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Reasoning tests than clinicians. Shows that clinical ethicists score higher in moral reasoning tests than clinicians. Furthermore, evidence shows that clinical ethicists score higher in moral reasoning tests than clinicians. Clinical ethicists could also contribute to the continuing education of healthcare staff in medical ethics through lecturing and private consultations. From my own experience in Canada, doctors expressed a greater understanding of the ethical requirements of informed consent and do not resuscitate orders after attending lectures on these topics. Ethicists could teach ethics to students and doctors at the bedside, exploring the links between technical skill and ethical decision making. The hands-on involvement of clinical ethicists in teaching is likely to reduce the occurrence or recurrence of ethical violations by highlighting key ethical issues and drawing lessons from previous cases.

The idea of using clinical ethicists gives cause for some concern. Doctors may offload their ethical problems on clinical ethicists, abnegating their moral responsibilities too easily. This could be avoided through an awareness of this danger. Some sceptics may frown at the suggestion of creating yet another expert, but ethical cases, like medicine itself, are complex and reduce life chances of employment and independent living. The learning disabilities. Learning disabilities are life long and reduce life chances of employment and independent living.

Psychiatric disorders are two to four times as common in children with learning disabilities, with 30-50% having a mental disorder. Children with milder degrees of learning disabilities are likely to be educated in mainstream schools and are often physically well. Children with more severe learning disabilities may attend special schools and frequently have associated medical disorders and sensory impairments, as either a cause or a correlate of the learning disabilities. Learning disabilities are life long and reduce life chances of employment and independent living.

While all psychiatric disorders are over-represented in children with learning disabilities, autism and hyperkinetic disorder are particularly increased. The relation between autism and low intelligence quotient has long been

Children with psychiatric disorders and learning disabilities

Their needs extend beyond the provisions in national service framework

G lobal learning disabilities, or mental retardation as it is still referred to in the International Classification of Diseases, occur in at least 3% of the population. Classification systems vary in terminology, but most distinguish on the basis of the severity of the learning disability. In the United Kingdom, children with milder degrees of learning disabilities are likely to be educated in mainstream schools and are often physically well. Children with more severe learning disabilities may attend special schools and frequently have associated medical disorders and sensory impairments, as either a cause or a correlate of the learning disabilities. Learning disabilities are life long and reduce life chances of employment and independent living.

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References


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Daniel K Sokol doctoral candidate in medical ethics

Medical Ethics Unit, Department of Primary Health Care and General Practice, Imperial College, London W6 8RP (daniel.sokol@imperial.ac.uk)
recognised, but the eightfold increase in hyperkinetic disorder has largely gone unnoticed. In general, psychiatric disorders are also less likely to be detected in children with learning disabilities than in the general population.

Diagnostic overshadowing, or the misattribution of psychiatric symptomatology to a manifestation of learning disabilities, is a well recognised phenomenon and can occur even with experienced mental health workers. Children are reliant on parents and other responsible adults for referral for possible psychiatric disorder; it may be more difficult for carers to detect symptoms in children who have reduced verbal communication. A similar challenge is posed for professionals where traditional psychiatric differential diagnosis relies on the patient’s ability to report subjective thoughts and experiences. Considerable dispute exists about the use of behavioural equivalents as an alternative to direct access through language in applying diagnostic categories. Whether or not behavioural equivalents are incorporated in assessments, specialist skills are required to diagnose psychiatric disorder in people with more severe learning disabilities. The treatment of psychiatric disorders in children with learning disabilities may also be more successful when conducted by professionals with specialist skills.

The psychiatry of learning disability has always been a neglected specialty, and the neglect is especially true in child psychiatry. An unspoken view exists that the psychiatric treatment of children with learning disabilities is less worth while because the effects of long term intellectual disability compromise recovery. However, we have no evidence that children with learning disabilities differ from children with average ability in the improvement in the quality of life they experience by alleviation of psychiatric disorder. The development of equal, although differentiated, mental health services for children with learning disabilities should be a priority for the NHS. This aim has been incorporated in the national service framework for children, where standard 9 embraces the mental health needs of children and young people with disability, along with other groups. In addition, standard 8 focuses on the need for high quality services for children with disability, and standard 1 highlights the importance of health promotion and early intervention.

The identification and successful treatment of psychiatric disorders in children with learning disabilities will require several developments not identified in the national service framework. Firstly, the awareness needs to increase of the possibility of psychiatric symptomatology to a manifestation of learning disabilities. The treatment of psychiatric disorders in children with learning disabilities may also be more successful when conducted by professionals with specialist skills.

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