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Commentary

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Spurious childhood psychosis is very rare, but there are important lessons to be learnt from this case history in relation to diagnosis and care.

The authors point out that the differential diagnoses considered for Adam when he presented at the age of seven years were atypical autism, childhood schizophrenia and severe depressive disorder (as defined in ICD–10) in view of his extreme withdrawal, flattened affect and ritualistic behaviours. The impact of neglect, abuse, living with a mother who suffered from paranoia, the vulnerability of his age, associated learning disability (of which there was some evidence) and social isolation were not considered in relation to his observed behaviour.

Understanding context in relation to observed behaviour is an established part of assessment. An *aide memoire* for clinicians to consider context when making a diagnosis of a child's disorder exists in the form of the multi-axial approach for classification of child psychiatric disorder, which was developed to cater for aetiological factors, form of disorder, and existence of comorbidity (Box 1) (World Health Organization, 1995). Using this scheme Adam, on the basis of known previous history, would have a diagnosis on axis 3 of learning disability (history of developmental delay and assessed as needing special school as a five-year-old) and axis 5 psychosocial situation. Axis 5 would have yielded care by a single parent, care by a mentally disordered parent, social isolation, experiential privation and neglect.

Box 1. The five axes

Axis 1 – clinical psychiatric syndrome
Axis 2 – specific developmental delay/disorder
Axis 3 – intellectual level
Axis 4 – serious physical/medical illness or disability
Axis 5 – psychosocial situation

The dilemma for the clinician is, however, that appreciating context must not ignore possible psychopathology in the child. It is not uncommon that a child with significant concentration difficulties due to attention deficit disorder may have this aspect of difficulty missed if there are important psychosocial factors within the family situation.

In Adam's case, the authors feel that admission to an in-patient facility would have impeded the diagnosis. Certainly in this case the foster care placement was fortuitous and cost-effective. However, admission to a children's in-patient facility, with the development of a relationship with a keyworker, may have eventually produced a similar result. It would be reasonable to adopt the principle that admission for diagnostic purposes should only occur in very complex cases where the behaviour of the child is impossible to contain as an out-patient, not as a substitute for care within the community.

When looking at care issues there are a number of instances where agencies failed Adam and his mother. There is still confusion and ambivalence among professionals about the rights of a parent, who may have their parenting affected by mental disorder, and the needs and rights of their children for appropriate levels of care. In this case the mother's history of serious psychiatric disorder predated his birth and should have been a risk factor which indicated monitoring by primary care services, certainly from the time of his birth, with alarm bells being raised if she refused or avoided such contact. He presumably did not appear for his two- to three-year developmental assessment. The first instance of outright failure of child-focused agencies came when at the age of five years he presented for school obviously with significant developmental delay due in part to inappropriate care, demonstrated by the relative rapidity with which he became toilet-trained. At the same time it is clear that his need for education was a motivation for his mother. He was presumably assessed and for his special educational needs, and this assessment should have looked at aetiological factors relating to delay. The Children Act 1989 imposes

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clear responsibilities to social service departments in Section 17(1) for children in need, as he was a child whose health and developmental needs were likely to be significantly impaired without provision of resources by the local authority. There should have been serious debate by professionals in health, education and social services as to what additional resources were required and whether remedial help in a mainstream setting would adequately meet his needs. Certainly the Code of Practice (Department of Education, 1994) makes it clear that provision must be adequate for special need. If it was felt that this remedial help would not do so, intervention should have led to a child protection conference on the basis, at the very least, of neglect. Action at this time may have prevented the subsequent sequence of events.

Adam's situation highlights the need for liaison locally between social services, education, adult psychiatric, child mental health and maternal and child health services at the very least, as well as the need for training inputs for social workers, most of whom have a generic background on issues relating to mental disorder, risk and indicators for intervention. Development of effective links is encouraged by excellent guidance documentation on service provision such as the Health Advisory Service (1995) publication *A Thematic Review of Child and Adolescent Mental Health Services*. However, it is unfortunate that in the current climate this is hampered by cuts in resources.

Reference

Department of Education (1994) *Code of Practice on the Identification and Assessment of Special Educational Needs*. London: Department of Education.

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