

Reflections of a paediatric fellow on child neurodevelopmental psychiatry

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As a general paediatrician, child psychiatry always intrigued me. The myth that it is a distinct subspecialty from paediatrics was disrupted after I had the opportunity to work in the Neurodevelopmental Team of the Department of Psychological Medicine at the Children's Hospital at Westmead, towards the end of my training. It was a period of revelations and learning in personal and professional development that I want to share with others. I realised that principals of general paediatrics and child psychiatry work intricately together and in many ways complement each other. I was exposed to concepts and experiences which made a permanent imprint and will always influence my professional practice. A number of key experiences stand out.

The central concept is recognising and supporting the development of the mind in childhood, evidenced by the development of theory of mind and the ability to modulate emotions according to developmental age and stage. This is the context for supports and interventions for children and adolescents with neurodevelopmental disabilities. With the development of theory of mind, children learn to match their arousal levels,

emotions and thoughts with their primary caregiver and other adults. These are the foundations of developing social skills and indeed reciprocity in emotions, thought, relationships and flexible creativity with others, particularly peers. In children with autism spectrum disorder or intellectual disability, the delayed development of theory of mind and social reciprocity leads to delay in the emotional regulation and skill, and relationship building (Baron-Cohen, 1991).

One of the most critical parents skills is to teach children non-violent ways of engagement (Szalavitz & Perry, 2010). Empowering parents and counselling against coercive parenting styles (Patterson, 1982) goes a long way in keeping everyone involved safe and is also a cost effective way of managing aggression in the disabled child. Giving way to aggression reinforces such maladaptive behaviours. Calm persistence of intervention is a key measure of caring. It is helpful to encourage parent participation in training programs as early as possible before a child's behaviour patterns and perception of self has developed a sense of permanency which will then require more intensive, pro-



longed interventions (Eldevik et al, 2009; Centre for Reviews, 2015). Safety and behaviour support interventions for children with intellectual disability and aggression is a crucial long term investment which cannot be underestimated. Medications can facilitate but at no point replace them as aggression is not a psychiatric disorder in itself. Parents still carry the basic responsibility of teaching the child emotional and behavioural regulation and need to learn for themselves the strategies to be able to do that.

The evidence-based behavioural interventions supported by professionals reduce the aggression and also allow other development-enhancing therapeutic interventions including emotional and behavioural social skill training to be effective. It also prevents establishment of long term negative/maladaptive patterns of affect and behaviour later such as disruptive behaviour, depression and anxiety and personality (Whatson L, Corfield D, Owens B, 2011). That children with neurodevelopmental disorders need skilled developmentally sensitive parenting is part of ensuring the wellbeing of all family members but also fosters their positive interaction with the intellectually disabled child. Effective regulation of the emotions and behaviours is arguably the most important ingredient for a better quality of life and facilitates overall educational and social development (Ali et al, 2015). Teaching aggressive children with disability to develop skills to settle themselves with self-soothing strategies such as using sensory toys and a low stimulating environment (including limiting screen time) can necessitate access to a 'calm or sensory room' which can provide a place of safety (Sutton, 2011). I have seen how these approaches reduce the need, often for frequent emergency services, call outs and requests for hospitalisation and enable a greater chance of these children being accepted in society. It is tragic witnessing a family's desperation when the size of their disabled child means they no longer have control or safety to teach them further, relinquishing their care to the state and access to group homes (Dossetor, 2016). A universal approach to enabling such optimal early development through parenting skills may arguably be the most important approach to preventing adult mental illness, which means it needs to be something that paediatrics and primary care take responsibility for.

I was also impressed with the impact of the Developmental Psychiatry Interagency Tertiary Clinic and Partnership (colloquially called the DPC) which is a novel collaborative approach which brings together specialised skills of paediatrics, child psychiatry, disability, education to support young intellectually disabled children with emotional dysregulation and behavioural issues. This model of assessment and intervention de-

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depends on the collaboration of interagency expertise and interdisciplinary approaches with medical and allied health staff, specialised in intellectual disability enabling multifaceted interventions to achieve better outcomes. It is not only a model of excellence using subspecialty skills but I feel sure it is a highly cost effective alternative strategy for dealing with complex patients and supporting the families who are at the end of their tether (Bernard, S. 1999).

Preventive approaches in mental health especially in children with neurodevelopmental disorders are still at a nascent stage. After 20 years research, there is now enough evidence to suggest that preventive strategies for heart diseases, hypertension, diabetes and infectious diseases have established cost effective ways of reducing morbidity and mortality. Despite significant impact of mental health problems in children and adolescents and in turn adults, the prevention of mental health has not received the attention that its growing impact demands because scientific and medical research and funding in this area has been limited as it

lacks status compared with other medical specialities. The lack of priority and initiative has contributed to a paucity of effort to develop better models of preventive mental health. However, neurodevelopmental disorders may be at the core of the problem with the increased risk of associated other psychiatric co morbidities and conversely major mental illness have been reconceptualised as neurodevelopmental disorders. Early detection and intervention for these is as important as any other medical problem (Durlak, J. A., & Wells, A. M. 1997) and intervention studies are showing high levels of cost effectiveness (Dossetor, 2013). It calls for increased education and awareness regarding disorders of the development of the brain and mind. I feel that the key to this is understanding the neurodevelopmental processes and skills in developing capacities of human reciprocity.

Early and middle childhood is the most important time and stage of the development of the brain and the mind, and where building resilience and hopefulness is possible. As they say ‘our children are our future’. The political and community interest in preventive mental health is reaching a critical time. I feel the prevention of mental disorders and the promotion of emotional wellbeing and resilience may be the most important area of epidemiology for the future of mankind. The clinical and research partnership between paediatrics and mental health is a critical building block and the time to act is now. Problems of neurodevelopment may have been the Cinderella of health and mental health, but I suspect that helping these children provides the key to unlocking our understanding of developmental processes of the brain and mind more broadly.

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