BEST PRACTICE

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

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.

BP6a (i) Organic brain disorders

The general principles of clinical assessment and case planning mentioned in the preceding paragraph are modified in each of the subgroupings because of the need for specialist expertise in the management of specific disorders. This is described in the Project Evidence subsections.

An arbitrary categorisation separates disorders which are shown or presumed to reflect biologically-based abnormal brain processes from those functional disturbances without demonstrated brain abnormalities. 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.

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).

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. It is important because it is accompanied by risks such as pulling out of IV lines and catheters, auto-detubation, stepping or falling out of bed etc. It may also lead to a post-traumatic stress disorder (PTSD).

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. There are various subtypes requiring specialist neurological assessment and management.

[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 10/2/2022