

# Establishing a Clinical Framework for Mental Health of Children and Adolescents with Intellectual Disability

Experiences from the development of a curriculum for  
inter-disciplinary training,

Identifying factors that impede training and service  
development for this population?

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# Context

- MH of C&A with ID is a public concern
- 30-50% of C&A with ID have signif MH probs
- MH for C&A with ID is 14% of MH burden (Emerson & Hatton 2007)
- The MH prob and the burden of care affect QOL
- 2-3x greater financial burden for care, treatment & education & reduced income capacity
- Over half of carers (59%) experienced a decline in physical health & two-thirds felt that their mental & emotional health was affected with depression, anxiety or stress (Cummins et al 2005)
- Context of no designated mental health service for MH & ID
- No previous textbook covering this area of multidisciplinary expertise?

# Method

- Developing the Training Curriculum Project (TCP)
- 3 years funding from 3<sup>rd</sup> NMHP and ADHC for project manager (**Donna White**) with partnership with Statewide Behaviour Intervention Service ADHC (**Lesley Whatson**)
- Sources of information
  - Literature review
  - What works in tertiary multidisciplinary multi-agency clinic
  - Areas of demand for training from SBIS
  - Stakeholders survey of areas of intervention focused learning
  - Evaluations and 3 month outcomes on workshops
  - Commissioned 30 chapters which were independently reviewed to be published in 6 months
- Have provided 4 2-day workshops to >500 clinicians

# Method

- Evaluation and feedback from the curriculum was positive and clinicians reported at three months that it had made a difference to their clinical practices.
- This raised the question as to why there was no previous textbook on MH for C&A with ID.
- The discourse with colleagues and trainees identified some of the differences of MH for C&A with ID from mainstream MH.

# Problems of MH in ID

1. Ambiguous Terminology
2. Dichotomous/Divisive Concepts
3. Reliability of identifying MH Symptoms
4. Reliability of identifying MH Disorders
5. Need for Special Diagnostic Skills
6. Different Definitions of MHPs in C&A
7. Differences of aetiology and validity of MHPs in C&A
8. Other problems in MH for C&A with ID

# 1. Problems of MH in ID

- Ambiguous terminology across continents eg
  - “Learning Disability”: In UK used for ID; in USA for Specific Learning Disorders +/- ID. ?Australia
  - Dual diagnosis means ID and MH probs in USA and UK, and MH and D&A problems in Australia.
  - Obfuscation through agency/discipline specific jargon; we identified 125 abbreviations in common usage

There is no evident common language

## 2. Problems of MH in ID

- Dichotomous/Divisive Concepts:
  - Challenging behaviours implies a linear behavioural approach by Disability Services;
  - Psychiatric Disorder implies syndromal approach & a responsibility of mental health services,yet both models acknowledge bio psycho social factors
- Discrimination against ID
  - “if the patient can’t talk then they can’t have a mental disorder”.
- Most condition specific research is limited to Mild ID.
  - There is little agreement on how mental disturbances are different in the earlier stages of mental development.

# Adult MH & ID: Diagnostic Problems

- MI is defined
  - “**a diagnosable illness** that significantly interferes with an individual’s cognitive, emotional, or social abilities.”
- Generally been recognised that those “with ID have the full spectrum of MI, but usual diagnostic criteria are difficult to apply”

Methodical approaches are recent

- **DM-ID (2007):** textbook of diagnosis of mental disorders in persons with an ID
  - Developed by an international (American) expert group
  - Reviews of the strength of the evidence supporting each diagnosis and the adaptations of diagnostic criteria for persons with ID
  - **The levels of Cochrane based scientific evidence are generally poor, mainly based on cohort studies and expert opinion.**
  - DSM methods gives people with ID entitlement to MH services
  - Clinical usefulness was evaluated in 2006: a field trial 900 patients, 80 clinicians from 11 countries.
    - The DM-ID was user friendly & more specific than the DSM-IV-TR (text revision 2004).
- **DC-LD (Diagnostic Criteria for Psychiatric Disorders for use with Adults with Learning Disabilities/Mental Retardation)** (2001, Royal College of Psychiatrists)
  - Provides a “consensus of current practice” for adults with moderate to profound ID leading to ICD10 diagnoses
  - “Sometimes it is not the criteria that need alteration but a different method of eliciting the necessary information”

