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 (iv) Mood Disorders,

The Royal Australian and New Zealand College of Psychiatrists and the Australian Psychological Society provide clinical practice guidelines for mood disorders with up-to-date guidance and advice regarding the management of mood disorders. Depressive and bipolar disorders are addressed.

Depressive disorders are characterised by persistently low mood and loss of interest and pleasure in previously enjoyed activities, as well as a range of other emotional, cognitive, physical and behavioural symptoms, including fatigue, sleep and appetite disturbance, reduced energy, concentration difficulties, feelings of low self esteem, excessive guilt or feelings of worthlessness and/or hopelessness and helplessness and suicidal ideation or ambivalence about living.

Clinically significant depression differs from regular mood fluctuation in its severity and persistence. When symptoms appear resistant to change in circumstance, and when they interfere with ability to perform normal day-to-day activities or general psychosocial functioning, assistance should be sought.

Depression is likely to be caused by a complex interplay of biological and environmental risk factors. The main factors include genetic (between 30 and 40%), traumatic experiences such as neglect and physical or sexual abuse and stressful life events such as loss of close relationships and major health problems for the child or family member, other familial stress factors such as poverty, bullying, trauma associated with refugee experiences.

Many children who have depression also have anxiety symptoms, most commonly generalized anxiety disorder (estimated at 67% of cases). Other comorbid conditions are social phobia, panic disorder, substance related disorder, obsessive compulsive disorder and eating disorders.

The way symptoms are likely to present for children will vary with age and cultural factors. For example, children under 12 years of age are more likely to present with somatic symptoms, anxiety, poor sleep, eating disturbance, social withdrawal. Many children in this age group can continue their daily activities whilst reporting and displaying depressive thoughts and feelings. Conversely, children aged 12 years and older are less likely to be able to continue their daily activities whilst they are depressed, more likely to express feelings of low worth, guilt, blame of self or others, failure, suicidal ideation and withdraw from regular activities such as sport and friendship circles. Academic performance is more likely to fall away and rebellious behaviour may be present.

Depressive disorders comprise several diagnoses distinguished by the precipitants and/or the frequency, intensity and duration of episodes. The following classification is widely accepted.

Primary:

- Bipolar Disorders
- Depressive Disorders

Secondary:

- Premenstrual Dysphoric Disorder
- Substance-induced mood disorder
- Mood disorder due to a medical condition such as endocrine disorders.

Bipolar Disorders.

The presence or history of mania/hypomania is the defining element of bipolar disorders and distinguishes them from depressive disorders. Mania or hypomania are rarely encountered in childhood but may emerge in adolescence or young adulthood. The excitable behaviour of children with Attention Deficit Disorders, Conduct Disorders and substance abuse problems should not be misinterpreted as manic symptoms. Most individuals will also have experienced one or more major depressive episodes, which often precede the onset of mania. Because of this, it may take five or more years before the definitive diagnosis is established.

As the onset of depressive disorders in children occurs most commonly in the context of stressful relationship and situational events, that require appropriate psychosocial intervention, an underlying biological predisposition may not be evident in early stages. Successful response to psychosocial interventions does not rule out the possibility of predisposition. Any episode of depression should be assessed and managed as necessary. If there are recurring episodes that have stronger physiological symptoms, the possibility of emerging bipolar disorder should be kept in mind. This is important in adolescence when the propensity for suicidal ideation heightens.

Most adult patients with bipolar disorder will suffer from multiple episodes of depression and mania during their lifetime and, therefore, in almost all cases long-term treatment is necessary. The course of illness and trajectory are difficult to predict and even with adequate treatment, almost half of all bipolar patients will have another episode within two years, and the majority will experience further illness within five years.

Depressive Disorders

Major Depressive Disorder (MDD) shows the features described above, without a history of manic phases. It may vary in intensity from mild to severe. Two related disorders share some of the features; Adjustment disorder with depressed mood results from identifiable life stressors; Dysthymic disorder is a fluctuating mood state in which a

person experiences depressed mood for more days than not over a period of two years (or one year in children and adolescents) and is closely linked to personality style.

