

PROJECT EVIDENCE

PROJECT EVIDENCE for Treatment of Mental Disorders. The project coordinator is Dr Allan Mawdsley. The version can be amended by consent. If you wish to contribute to the project, please email admin@mhyfvic.org

[6] Standard Treatment

- a) Outpatient psychotherapies, medication and procedures
- b) Inpatient psychotherapies, medication and procedures
- c) Ancillary support services

[6 a] Outpatient psychotherapies, medication and procedures

Specialist mental health services should offer a range of therapeutic programs for disabling mental health problems in the community. Service provision, clinical research and training are closely linked in the Tier Three facilities but the practice guidelines published by those services should be implemented at all levels of their service delivery facilities.

These are grouped under nine headings: (i) organic brain disorders, (ii) substance abuse disorders, (iii) psychotic disorders, (iv) mood disorders, (v) anxiety disorders, including stress-related, somatoform and obsessive-compulsive disorders, (vi) physiological disorders, including eating, sleeping and sexual, (vii) personality disorders, (viii) intellectual disability and developmental disorders including autism spectrum disorders, (ix) behavioural and relationship disorders of childhood.

All disorders in childhood require wholistic management involving caregivers. See PE4 for a general outline of case identification and assessment and PE2a(i) for infant mental health. See PE6a(ix) for a general outline of case management for young people.

PE6a (viii) Developmental Disorders and Intellectual Disability

Every Human Being is unique but will share many characteristics with other humans. Our diverse range of abilities differs amongst individuals and attempts are made to describe and measure the differences. The descriptions generally consider our abilities in the domains of cognitive, language, motor, and social abilities, notwithstanding that there is considerable overlap across domains.

Observations of development in populations reveal normative patterns and examples outside the typical patterns. Attempts are made to measure the degrees of abilities by construction of normative tests, which are generally useful although always merely approximations of the actual abilities. High levels of abilities are generally valued whereas low levels are generally called disabilities. Scientific studies of the biological, psychological and social factors underpinning development attempt to define the reasons for disabilities (the etiology). This can open the way to prevent or ameliorate disabilities. Scientific study not only attempts to find the etiological disorder and define the degree of disability or impairment but also to avoid social factors that make the disability a handicap in daily life.

When a child's developmental progress is suspected of being outside the normal range, a careful clinical assessment should be undertaken. This is described in PE4 (Case identification). The generic assessment approach is modified by the addition of specific elements as the nature of the underlying disorder is clarified. It is not the purpose of this paper to separately consider each of the vast number of different disabilities, but in outlining some general principles will use two commonly encountered examples as a platform for approach. These are 1) Intellectual Disability as an example of global impairment, and 2) autism spectrum disorder as an example of a more focal impairment.

INTELLECTUAL DISABILITY

The term 'intellectual disability' (ID) is defined as "a condition of arrested or incomplete development of the mind, which is especially characterized by impairment of skills manifested during the developmental period, which contribute to the overall level of intelligence, i.e., cognitive, language, motor, and social abilities." (World Health Organization, WHO, 1992).

The etiology of ID is heterogeneous. Injury, infections and toxins have become less prevalent causes because of improved antenatal care, while genetic factors have become more prominent. No specific etiology can be found in up to 40% of cases, particularly in mild ID. Environmental influences (e.g., malnutrition, emotional and social deprivation experienced, for example, in poorly run orphanages) can also cause or aggravate ID.

Currently the test results are standardised against a representative sample of the population; IQ scores for children are relative to children of the same age. The median result is defined to be 100 and one standard deviation is 15 points, therefore, 95% of the population have scores within two standard deviations of the mean (i.e., within an IQ range of 70 to 130). For IQ to be accurate it needs to be standardised against a population culturally similar to that of the person being tested.

Although IQ can change to some extent with increasing age, it is a surprisingly robust construct that is strongly predictive of achievement. IQ has a large inherited component, but environmental factors have a strong effect as well.

IQ measurement is mandatory in all cases in which ID is suspected. IQ should be measured using, if at all possible, widely accepted tests that have been standardized for the specific – or culturally similar – population. Widely used tests include the *Wechsler Intelligence Scale for Children* and the *Stanford-Binet Intelligence Scales*.

It is also useful to evaluate adaptive behaviour. To do that, professionals compare the functional abilities of a child to other children of similar age and education. There are many adaptive behaviour scales available, such as *Vineland Adaptive Behavior Scales* and *Adaptive Behavior Assessment System-II*, but an accurate assessment of children's adaptive behaviour requires clinical judgment as well.

IQ scores more than two standard deviations below the mean, accompanied by adaptive impairments, are designated as intellectually disabled. Degrees of ID are designated Mild, Moderate, Severe or Profound when scores are three, four, five or more standard deviations below the mean. The following table gives a general indication of adaptive functioning at the different levels.