# 3. Special problems of phenomenology in ID

- Eliciting subjective mental phenomena reliably < 7 years or IQ <45.
  - Only in the 80s did psychiatry recognise depression in children > 7 yrs.
- Articulating abstract or global concepts eg depressed mood from cognitive and verbal skills.
- Giving answers to please the interviewer
- Intellectual distortion
  - e.g., saying “yes” to “hearing voices”, not understanding the implication of question.
- **Diagnostic overshadowing:** failure to identify co-morbid psych disorder
- Baseline exaggeration or intensification of existing maladaptive behaviour
  - e.g., increase in self injurious behaviour under a time of stress.
  - e.g., anniversary of a loss may be a sufficient pptant that carers may not identify.
  - e.g., change of a teacher or other staff, or a classroom or accommodation or of family visits
- Stress on coping with a lack of cognitive reserve leads to disintegration, disorganisation or psychotic behaviour
- Delusions and hallucinations are frequently very difficult to distinguish from a range of normal developmental phenomena
  - e.g., concrete thinking, pretend friends, stereotypic thinking and imagination, esp in ASD.
- Irritability occ assoc with explosive anger can be mania and depression

Indeed: Families and professionals alike are at risk of diagnosing serious psychiatric disorder where none exists.

Conversely non specialised doctors (GPs) fail to identify mental disorder eg depression

# 4. Comparing Psychiatric Disorders in ID?

**a) in USA** (Tsiouris et al, 2008).

Study of **4468 clients**,  $\frac{3}{4}$  in out of home residential settings, found **psychiatric disorder in 60%**

The main DSMIV psychiatric diagnoses in order of frequency:

- Impulse Disorder 21%
- Anxiety Disorder 19%
- Schizophrenia and other psychoses 18%
- Depression 14%
- Bipolar Disorder 12%

Obsessional Compulsive Disorder 11%
Personality Disorder 8%
Sleeping Disorder 4%
Eating Disorder 3%
Tourettes 2%

No psychiatric diagnosis 40%

Did not identify any other diagnoses identified in DM-ID eg:

- Adjustment Disorders; Post traumatic Stress Disorders;
- Substance-related disorders; Sexual & Gender Identity Disorder;
- Dementia; Mental Disorders due to a General Medical Condition Nos;
- Learning Disorders; Motor Skills Disorders; Elimination Disorders;
- Pervasive Developmental Disorders; ADHD and Disruptive BDs;
- Somatoform & factitious disorders; Other Disorders of Infancy, C&A eg Attachment Disorders and Stereotypic movement disorders incl. SIB; Behavioural Phenotype of Genetic Disorders

# 4. Comparing Psychiatric Disorders in ID?

## b) in UK/WHO (Cooper et al, 2007)

- **Epidemiological study in Scotland of 1023 adults > 16yrs with mild, mod or severe ID**
  - The PAS-ADD 10 (The psychiatric assessment schedule for adults with a developmental disability) (Costello et al, 1997).
  - Relies on a key informant to identify and rate symptoms and produces diagnoses using algorithms
  - The PAS-ADD checklist is a screening questionnaire, used with the Mini-PAS-ADD (Moss 2000)
- **Found prevalence rates of Psychiatric Disorder:**
  - Mental ill-health of any type 40.9%
  - Problem Behaviour 22.5%
  - Mental ill-health of any type excluding problem beh 28.3%
  - Mental ill-health of any type excluding ASD 37%
- 54% of Problem Behaviours had MHP

# 4. Comparing Psychiatric Disorders in ID? b) in UK/WHO (Cooper et al, 2007)

- **The types of ICD10 Psychiatric Disorder were:**

- Psychotic Disorder 4.4%
- Affective Disorder 6.6%
- Autistic Spectrum Disorder 7.5%
- Anxiety Disorder 3.8%
- Organic Disorder 2.2%
- Pica 2%
- Hyperkinetic Disorder 1.7%
- Personality Disorder 1%
- Alcohol/substance abuse 1%
- Obsessional Compulsive Disorder 0.7%
- Sleep Disorder 0.6%
- Other mental ill-health 1.4%

**Compare with USA**

Impulse Disorder 21%

Anxiety Disorder 19%

Schiz and other psychoses 18%

Depression 14%

Bipolar Disorder 12%

OCD 11%

Personality Disorder 8%

## 4. Reliability of Psychiatric Disorders in ID?

- The rates of diag in the USA and UK are strikingly different
  - A lack of uniformity of diagnostic thinking and processes.
  - Other methodological differences such as sample selection and screening processes.

## 5. Need for Special Diagnostic Skills: **Identifying Depression in ID**

- a retrospective clinic pop found that **most** patients with ID and depression did not meet the required no. of diag criteria for DSM or DM-ID (Hurley (2008))
  - patients with ID and dep do not complain of depressed thoughts.
  - But had dep mood, sadness, crying, anhedonia & withdrawal which distinguished from anxiety or bipolar disorder.
  - Few reported suicidality.

