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

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

BP6a (ix) Behavioural and Relationship Disorders

Best practice in a specialist mental health service will include wholistic management involving child and caregivers together with collaborative support to relevant community partners such as schools. The assessment and case management will incorporate the principles outlined in PE4 and the range of therapeutic modalities necessary for such case management, such as family therapy, parent guidance (including behaviour modification) and child psychotherapies.

The mental health service will offer diverse responses to the spectrum of needs posed by:

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

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. 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 which seeks to empower them with understanding of strategies which can be tried to help the child and how to discuss these with their child if relevant and monitoring success again with the child having an active role if possible. Working with the teacher /school as a partnership will also be important.

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.

The CASEA (CAMHS and schools early action) program for children with disruptive behaviour has been implemented in some schools with significant success. 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.

[To go to Project Evidence BP6a close this file and go via Project Evidence Index]

[To go to Policy POL6a close this file and go via Policy Index]

Last updated 29/1/2022