detention under the Mental Health Act as well as 'routine', informal admissions; and placements for offenders. Thought needs to be given to the provision for the latter, as well as for those with autistic spectrum disorders; people with violent behaviour and/or severe learning disabilities will require higher staffing ratios than those in most other psychiatric adolescent units, as well as a physical environment that meets their particular needs.

In-patient resources complement (rather than replace) the community approach for young people. Outreach work by a team based in the in-patient unit can shorten or even eliminate admission. The need for this as well as for out-patient work must be recognised and budgeted for as a part of any admission. Commissioners should ensure that the beds they commission meet their need, with clear operational policies for the process. These should include clear protocols and criteria for admission with provision for a thorough community assessment. If the disruption and duration of admission is to be minimised, there has to be close liaison between the in-patient service and the local team. Commissioners should expect good links with community services and a clear, integrated pathway of care that includes a plan for discharge.

References

- Berney, T. P. (2000) Psychiatric services. In *Developmental Disability and Behaviour* (eds C. Gillberg & G. O'Brien), pp. 159–170. Cambridge: McKeith Press/Cambridge University Press.
- Bicknell, J. (1983) The psychopathology of handicap. *British Journal of Medical Psychology*, **56**, 167–178.
- British Paediatric Association (1994) *Services for Children and Adolescents with Learning Disability (Mental Handicap)*. London: British Paediatric Association.
- Chamberlain, A., Rauh, J., Passer, A., *et al* (1984) Issues in fertility control for mentally retarded female adolescents: I. Sexual activity, sexual abuse, and contraception. *Pediatrics*, **73**, 445–450.
- Committee of Inquiry into Meeting the Mental Health Needs of Young People with Learning Disabilities (2002) *Count Us In*. London: Foundation for People with Learning Disabilities/Mental Health Foundation.
- Department of Health (1990) *Needs and Abilities – A Policy for the Intellectually Disabled. Report of a Review Group on Mentally Handicap Services*. Dublin: Government of Ireland.
- Department of Health (2001a) *Valuing People: A New Strategy for Learning Disability for the 21st Century – Towards Person Centred Planning Approaches*. London: Stationery Office.
- Department of Health (2001b) *Valuing People: A New Strategy for Learning Disability for the 21st Century: Implementation Guidance*. London: Stationery Office.
- Department of Health (2002) *The NHS Plan. Improvement, Expansion and Reform: The Next 3 years. The Priorities and Planning Framework 2003–2006*. London: Department of Health.
- Department of Health (2003a) *Child and Adolescent Mental Health Service (CAMHS) Grant Guidance 2003/2004*. London: Department of Health.
- Department of Health (2003b) *Getting the Right Start: National Service Framework for Children. Emerging Findings*. London: Department of Health.
- Dupont, A. (1986) Socio-psychiatric aspects of the young severely mentally retarded and the family. *British Journal of Psychiatry*, **148**, 227–234.
- Dykens, E. M. (2000) Psychopathology in children with intellectual disability. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, **41**, 407–417.
- Emerson, E. (2003) Prevalence of psychiatric disorders in children and adolescents with and without intellectual disability. *Journal of Intellectual Disability Research*, **47**, 51–58.
- Fraser, W. I. & Murti Rao, J. (1991) Recent studies of mentally handicapped young people's behaviour. *Journal of Child Psychology and Psychiatry*, **32**, 79–108.
- Hoare, P., Harris, M., Jackson, P., *et al* (1998) A community survey of children with severe intellectual disability and their families: psychological adjustment, carer distress and the effect of respite care. *Journal of Intellectual Disability Research*, **42**, 218–227.
- Hollins, S. & Bradley, E. (1987) Mental handicap in context: medical undergraduate education. *Bulletin of the Royal College of Psychiatrists*, **11**, 389–391.
- Home Office (2003) *The Victoria Climbié Inquiry: Report of an Inquiry by Lord Laming*. London: Stationery Office.
- Irish College of Psychiatrists (2004) *Position Statement on Psychiatric Services for Children and Adolescents*. Dublin: Irish College of Psychiatrists.
- Kiernan, C. & Qureshi, H. (1993) Challenging behaviour. In *Research to Practice? Implications of Research on the Challenging Behaviour of People with Learning Disabilities* (ed. C. Kiernan), pp. 53–85. Birmingham: British Institute of Learning Disabilities.
- Le Couteur, A. & Baird, G. (2003) *National Autism Plan for Children*. London: National Autistic Society.

- Lindsey, M. (1998) *Signposts for Success in Commissioning and Providing Health Services for People with Learning Disabilities*. London: Department of Health.
- Lindsey, M. & Flynn, A. (2003) A survey of consultants in the psychiatry of learning disability. *Psychiatric Bulletin*, **27**, 342–345.
- Linna, S.-L., Moilanen, I., Ebeling, H., *et al* (1999) Psychiatric symptoms in children with intellectual disability. *European Child and Adolescent Psychiatry*, **8**, 77–82.
- Lyon, C. (1995) *Legal Issues Arising from the Care, Control and Safety of Children with Learning Disabilities Who Also Present Severe Challenging Behaviour*. London: Mental Health Foundation.
- Mental Health Foundation Committee (1997) *Don't Forget Us: Children with Learning Disabilities and Severe Challenging Behaviour*. London: Mental Health Foundation.
- National Assembly for Wales (2001) *Everybody's Business: Child and Adolescent Mental Health Services (CAMHS)*. Cardiff: National Assembly for Wales.
- O'Herlihy, A., Worrall, A., Banerjee, S., *et al* (2001) *National In-Patient Child and Adolescent Psychiatry Study (NICAPS)*. London: Royal College of Psychiatrists' Research Unit.
- Public Health Institute of Scotland (2003) *Needs Assessment Report on Child and Adolescent Mental Health: Final Report*. Glasgow: Public Health Institute of Scotland.
- Quine, L. & Pahl, J. (1989) *Stress and Coping in Families Caring for a Child with Severe Mental Handicap: A Longitudinal Study*. Canterbury: University of Kent.
- Richardson, S. A., Koller, H. & Katz, H. (1986) A longitudinal study of numbers of males and females in mental retardation services by ages, IQ and placement. *Journal of Mental Deficiency Research*, **30**, 291–300.
- Scottish Executive (2000) *The Same as You? A Review of Services for People with Learning Disabilities*. Edinburgh: Scottish Executive.
- Slatter, M. A. & Black, P. B. (1986) Urban–rural differences in the delivery of community services: Wisconsin as a case in point. *Mental Retardation*, **24**, 153–161.
- Stromme, P. & Diseth, T. H. (2000) Prevalence of psychiatric diagnoses in children with mental retardation: data from a population-based study. *Developmental Medicine and Child Neurology*, **42**, 266–270.
- Williams, R. & Richardson, G. (1995) *Together We Stand: The Commissioning Role and Management of Child and Adolescent Mental Health Services*. London: HMSO.
- World Health Organization (1992) *The ICD–10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines*. Geneva: WHO.