# 5. Need for Special Diagnostic Skills: Identifying Depression in ID

- **Australian study compared GPs and LT paid carers' capacity for identifying features of depression in pts with ID having routine assessment (Torr, 2008)**
    - the aid of a 53 item checklist for depression
    - compared with subsequent assessment with a comprehensive psychiatric ass.
  - Factor analysis identified the consistent features of depression:
    - dep mood (6 items), loss of interest (5 items), loss of social interaction & comm'n (8 items)
  - Carers identified the features that the GPs failed, even with the carers present.
  - Depressed thinking was not a reliable feature of dep reflecting limited comm'n skills
  - GPs focussed more on sleep, appetite, weight control and general functioning.
  - 30% of this clinical cohort had depression but 25% had a PDD (not discussed)
- 
- **Access to MH service for people with ID is disadvantaged by the lack of trained workforce, both GPs & psychiatry where we need for subspecialty skills in ID.**

# 6. Different Definitions of MHPs in C&A with ID

- *A signif psychiatric disorder is any disturbance of beh or emotions sufficient to cause signif impairment to the child or those caring for them*
- The longitudinal study of young people with ID (Einfeld & Tonge, 1996) indicates
  - 40% have a severe mental health disorder,
  - DBC measures a severity of disturbance, doesn't translate to psych disorders.
  - There is no study describing the additional impairment of Psych Dis vs ID
- Whether a problem is a Mental Illness, Mental Disorder, a Developmental Disorder a Challenging Behaviour or behaviour problem is a Subjective determination
  - Affected by profession, employing agency & different theoretical models
- Mental health services have prioritised their business to **severe MI and emergency services for acute mental disorder**
- “Mental health is everyone’s business” suggests all child services have to understand and manage mental health problems.
- Agg is a chronic problem that doesn't improve in psychiatric in-patient units.
- Most conditions are best treated in the community: a shared responsibility between families, neighbourhoods and all government departments.

# 7. Differences of aetiology and validity of MHPs in C&A

- 50% of children with ID have ASD
- 30% have ADHD
- Validity of Diagnosis at different Levels of ID
- ADHD in Mild ID Antshel K, Phillips M, Gordon M, Barkley R, Faraone S. Clinical Psychology Review 2006
  - reliability and predictive validity
  - prevalence of 30%, M=F,
  - possibly greater family factors, depression and social impairment.
  - standard drug Rx is not as effective and more prone to side effects
- ADHD in severe ID
  - lacks research for reliability and validity,
  - affected by more gen biol factors vs genetics
  - an association with other developmental disorders

## 7. Differences of aetiology and validity of MHPs in C&A

### **ADHD and other Developmental Disorders in ID**

- ADHD and DCD each occur in 7%, but co-occur in 50%
- ADHD in 50% teens with ID+autism vs 15% with ID-autism(Bradley 2006)
- ADHD is found in 78% of PDD in clinic population (Lee & Ousley 2006)
- Genetic linkage between ID & Autism
- ADHD in behavioural phenotypes
  - SMS 90%, Fragile X 75%, Williams Syndrome 65%, Charge Syndrome 50%, Neurofibromatosis 50%, VCFS 43%, Cornelia de Lange's Syndrome 40%, Soto's Syndrome 38%, Tuberosc Sclerosis 35% and Turners Syndrome 24%.
  - Fetal alcohol syndrome:
    - ADHD 49%, ID in 55%, learning disorders 46%, ODD 41%, anger problems, mood disorders and sleep disorders in 50%
- ADHD in ID suggests a model of developing coherence & efficiency consciousness
- Helpful to identify co-morbid ADHD for ?drug treatment
- Rules of Development: Developmental disorders have high risks of co-occurrence, relate to developing neural complexity & are genetic

# 8. Other problems in MH for C&A with ID

Different models for different disciplines and agencies

Individual centred and lack of family centred approach

Lack of clinicians with EBP expertise & experience in both MH & ID

Increased association with complex medical problems

Lack of recognition of the range of the disciplines and agencies involved

Lack of inter agency collaboration with service cost shifting

Lack of service structure for more severe problems.

