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 (see PE5c) 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 (i) Organic Brain Disorders

Insofar as consciousness and all cognitive, language and emotional processes are mediated by brain functions, it could be argued that all psychological disorders are brain disorders. However, an arbitrary categorisation separates those which are shown or presumed to reflect biologically-based abnormal brain processes from those functional disturbances without demonstrated brain abnormalities. There remain many ambiguous examples, such as psychotic disorders and developmental disorders, where there are abnormal brain mechanisms that are nevertheless not included as organic brain disorders.

The included categories are delirium, dementia, epilepsy, brain damage and mental disorders due to medical conditions. See PE3a(i) for further discussion of Brain Injury.

DELIRIUM

ICD-10 (World Health Organization, 2015) defines delirium as an etiologically nonspecific organic cerebral syndrome characterized by concurrent disturbances of consciousness and attention, perception, thinking, memory, psychomotor behaviour, emotion, and the sleep-wake schedule. The duration is variable and the degree of severity ranges from mild to very severe.

This definition covers a wide range of disturbances of brain function from a wide variety of causes, and the consequence of this is that a strong emphasis has to be put on clarifying the cause.

Delirium has a high prevalence; it affects 10% to 30% of general hospital patients and up to 80% in tertiary intensive care units (ICUs). Delirium in adults and the elderly is strongly associated with increased length of hospital stay, morbidity and mortality. In the elderly it is associated with a faster cognitive decline, loss of independence, and increased mortality in the year following hospital discharge. Delirium is the most important predictor of the proximity of death in the elderly and in oncological patients, young or old (terminal delirium).

The reported prevalence of delirium in critically ill children varies from 20% to 30%. Rates depend on age (more common in younger children), severity of the illness, number of medications, diagnostic tools used, and group under study (e.g., paediatric ICU patients, general ward). Mental retardation and a previous episode of delirium are also known risk factors.

According to seriousness, paediatric delirium can be benign and non-benign. There are two types of benign paediatric delirium: emergence delirium and the common delirium seen in general practice.

Emergence delirium, also known as emergence agitation, is a well-documented phenomenon occurring in children—and adults—in the immediate postoperative period, after the withdrawal of anaesthetic drugs.

In general practice paediatric delirium frequently occurs in the context of an infection (febrile delirium).

There are important clinical reasons for assessing pediatric delirium and taking it seriously:

- Delirium is an *acute brain failure* and the consequences of such a failure can be severe.
- The neuro-metabolic stress of delirium probably has a negative impact on the outcome and recovery from critical illness. A hyperactive delirium is accompanied by various risks, such as pulling out of IV lines and catheters, auto-detubation, stepping or falling out of bed etc.
- It is stressful for the patient who may experience terrifying hallucinations or delusions (sometimes without amnesia) that may lead to a post-traumatic stress disorder (PTSD) and
- It can also be very stressful for the child's family and clinical staff (up to 25 % of parents of children who have been in a pediatric ICU may develop PTSD).

The acute occurrence of a disturbance of cognition, emotions, consciousness, or a behavioural disturbance in a critically ill child should raise the suspicion of paediatric delirium and the need for thorough medical assessment.

Apart from involvement in the daily care of their hospitalized child, parents can have a major role in the prevention, detection and treatment of delirium. A model that recognizes and respects the uniqueness of each family and empowers and encourages them to partner with health care providers is useful.

Symptoms associated with delirium, such as delusions or hallucinations, may come as a complete surprise, something the family has never encountered before, and can be very frightening for both child and parents. This may lead to parents not recognizing their child's behaviour, becoming afraid that neurological damage has occurred or that their child is going to die. Not knowing how to cope with these behaviours in their child makes parents insecure and anxious; this in turn can influence the child, causing the delirium to worsen. A soothing stimulation of all the five senses of the child with delirium is advocated. The constant presence of

one parent during the hospitalization, hearing parents' voices, readily visible photographs of parents or other well-known family members, and favourite toys decrease the severity of delirium.

Reference

Schieveld JNM, Ista E, Knoester H, Molag ML. Pediatric delirium: A practical approach. In Rey JM (ed), *IACAPAP e-Textbook of Child and Adolescent Mental Health*. Geneva: International Association for Child and Adolescent Psychiatry and Allied Professions 2015.

DEMENTIA

Dementia is a disorder of significant mental decline in multiple cognitive functions from the individual's previous intellectual level. This includes memory problems, aphasia (impaired verbal communication), apraxia (impaired performance of fine motor tasks), agnosia (impaired recognition of objects or tasks) and impaired executive functioning (planning, judgment, tactfulness and impulse control). The disturbance is severe enough to interfere with work, social activities and relationships. It is ongoing, in contrast to the transience of delirium.

Amnestic disorders characterised by memory impairment and more limited cognitive impairments may occur in cases of brain damage.

Management involves long-term care and specific treatments depending upon the different causes.

EPILEPSY

Epilepsy is a group of chronic neurological disorders characterized by seizures, which are the result of abnormal, excessive or hypersynchronous neuronal activity in the brain. Epilepsies can be classified by the:

- Etiology - Idiopathic or Symptomatic (secondary)
  - Idiopathic (primary)
    - Seizures start during childhood or adolescence
    - Genetic origin
    - Good respond to pharmacological treatment
    - Good prognosis,
    - No brain damage
  - Symptomatic (secondary)
    - Seizures start at any age
    - Multiple etiology
    - Uncertain pharmacological response
    - Variable prognosis
    - Usually brain damage
- Characteristics of the seizures, such as absence, myoclonic, clonic, tonic, tonic-clonic, and atonic (which are terms describing different movement patterns).
- Location in the brain where seizures originate:
  - − Partial or focal onset seizures:
    - simple partial (consciousness is not impaired) or

complex partial (psychomotor seizure).
Partial seizures may generalize (secondary generalized)
- Generalized seizures
- Frontal, temporal lobe

- Medical syndromes of which they are a manifestation (e.g., juvenile myoclonic epilepsy, Lennox-Gastaut syndrome)
- Event, if any, that triggers the seizures, such as reading or music.

Epilepsy is a worldwide problem that affects between 2% and 3% of the population, 75% of the cases begin before adolescence. Epilepsy can be caused by genetic, structural, metabolic or unknown factors. Among the structural factors, the most common causes in developing countries are infectious and parasitic diseases (especially neurocysticercosis), perinatal brain damage, vascular disease, and head trauma – all preventable (Barragan, 2004). The prognosis of epilepsy depends on the etiology of the illness as well as on early and sustained treatment.

About one in 200 children has epilepsy. One in 20 children will have at least one seizure during their childhood – often a febrile convulsion (associated with high temperature). Such a once-off seizure is not considered epilepsy.
It is estimated that up to 70% of people with epilepsy can live normal lives if they receive proper care.

Reference

Barragan E. Epilepsy and related psychiatric conditions. 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.

Royal Children's Hospital fact sheet: https://www.rch.org.au/kidsinfo/fact_sheets/Epilepsy_an_overview/..

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