Assessment of Depressive Disorders

Assessment carried out by the clinician usually includes a clinical interview with parents and child – with younger children play tools are often used as appropriate for their age. Self-report scales are also often used to assist – their effectiveness depends on the child's preparedness to share his/her inner experiences. Scales usually have a form for parents and possibly teachers to report their perception of the child's feelings. It is common for parents to differ between themselves in respect to their perception and report of their child's experience and for one or both parents to report different perceptions about the child's feelings than the child does. There is value in these differences and the clinician can work with these differences to assist families to move forward to hear each other so that the depression can be heard.

This process can be facilitated using the Australian Children's Depression Scale (Lang and Tisher 2004), a set of boxes and cards which the child posts into one of five boxes. This scale offers a form for children, parents, teachers and health professionals and invites and encourages conversation between family members about the child's feelings. It also offers norms against which the child's depression can be evaluated.

Assessment using the biopsychosocial and lifestyle model (BPSL Model) considers predisposing, precipitating and perpetuating factors. These are obtained through detailed information gathering, a comprehensive clinical assessment, including a detailed mental state examination and the careful piecing together of corroborative information. The appraisal of context is pivotal because this provides the understanding as to ***why*** a person has a mood disorder at this particular point in their life and is best constructed via thorough clinical assessment. Children who express their distress or adjustment to stressors by sharing depressive feelings or by behaving differently are often trying to communicate their distress as best they can – most young children in particular do not have the language to communicate depression. Accordingly, appraisal of context is important in assisting families to hear their children's response to stressors. Facilitating hearing a child's depression can be a significant treatment.

The components of the model represent seemingly distinct domains, however recent research has shown that there are important iterative links between various components, and these cumulatively contribute to the onset and maintenance of mood disorders. The model provides the necessary framework for the development of a mood disorder formulation in an individual.

Aims of treatment.

The general aims of treatment of any mood disorder are to relieve symptoms, reduce the morbidity associated with the mood disorder and limit the disability and self-harm risk or potential risk of fatality. The end goal is achieving recovery to premorbid level of functioning with improved health awareness and quality of life.

More specifically, treatment objectives include sharing of the clinician's biopsychological understanding of the child's/ family's presenting concerns. Psychoeducation concerning factors relevant in the maintaining of the depression and recommended evidence-based treatments and interventions. Establishing goals for treatment and methods or indicators for success or lack of success of treatment options is important, preferably using concrete measures such as "returning to school once a week", changing eating habits in a specific way, connecting with peer group on a basis that can be reported. Indicators such as these are preferable to "feeling better" which is harder to measure for all family members. Explaining the treatment process and indicators for closure, clarifying who will attend for treatment sessions, monitoring and managing risk and planning for closure including work around relapse prevention are all part of this process.

Main treatment modalities reported in the literature are Cognitive behaviour therapy, brief psychodynamic therapy, interpersonal therapy (including family therapy) and CBT self-help programs. A common underlying theme/narrative for depressed people is a belief that they are a failure in life. This repetitive narrative is sometimes expressed, but in children often not. Nonetheless, it drives children's thoughts, feelings and behaviours and often drives them to behave in a way consistent with that belief. For example, expressing suicidal ideation ("everyone would be better off if I was not here") or behaving badly to invite punishment confirming they are bad. All treatment modalities need to create a safe space where such underlying and repetitive narratives can be heard without judgment as a first step before offering cognitive restructuring options and an opportunity to try a more positive view of himself/herself. Ideally, the parents would be engaged in this process.

Where treatment fails to assist the child / family, a review is important and other referral options should be considered, including a second opinion from another clinician. Medication options should also be considered and discussed, including benefits and reported side effects.

Types of Treatment

Biological Treatments

The biological treatments commonly used in adult psychiatry have little place in child and adolescent services. There is no indication for ECT (with a possible exception for catatonic psychotic states), no evidence for the use of Transcranial Magnetic Stimulation, and minimal usefulness of medication. Mood stabilizer medication is only relevant after a diagnosis of bipolar disorder has been established, which is generally not until adulthood.