Lack of attention to Prevention Promotion and Early Intervention

Limited empirical evidence on OT, physio, speech, psychopharm, FT & systemic practice (best evidence in parent training and behaviour Rx)

## **Result:**

Families experience the rotating front door of inexperienced community clinicians

Problems escalate: frequent presentation of parental murder/suicide ideation

# A Coherent Curriculum for MH for C&A with ID

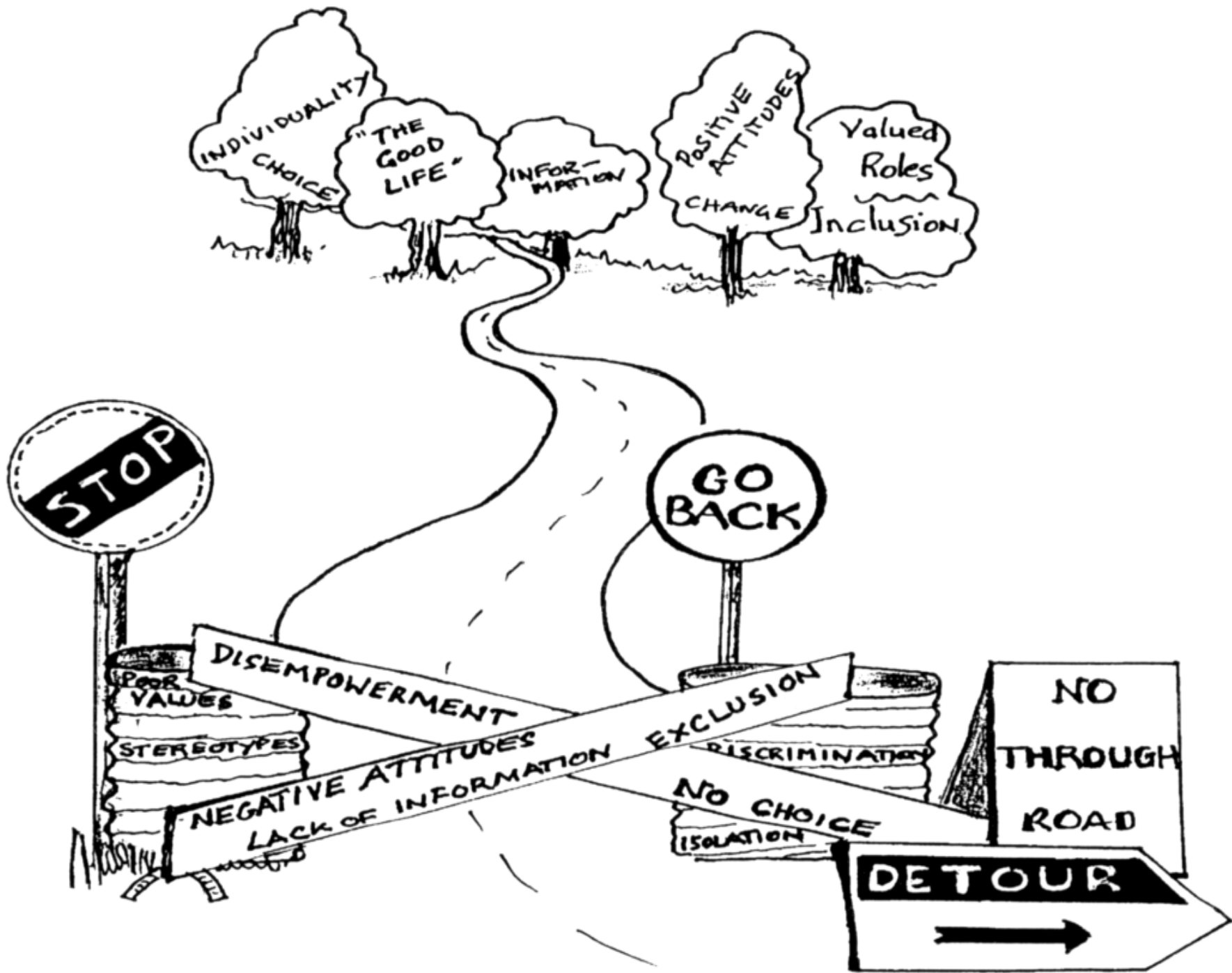
- A framework that is applicable for all professionals working C&A with ID
- Context of the Family life cycle for a child with ID
- Quality of life for child with ID and family
- Developmental framework
  - informs multidimensional assessment
  - Context for understanding behaviour
  - Alternative framework for understanding developmental psychiatric disorders eg ADHD and ASD
- Multi causal mechanisms to disturbance and disorder
- Emphasis on multimodal skill building/positive psychology
- Requires multidisciplinary/multiagency collaboration

