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.

Where children have mental health problems, parents are involved in the process of noting the symptoms, probably working with schools, identifying appropriate treatment options and monitoring and reviewing the treatment. Guidelines for selecting, monitoring and reviewing appropriate treatments are set out below. In a general sense treatment is successful when symptoms abate and/or the child or adolescent is able to continue or resume daily living activities. Clarifying what type of treatment is best and what to do when one treatment doesn't work can be challenging.

Parents can be engaged in a psychoeducation model, where the treating practitioner will meet with the parent/s occasionally to update and seek feedback but the work will be mainly done with the child. Such meetings will be with the child's knowledge and preferably consent. Parent/s can be important in learning strategies to manage their children's symptomatic behaviour, as well as developing a narrative in the family for the behaviour.

Another model which includes parents is family therapy, where the family is the client. Reviews of effective use of family therapy include Carr (2000), Evidence based practice in family therapy and systemic consultation 1> Child focused problems *Journal of Family Therapy* 22: 29-60; Cottrell and Boston (2002) Practitioner review: the effectiveness of child and family therapy for children and adolescents. *J Child psychology and psychiatry* 43(5), 573-586. Many papers document the effectiveness of family therapy models with eating disorders and school refusal in particular.

Context is important when identifying symptoms or changes in behaviour in children.

1. **Family stress** and/or illness is an example. When one or both parents are in a high stress situation, they are struggling to cope with the stress. Therefore, it is difficult to be aware of the child's stress and patterns of coping, thereby, usually unwittingly, creating emotional distance, being unable to identify the child's stress

and to assist the child. Common examples of this type of family stress include parents fighting and separating, family violence, financial stress and/or unemployment, illness in any family member, stress associated with caring responsibilities e.g. with aged parents or unwell person, migration, homelessness, post-natal depression.

2. **School / social issues** is another common example. These can be grouped in two broad categories
    a. Social / bullying concerns, where the child is uncomfortable in the social school community, feels alone and perhaps bullied, either by teachers or students.
    b. Academic performance issues, where the child feels or is made to feel s/he is underperforming at school. Often these issues require assessment to clarify whether there are learning patterns contributing to the performance issues and appropriate help to be given to the child and teachers. Learning difficulties often present as bad behaviour because the child does not understand why s/he is not like the others. ADHD and ASD are also in this category of context.

PE6a (ix) Behavioural and Relationship Disorders

This section will consider child and adolescent behavioural disorders and family relationship problems but not Juvenile Justice issues which are considered in PE3c ii.

A child's social development, like all other aspects of development, occurs primarily within a family context. Healthy nurturance by caregivers provides positive reinforcement for socially acceptable behaviours. Socially unacceptable behaviours are shaped by withdrawal of positive reinforcement and introduction of negative reinforcements. Along with this social learning there is a process of physiological maturation which underpins impulse control, affect regulation, planfulness, awareness of consequences and the differences between self and others. Secure attachment enables empathy and consideration for others to take priority over self-gratification. Insecure children have difficulty with these executive functions and require more positive reinforcement of acceptable behaviour and more systematic management.

Social learning is not a one-way process. One person's behaviour shapes another's whilst the latter's shapes the former's. A central task is to objectively view events to understand how behaviours are being reinforced. Understanding the "meaning" of behaviours enables a systematic change in what reinforces their continuation and what alternative reinforcement can produce more adaptive behaviour. This is as equally applicable to adult-adult communication as it is to adult-child.

The adult-adult principles are outlined in the following notes from the Relationships Australia website, found on https://www.relationships.org.au Many of these principles apply in families, parenting, sibling and friendship patterns.

> Some conflict in relationships is inevitable, but there are ways to handle it so it is not destructive to you individually or within family and social relationships. Relationships can become stronger if you can talk about differences and stress as a normal part of their relationship. Conflict can often be resolved and serious matters dealt with through respectful communication and a bit of give and take.
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> The key questions are:
> - how can you manage not to hurt each other or your relationship when you have a row? and
> - how can you learn from the conflict?
>
> Avoiding conflict, or agreeing not to talk about the issue that caused the conflict, might provide short-term peace. However, it's better to sort out important relationships issues. Conflict is a symptom – if you patch things up without finding out what's at the bottom of your differences, you'll probably find yourselves in conflict again.

People who express their anger without restraint often claim that their anger takes over, and that they can't help their actions. It may feel as if anger is beyond your control, but in reality everyone can learn to control their response to anger.