Degree	IQ-range	Adult-attainment
Mild	50-70	<ul style="list-style-type: none"> • → Literacy +¶ • → Self-help skills ++¶ • → Good speech ++¶ • → Semi-skilled work +□
Moderate	35-50¶	<ul style="list-style-type: none"> • → Literacy +/-¶ • → Self-help skills +¶ • → Domestic speech +¶ • → Unskilled work with or without supervision +□
Severe	20-35	<ul style="list-style-type: none"> • → Assisted self-help skills +¶ • → Minimum speech +¶ • → Assisted household chores +□
Profound	Less than 20¶	<ul style="list-style-type: none"> • → Speech +/-¶ • → Self-help skills +/-□

Note: · +/- sometimes attainable; + attainable; ++ definitely attainable □

Management

In all cases of ID, the crux of treatment is early detection and early intervention. As no specific etiology can be found in up to 40% of cases and many known causes cannot be cured, in the majority of cases, the aim of treatment is not a "cure" but to minimize symptoms and disability through reducing risk (e.g., helping individuals to be safe at home or school), teaching life skills, improve life quality and support families and carers. Detailed goals and modalities of treatment for each individual will largely depend on the cause and severity of ID and comorbid conditions.

Challenging behaviours is a term used to describe comportment that interferes with the daily life of individuals with ID and their carers, reduce their quality of life and survival. These represent a wide range of problems that includes, among others, aggression, self-injury (such as head banging or ingestion or inhalation of foreign bodies), destroying objects, non-compliance, idiosyncratic habits (e.g., restricted range of foods), and socially inappropriate behaviour. These problems frequently result in carers seeking medical help and can easily overwhelm families' ability to cope with and care for these young people, often resulting in rejection or, in more severe cases, institutionalization.

As in non-ID individuals, challenging behaviours serve a function and they are maintained or reinforced if the person with ID is successful in altering their internal or external environment through their behaviour – such as by gaining attention, avoiding duties or demands, achieving access to preferred activities or objects or control over their own life, sensory feedback (eg. hand flapping, eye poking), and reduction of arousal and anxiety.

The current trend is to educate children with ID as far as possible in normal rather than special schools (inclusive education). This especially applies to those with milder forms of ID. However, there is limited evidence to compare the school experience of children with mild to moderate ID in

mainstream and segregated education. Another approach is to conduct special classes for children with ID in normal schools (opportunity classes). More severely retarded children may benefit from special schools. Whatever the approach, children with ID need education – even more so than other children – to maximize their development and chances in life.

A major barrier to integration is the stigma that surrounds people with intellectual disability. The basis of this rejection of feared “Not-like-us” people is discussed in PE1d(ii). The extent of the rejection is easily seen in how past terminology of degrees of ID [idiot, moron, imbecile] has been incorporated as terms of abuse in everyday language. A significant part of management should include measures to reduce stigma and discrimination.

Reference

This paper has been largely taken from: Ke X, Liu J. Intellectual disability. In Rey JM (ed), *IACAPAP e-Textbook of Child and Adolescent Mental Health*. Geneva: International Association for Child and Adolescent Psychiatry and Allied Professions 2012.

AUTISM SPECTRUM DISORDERS

Autism spectrum disorder (ASD) refers to a neurodevelopmental condition defined by several behavioral features. The core clinical characteristics of ASD include impairments in two areas of functioning (social communication and social interaction), as well as restricted, repetitive patterns of behavior, interests or activities. These symptoms are present in the early developmental period but may not be fully manifest until social demands exceed the child’s limited capacities or may be masked by learned strategies in later life. Despite its early unfolding, this condition is not necessarily diagnosed until a few years later.

There is a discussion in PE3a(ii) about Developmental Disorders including Autism Spectrum Disorders indicating that research has gradually changed the necessary and sufficient diagnostic criteria over the decades since initial description in scientific literature. The changed criteria have resulted in a greater acknowledged prevalence, about 1% of the child population. This increased identification of this disorder, its emotional impact on families and the challenging financial demands associated with its treatment and support currently make ASD an important illness at the scientific, clinic and public health levels.

The current ASD category is characterized by:

- Persistent deficits in social communication and social interaction across multiple contexts
- Restricted, repetitive patterns of behavior, interests or activities either current or elicited through the clinical history
- Clinically significant impairment in social, occupational, or other important areas of functioning
- Presence from early childhood (although it may not become fully manifest until social demands exceed the child’s limited capacities), and
- Not explained better by intellectual disability or global developmental delay.

The broad ranging patterns of functional impairments in ASD highlight the importance of careful clinical assessment of the young person's strengths and limitations to arrive at optimal programs to maximise developmental progress in all domains.

Reference:

This paper has been largely taken from: Fuentes J, Bakare M, Munir K, Aguayo P, Gaddour N, Öner Ö. Autism spectrum disorder. In Rey JM (ed), *IACAPAP e-Textbook of Child and Adolescent Mental Health*. Geneva: International Association for Child and Adolescent Psychiatry and Allied Professions 2014.

See also PE3a(ii)

[\[To go to Best Practice Model BP6a close this file and go via Best Practice Index\]](#)

[\[To go to Policy POL6a close this file and go via Policy Index\]](#)

Last updated 19/1/2022