# A mental health service for C&A with ID

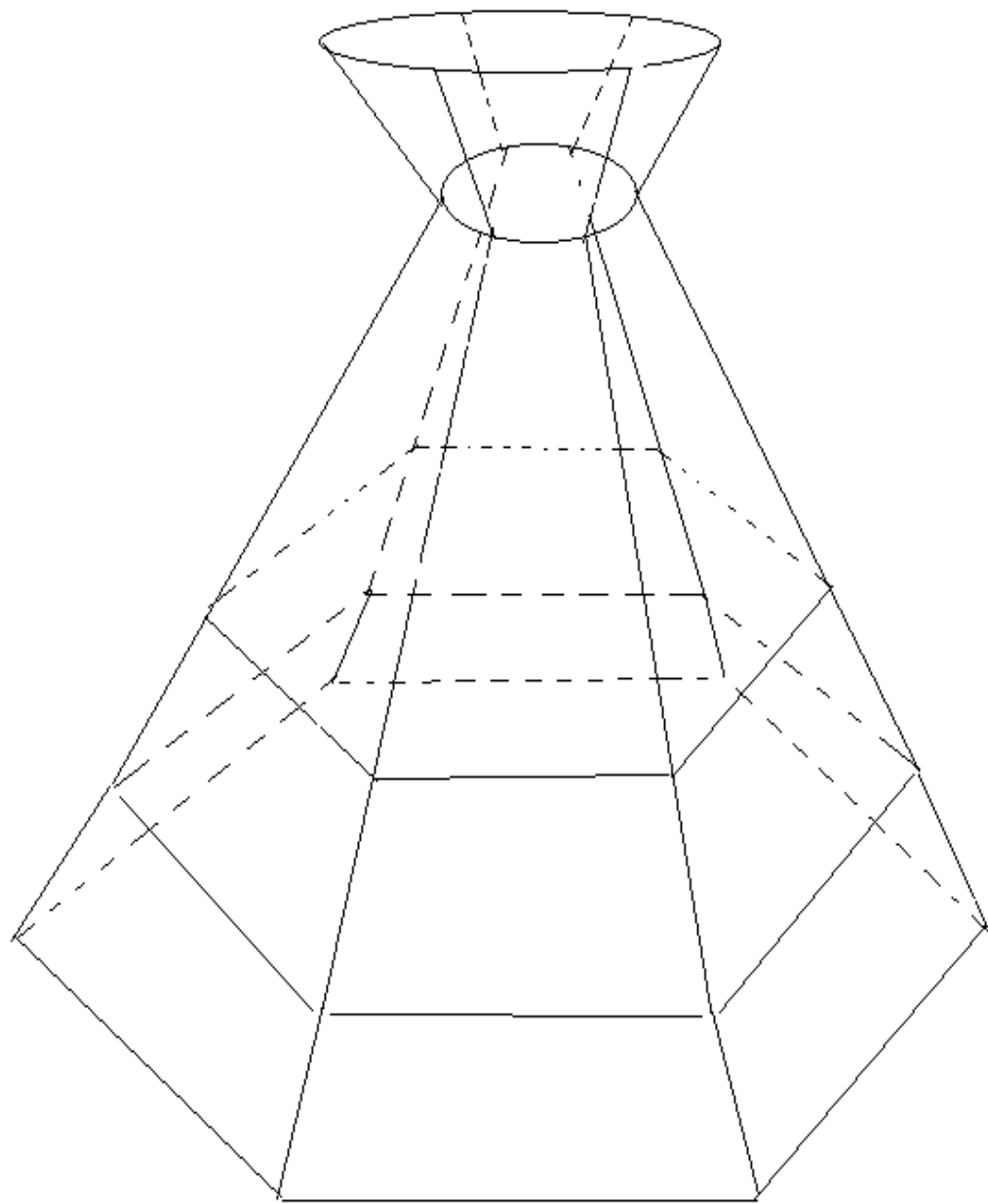
- A multi causal framework for MHP in ID
  - Sometimes additive, sometimes one may be dominant
  - Tension between developmental models vs deconstructive (illness) model
- Problem solving tiered service systems with collab
  - Final common pathway of complex case conference, where clinical judgement and service management meet
- Prevention, Promotion and Early Intervention
  - Universally available specialist parent training
  - Emotional literacy programs in schools
- Multidisciplinary skill building skills

# Conclusion

- The scientific evidence in MH in ID is in early dev
- MH for C&A with ID is different from Adult Psych for ID & Mainstream C&A Psych
- A curriculum framework is necessary to establish a coherent service and interdisciplinary and interagency collaboration
- Specialised clinicians are positive on the impact that such services can have on the morbidity from co occurring psychiatric disorder in partnership with families and child orientated agencies.
- How can you be interested in “losing your mind” without studying the development of the mind.







# Studying The Development Of The Mind: A Prerequisite To Understanding Losing One's Mind?

Development of the mind involves developing capacities of:

- Sensory integration and the identification of self and non self;
- Motor regulation and coordination;
- Arousal modulation and selective attention;
- Communication skills and an internal voice;
- Mood regulation and Self concept
- Emotional recognition and Reciprocal social interaction;
- Theory of mind, Reality testing, Perspective taking & Problem Solving.