A trial of anti-depressant medication is reasonable for cases that have strong physiological symptoms and are poorly responsive to psychosocial interventions. The important physiological symptoms are sleep disturbance, appetite disturbance, weight loss, anergia (loss of energy and motivation) and anhedonia (loss of pleasure in life). If used, it is a component in a case management plan, avoiding any message that "problems are solved by pills". *A*n adequate trial of an antidepressant should be a minimum of three weeks at the recommended therapeutic dose. If no improvement is apparent, the use of medication should be re-considered (rather than increasing dosage or switching to alternative anti-depressants, as is usually done with adult patients).

Psychological Treatments

Cognitive Behavioural Therapy
Relationship-based therapy
Family therapy

There is little evidence for differential effectiveness of various relationship-based psychotherapies. The relationship between therapist and patient is the primary therapeutic factor. There is strong clinical consensus that treatment is best guided by well-trained therapists using an evidence-based treatment manual, tailored to the individual patient, and with proper attention to the therapeutic relationship.

Social Treatments

Family psychoeducation
Family/friends
Formal support groups
Community groups
Caregivers
Schooling/ employment/ housing

Lifestyle Treatments

There is evidence that lifestyle issues can adversely affect the onset, severity and duration of depression and, conversely, can play a role in ameliorating depression. A discussion with patients about lifestyle issues can assist overall engagement with care and help build rapport. This is not telling them what to do, but exploring with them the meaning of the issue and what would empower them to get the best outcome for themselves. Personal cleanliness, grooming, diet and exercise are closely related to their mastery of their circumstances as well as being central to self-image.

The discussion issues could include Diet, Exercise, Smoking cessation, Alcohol cessation, Ceasing drugs, Sleep.

If done within a family context such discussions have a high risk of derailment from personal development into authority and control battles. However, with care, such discussions could assist both personal development and family functioning.

Clinical Management of Bipolar Disorder

Compared with major depressive disorder, bipolar disorder is more complex and difficult to treat. Although rarely seen before adulthood, manic symptoms can occur within depression as mixed features, and with increasing severity from hypomania and mania through to mania with psychosis. The pharmacotherapy of mania involves treatment with anti-manic agents. The fundamental goals of such medications are to reduce arousal, agitation and aggression, and begin the process of treating core manic symptoms including behavioural disturbances and psychosis, if it is present.

In long-term treatment, it is important to maintain euthymia and only if this can be ensured should a gradual reduction of medication dosage be considered along with withdrawing medication to achieve monotherapy. Maintaining compliance and ensuring adequate adherence to treatment instructions is extremely important. The main goal of maintenance treatment is to prevent future episodes of illness (recurrence) and enhance resilience. In practice, even with optimal treatment, complete prophylaxis is seldom achieved; therefore, subsidiary goals warrant consideration. These include reducing the number, intensity and length of episodes and achieving functional mood stability with fewer inter-episode subsyndromal symptoms.

Clinical Management of Major Depressive Disorder

In mild to moderate episodes of MDD, psychological management alone may be adequate, especially early in the course of illness. However, episodes of greater severity, and those that run a chronic course, are likely to require the addition of antidepressant medication, or some other combination of psychological and pharmacological treatment. In severe episodes of MDD pharmacotherapy is typically needed and, where there is a high risk of suicide or when the patient's welfare is threatened hospitalization is sometimes necessary.

Where children do not respond well or sufficiently to psychological treatments, and medication is needed, it is important to review the language for the need for medication. Many young people resist medication, seeing this as evidence they are "not normal" and "can't cope" without pills. Also, after taking medication for a while and feeling better they often decide "they don't need it any more" and stop or vary the dosage. This can be difficult for parents and for clinicians. Often parents don't know their children have not been complying with medication until there is a change of behavior or reversion to old behaviours. This can lead to request for increased dosage etc.

When medication is prescribed, the conversation with the child and the family is important, in terms of psychoeducation for child and parents. Best outcome will be where the child has ongoing therapeutic relationship where s/he can feel free to discuss changes s/he might want to make, perhaps including monitoring or rating his/her symptoms. A therapeutic relationship with parents is also helpful, assisting them to monitor their child's symptoms and to discuss any concerns. Battles between parents and children around taking medication should be avoided.

Children and families also need psychoeducation about interactions between psychotropic medications and substance usage.

Notes from:
Gin S Malhi et al. "**R**oyal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders" *Aust.NZ J Psychiat.* 2015:49 (12) 1-185.

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