Physical violence in intimate and family relationships is a serious criminal offence and is never acceptable as a response to conflict or provocation. If you feel unsafe, it is essential you get help. Get away if it is safe to do so, or call for help. Police Emergency 000

If you find you are getting worked up and starting to argue, there are things you can do to prevent things getting out of hand:

- if you are angry, it's usually better to say so, rather than pretend you are not. Admitting to feelings of anger helps to get it out into the open, so you can address the problem
- a verbal attack on another when you are angry is unlikely to help the situation
- it's ok to ask for 'time out' and encourage the other to do the same if either of you feels too angry or upset to talk about the problem. When you are calmer you can come back and try to sort things out
- often there is something underneath the anger. It could be sadness, hurt, disappointment, or a sense of being let down or taken for granted. The underlying feeling will usually be a clue to the real issue that you and your partner need to work through
- you might both have to back down a bit and make changes. There may be an angle on the situation that you haven't considered. Compromising is not a sign of weakness, it's part of the give and take needed in a relationship
- apologise when you are able to, though don't make your partner wait as a punishment. Saying sorry doesn't mean you are accepting all the responsibility
- remember that the other did not 'make you angry'. He or she may have said or done something you didn't like, but *you* are angry - no-one forced you to feel that way. You can choose to learn how to react differently to things you don't like and be responsible for your own behaviour
- ask yourself what you can learn from the conflict. This could lessen the chances of a similar conflict happening again.

If you want to find out more about Relationships Australia courses that focus on managing anger phone 1300 364 277.

Similar principles underpin the management of child and adolescent behaviour disorders although the younger the child the lesser expectation of internalised controls and the greater reliance on adult-child power imbalance and capacity for limit-setting and application of positive reinforcements.

Childhood behavioural disorders occur commonly in primary school aged children but can also be seen in pre-school children. There are varying degrees of disruptive behaviour disorders recognised by mental health services, with varying degrees of seriousness of outcomes and responsiveness to intervention. The whole life trajectory of the young person is at risk. The spectrum ranges from:

- disruptive behaviour disorder,
- oppositional defiant disorder,
- conduct disorder, through to
- antisocial personality disorder.

Early behavioural problems may reflect poor socialisation or responses to stressful environments but may also include other clinically significant predispositions such as mood and anxiety disorders, attention deficit hyperactivity disorder or developmental disorders of autism spectrum or language processing which impair the child's capacity to meet expectations. It is important to undertake proper assessment of underlying difficulties.

In general, children with seriously disruptive behaviour have less satisfactory school progress and social relationships than children with normal behaviour. This tends to persist and result in poor educational outcomes, less stable partnerships, lower socio-economic levels and higher rates of involvement in welfare and justice systems.

Childhood behavioural disorders can significantly affect other members of the immediate and extended family. Teachers and parents can become frustrated, feel helpless and inadequate because they can't change the child's behavior and often feel that their children's behavior is a reflection of their poor parenting. Siblings can become embarrassed and ashamed of the behavior and reluctant to bring their friends home. Battles at school and home often ensue with blame by each party of the other – typically parents blame each other, the child, the school and the child feels unheard and without options to change his/her behaviour.

If the child's disruptive behaviours manifest in delayed development in one or more areas the psychologist is likely to assess cognitive function and developmental markers. This can be very important in identifying children who have learning disabilities which may be affecting their academic performance and their capacity to learn. Many children show behavioural difficulties in association with such delays in areas of functioning. If a learning disability is identified different ways of learning will be planned so that the child's strengths can be the focus. Children with Attention Deficit Hyperactivity Disorder (ADHD), a developmental disorder of the neurological impulse-control system, are at risk of developing disruptive behaviour disorders although this is a secondary complication of the underlying ADHD, not part of its syndrome. This pattern may also be relevant in Autism Spectrum Disorders.

Treatment plans may include psychoeducation for parents:

- to understand strategies that can be tried
- how to discuss these with their child
- monitoring success, with the child having an active role as much as possible
- working with the teacher /school as a partnership.

Cognitive behavioural interventions may be helpful with the child if the child is receptive and motivated, but not likely to succeed if the parents or teachers are wanting the child to do this but the child is not ready or open to this. Battles about behaviour should be avoided as far as possible.

Children with behavioural or relationship difficulties are likely to become more challenging in the context of family stress, notably poverty, relationship difficulties between parents, illness in the family, migration. Generally supporting the family to strengthen its relationship is important. Research shows that early intervention can have major beneficial effects in improving the outcome as compared to children who are not helped. In general, the earlier the intervention, and the less well-established the behavioural disturbance is at the time of intervention, the better the chance of satisfactory outcome.

A pilot program for children with disruptive behaviour has been trialled in some Victorian state primary schools with significant success. The program CASEA (CAMHS and schools early action) has been implemented in schools serviced by four metropolitan (Austin Health, Southern Health, Royal Children's Hospital, and Eastern Health) and four rural (Gippsland health, Bendigo Health, Ballarat Health, and North Eastern Health) mental health regions. The program involves a series of small group 'play sessions' in which the rules of social behaviour are explored and reinforced. The principles communicated in the sessions are carried over to the daily classroom activities. Concurrently, parent groups explore the principles of behaviour modification.

The research literature and results are published by the Mental Health Branch of the Victorian Health Department.

MHYFVic advocates that this proven initiative of preventive mental health should immediately be made available in **all** primary schools and that research be undertaken for possible implementation in pre-schools. The future costs to the community of a behaviourally-impaired life trajectory can be immense, and the savings by a favourable

improvement far outweigh the costs of the program. This is an extremely important health initiative not only because it can improve the life of individuals but also the lives of current and future families and friends.

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