The capacity for developing good quality peer attachment relationships is the best measure of youth and future MH as an adult.

The neurobiology of the basis of mental illness suggests there are commonalities between the processes of development of the mind and losing one's mind (Starling & Dossetor, 2009) (Mouridsen & Hauschild, 2008).

The Curriculum promotes an understanding of behaviour from a developmental bio psychosocial cultural framework in tension with a deconstructive scientific model

## **Section 1: Understanding the Issues and Integrating Scientific Approaches**

**Quality of life** for individuals with Intellectual Disability and Developmental issues

**Empirical approaches, a common language and formulation** for understanding intellectual disability, development, emotions and behaviour.

## **Section 2: The Impact of Disability and Family Well-being**

**Parental Emotional Adaptation** Adjustment, acceptance and hope; Family and cultural issues

**Parental Practical Adaptation: Promoting Healthy Habits and Routines** Sleep, limit setting, skill building, rewards, and stereotypic/ obsessive interests

**Burden of Care** Care needs at different impairment levels and common medical issues

**Models of Respite** Family, friends and respite services

**Maintaining Parental and Family Mental Health and Well-being**

Health, stress, burnout, depression;

Family relationships, siblings and networking.

## **Section 3: Individual Emotional and Behavioural Well-being**

### **1. Interventions to Promote Skill Development**

Physical development, coordination, safety, balance and control.

Sensory diet and activities for calming, concentration and emotional regulation

Communication strategies and symbolic supports for understanding, expression and interaction

Attention, coping strategies and problem solving

Emotional understanding, emotional recognition and social skills.

### **3. Understanding and Managing Mental Health Issues**

At-risk behaviours and related issues i.e. life events, stress, transitions and changes (abuse, attachment and separation experiences)

Mental illness (depression, PTSD & psychosis) versus developmental disorders and psychopharmacology

Modifications of counselling, cognitive-behaviour therapy and other psychological interventions

Adolescence and young adulthood i.e. developmental changes, sexualised behaviours and offending.

## **Section 4: Integration of Service Systems**

The role of education and community access

**Services:** Expertise, coordination, integration and collaboration

Parents' experiences; Advocacy isn't an option it is a must

# Parent Training approaches to intervention

- Stepping Stones Triple P: the best empirical evidence for theory & outcome (Roberts et al, 2006)
  - A normalising philosophy & framework
  - Create a safe engaging environment, that facilitates learning of skills and positive beh,
  - Having developmentally realistic expectations; assertive discipline to shape behaviour,
  - Parental emotional adaptation to the (disabled) child,
  - Being a part of the community & taking care of ps' wellbeing.
- Skill growth, independence & self determinism improves prob beh (Nota et al, 2007).
- However parent training approach assumes a complex understanding of beh probs: These include:
  - **Genetic Factors** eg sociability, reactivity and activity levels
  - **Family Environment Factors** eg accidental rewards of undesirable behaviour, escalation traps, emotional messages, ineffective use of punishments, parents beliefs and expectations, parents' relationships and emotions, stress.
  - **Influences outside of the home:** other relationships incl peers, school, media & techn
- The reasons for working on family environment factors are:
  - Most accessible & easiest for parents to influence.
  - 2<sup>ndary</sup> influence on the genetic factors, & makes easier to sort out outside influences
  - Has a long term effect by improving emotional communication & attachments.

# **Framework for Professional Practice for Children and Adolescent with Intellectual Disability**

- **Focus on a child in a family context**
  - adaptation, dev framework, relationship building, community participation
- **Common language to assess and treat emotional/behav disorder in ID**
  - the developmental-bio-psycho-social-cultural model
- **Skill building models for dev maladaptive beh require subspecialty skills**
  - Doctors for bodily health, including vision, hearing, nutrition & fits;
  - Physiotherapy for motor development and coordination;
  - Occupational therapy for proprioception and sensory integration;
  - Speech therapy for receptive, expressive and pragmatic communication;
  - Psychology for the dev of understanding of behaviour, thought, feelings and social interaction;
  - Psychiatry to assess abnormal subjective mental state & Psychopharm
  - Family therapy/cybernetics for how communication & beh shape systems
  - Role of risk management
- **YP with ID need interagency collaboration & service pathways & planned & improved future service development**

# **The Principles for a Service Models for emotional and behaviour disturbance in ID:**

## **What specialist mental health service in ID should we have when there isn't one!**

- Parents have complex explanations for the behaviour in their child,
- Our explanations of mental health problems are limited, complex, and uncertain.
- No single profession or service is sufficient
- Improving our capacity to cure conditions, improve disabling problems, build compensatory skills, minimise handicap and hopefully provide care and humanising support.
- services systems should be designed with a spectrum of responses within a holistic framework:
- Common/milder problems managed with preventative and universal approaches at one end of the range
- With increasing of involvement of different professionals for assessment and intervention for complex severely disabling problems.
- Couched in a humane and community based system of service provision and care.
- A holistic developmental-bio-psycho-social-cultural model that underlies child and adult psychiatry
- The mental health needs of young people with ID necessitates across organisational collaboration
- Service tiers according to need, severity and complexity.

# Tiered Pyramid of Services for C&A with ID & MH problems:

## The specialist MH in ID Service for C&A when there is none.

### **Tier 5: Acute short/medium term interventions that inform Tier 4**

Includes: Emergency departments, MH in-patients assessments, other residential behaviour services; and

**Specialist/Tertiary MH in ID clinicians** from mental health & disability services.

### **The Tier 4 Circle: The Final Common Pathway**

Complex case management decision making; ‘best endeavour’ obligations including decisions about out of family community placements.

### **Tier 3: Multidisciplinary and Multi-agency Collaboration**

**Disability Service:** ADHC behaviour clinician, speech pathologist, OT, other specialist psychology service;

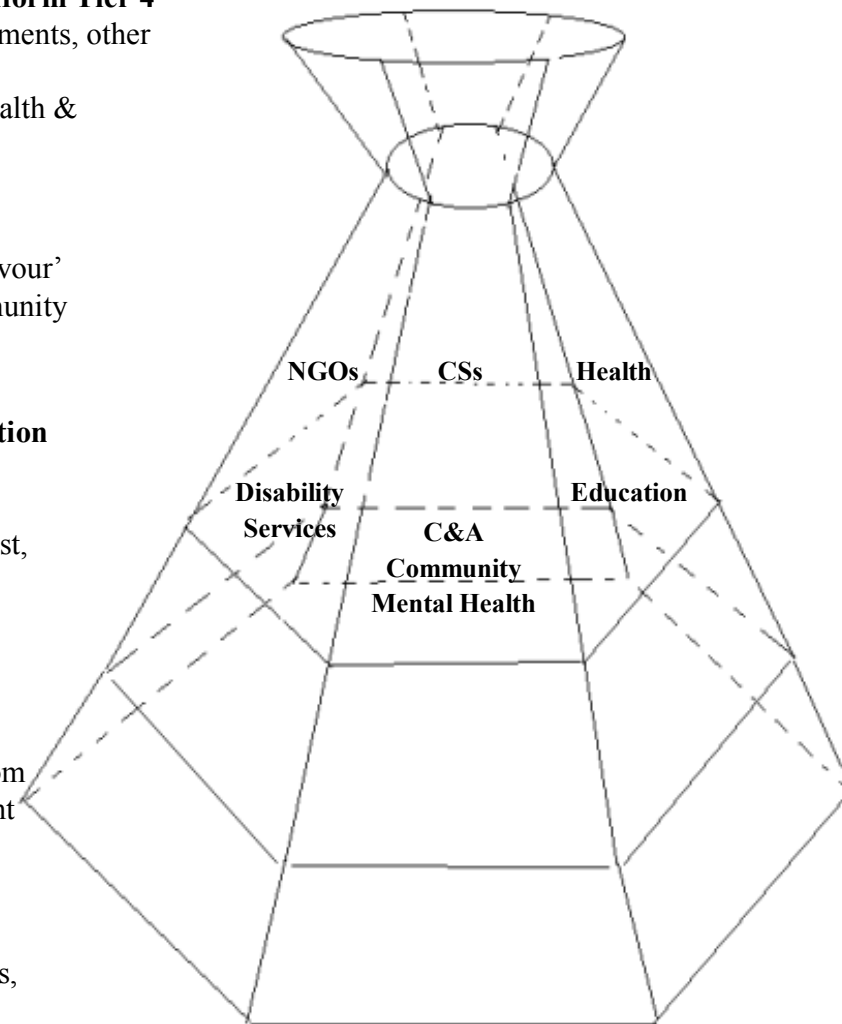
**Health:** GP, paediatrician or neurologist; MH Psychologist, SW, family therapist, psychiatrist; and

**Education:** teacher, aide, school counsellor, principal, behaviour support specialist.

**Tier 2: Community Disability Services providing case management and specialist parent training.** Mainly from ADHC but can be MH or other agency or non-government organisations.

### **Tier 1: Generic Health Provision** for families

Includes: GPs, community nurses, child community teams, Families NSW, Triple P



*3D Model provides for all other human services to be part of the pyramid*

# *Clinical Expertise And Innovation In Mental Health And Intellectual Disability*

1. Specialist evidence-base parent training skills e.g., Stepping Stones Triple P (Sanders, Mazzucchelli, & Studman, 2003).
2. General health promotion and prevention especially with a focus on other chronic disabilities.
3. School based prevention and early interventions e.g.,
  1. Positive behaviour learning;
  2. Inclusion approaches and practices;
  3. Inclusive communication strategies;
  4. Focus on developing mindfulness of self and others; and
  5. Focus on emotion-based social skills learning
4. The role of exercise and coordination for self esteem, motor/sensory modulation and attention.
5. Sensory profiling and sensory diet interventions for management of arousal levels and motor calmness, relaxation and playfulness e.g., Floortime (Greenspan & Wieder, 1998).
6. Augmentative and alternate communication, especially capitalising on using new electronic devices for socially acceptable forms of visual communication.
7. Problem solving and self monitoring skills.
8. Emotion-based social skills training.
9. Modification of cognitive behaviour skills therapy.
10. Neuro-biological research e.g., based on behavioural phenotypes, new metric and imaging techniques and the effects of medication.

# Understanding the pathways to

Dev-bio-psycho-social-cultural holistic model of MHPs ie DSM MH Disorders

Primary agencies for MHPs

DADHC

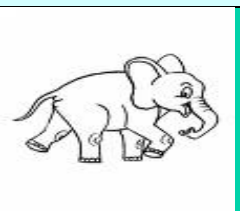
Health/Paediatrics

CAMHS

**Challenging Behaviour**  
*Linear* model of understanding  
Maladaptive or externalising Beh

**Developmental MH Disorders**  
Eg ASD, ADHD  
**Diagnosis & Assessment** of ID  
Physical health,  
Genetics; Sensory Deficits

**Mainstream Mental Disorders**  
*Syndromal* patterns of symptoms eg  
Anxiety Disorder, Depression, Psychosis



**Dangerous/complex Challenging behaviour with risk of severe MHP**  
Not managed early by Education System  
threatens self harm or public safety  
Failure to treat threatens placement in the family/abuse  
doesn't have intent or sufficient verbal skills for CAMHS  
Leading to long term placement and cost/blocked beds

Mental Disorders  
Brought in to ED by  
Ambulance or police

Acute MH  
In-patients

DCSs

Education & Special ED

Child and Family  
Community Health

Psychiatrists who identify as  
having specialist skills in ID  
For diagnosis and psychopharm

NGOs

General Practice

Private Practitioners  
Psychiatry and Psychology

# What is the relationship between development of the mind and losing your mind?

- Autism Spectrum Disorder (ASD):
  - Thought disorder and overvalued stereotypic thinking
  - Catatonia
  - Pretend friends
  - Concrete externalisation of thoughts
- Schizophrenia:
  - Premorbid problems with social relating
  - Loss of empathy associated with delusions
  - Poor self esteem
  - Acute onset of loss of emotional recognition

**How can you be reliable in the diagnosis of psychosis without core training in child and adolescent intellectual disability and ASD?**

# 4. Comparing Psychiatric Disorders in ID:

## a) in USA (Tsiouris et al, 2008).

- ? Other diagnoses are only applied to children :
  - Learning Disorders
  - Motor Skills Disorders
  - Elimination Disorders
  - Pervasive Developmental Disorders
  - ADHD and Disruptive Behaviour Disorders
  - Somatoform and factitious disorders
  - Other Disorders of Infancy, Childhood and Adolescence (Attachment Disorders and Stereotypic movement disorders including Self Injurious Behaviour)
  - Behavioural Phenotype of Genetic Disorders
- Adult psych disorders vs child psych disorders
  - Applied to adolescents and occ children (except personality disorder by defn)
  - Less clear to what extent the child psychiatric disorders apply to adults  
e.g. What is the relationship between ADHD in childhood and Impulse Disorder
  - PDD is a lifelong disorder, yet it is not identified as an adult psychiatric diag.
- ASD is a dimension of impairment not solely a categorical diagnosis,
  - What is the relationship between stereotypic behaviour or thinking & OCD?

# Definition of Disturbance vs Disorder

- “disturbance” is “a *temporary* change in average environmental conditions that cause a pronounced change in the ecosystem” vs “disorder” is “a *physical or psychical malfunction*”.

suggests disturbance is a temporary affair and disorder assumes a biological malfunction of the brain.

- less straight forward to apply this defn of disturbance in MH functioning to a minority population whose functioning is in many ways different to those in mainstream due to their ID.