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 (vi) Physiological 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. The subsections are:

- Eating disorders (Anorexia and Bulimia Nervosa),
- Sleep disorders,
- Toileting disorders (enuresis, encopresis),
- Sexual disorders (Gender Identity Disturbance),
- Attentional disorders (ADHD),
- Motor disorders (tics, stuttering).

EATING DISORDERS

EVIDENCE BASED TREATMENTS:

- Family-Based Treatment (FBT) / Maudsley Model For young people with Anorexia Nervosa
- Cognitive-Behavioural Therapy (CBT-E)
- Other treatment options for adults with Bulimia Nervosa and Binge Eating Disorder:
    - CBT-E (AN);
    - Specialist Supportive Clinical Management (SSCM) for AN;
    - Interpersonal Psychotherapy (BN)
    - Mindfulness based therapies (ACT; DBT),
    - Cognitive Analytic Therapy (CAT);
    - MANTRA;
    - Cognitive Remediation Therapy;
    - Motivational Enhancement Therapy (MET);
    - Schema Therapy;

    - Guided Self-Help

TREATMENT REFRRALS: PUBLIC/COMMUNITY

- Refer client based on MH Catchment area
- Child/Adolescent/Youth Mental Health Service (CAMHS) (CYMHS)
- Adult Mental Health Service (AMHS)
- Local Hospital / Emergency Department Acute paediatric/adult medical care
- Eating Disorders Victoria www.eatingdisorders.org.au
- Headspace •12-25 years

REFERRALS PRIVATE SECTOR (FEE FOR SERVICE)

- Eating Disorders Victoria (EDV)
    - Psychology Service, Abbotsford
    - Inpatient / Outpatient / Day Program Services
- The Melbourne Clinic, Richmond
- The Geelong Clinic
- Delmont Private Hospital, Glen Iris
- Private clinicians, Psychologists (APS), Dietitians (DAA)
- Mindful Moderate Eating Group (MMEG), Swinburne University School of Psychology, Hawthorn
- Clinic for Healthy Eating and Weight (CHEW), Australian Catholic University School of Psychology, East Melbourne
- Recovery is Possible for Everyone (RIPE) Group, Body Positive Australia, Hawthorn

A recommended reference for this topic is provided by the Royal Australian & New Zealand College of Psychiatrists clinical practice guidelines for the treatment of eating disorders Aust NZ J Psychiatry 2014 4:48:977.

Other information came from Eating Disorders Victoria. This group offers telehealth nurse, peer mentoring program, psychology and dietetics, education, primary health, support groups and stories of recovery.

SLEEP DISORDERS

Recommendations for healthy sleep usually include guidance across a wide range of activities such as adoption of a bedtime routine, consistent bedtime and wake time, a quiet, dark and cool bedroom, avoidance of caffeinated products, and daily physical activities. Healthy sleep practices are also a fundamental component of sleep education designed to prevent sleep problems from developing (primary prevention), to address poor sleep quality (secondary prevention), and to treat existing sleep disorders.

Healthy sleep practices are potential mediating factors between biological sleep needs and environmental circumstances which facilitate or impede sleep. For example, one of the most important elements of a healthy sleep practice is a regular sleep and wake schedule. A consistent bedtime and wake time helps to reinforce circadian rhythms and optimize the *sleep drive*, processes which are instrumental in regulating healthy sleep-wake cycles.

Another important aspect of healthy sleep practices involves ensuring adequate opportunity for sleep. While there is some variability in sleep needs across individuals, guidelines exist for recommended sleep amounts in children across different ages. When assessing individual sleep needs, it is important to also educate parents about clues which suggest that a child is not getting sufficient sleep (e.g., the child is difficult to wake in the morning or dozes off during the day).

The assessment of sleep and sleep disturbances in children (as well as in adults) is performed by means of subjective (i.e., based on reports by the child and/or parents, +/- rating scales) or, when needed, objective tools (i.e., neurophysiological tests such as polysomnography or infrared video). The latter are undertaken by specialist sleep disturbance programs in paediatric settings.

TOILETING DISORDERS

Enuresis

Assessment and a careful diagnosis are the bases for successful treatment – each subtype of enuresis and urinary incontinence responds best to its specific treatment. It is essential that organic causes of incontinence are ruled out. A paediatric and neurological assessment is recommended. At least one urinalysis (with a urine stick) is recommended to be sure that no signs of bacteriuria and manifest urinary tract infection are present.

Treatment should always be symptom-orientated, aimed at achieving continence (i.e., complete dryness). Primary psychotherapy for enuresis is not effective and not indicated. Comorbid disorders should be treated separately according to evidence-based recommendations. When there are several concurrent disorders, encopresis and constipation should be treated first because some children will stop wetting once these problems have been dealt with. Daytime incontinence should be treated first, as many children will stop wetting at night once the daytime problems have been treated.
A baseline period is recommended with a simple observation and recording of wet and dry nights over a period of 4 weeks. Children are asked to draw a symbol for wet and dry nights (clouds and suns, stars, etc.) in a chart and bring it to the next consultation.

Two main interventions are available: alarm treatment and pharmacotherapy. As alarm treatment is more effective and has the best long-term results, this should be the first line treatment if child and parent are motivated.

Encopresis

The assessment of children with encopresis should be as non-invasive as possible and should always include parents or other caregivers. For most children, a basic evaluation that can be conducted in many primary care settings is sufficient. If conducted correctly and empathically, the most relevant information will be gathered through the history.

A very useful chart is the Bristol Stool Chart. Seven types of stool forms are depicted ranging from "separate hard lumps, like nuts (hard to pass)" (type 1) to "watery, no solid pieces, entirely liquid" (type 7). The scale enables parents and children to identify the predominant type of stool easily and without lengthy descriptions. The course of treatment can also be monitored using this scale.

Each child should have a physical examination. If sonography is available, this can replace the rectal exam if no organic form or fecal incontinence is suspected. Other examinations are not routinely indicated – only if an organic type of fecal incontinence is suspected. It is important to avoid unnecessary and invasive investigations. Somatic causes are present in only 5% of children with chronic constipation, and 1% of children without, but must be ruled out.

Following assessment, children and parents are given detailed information on the subtype of encopresis. High fibre diet with ample fluids is recommended. Toilet training is initiated right from the start for both types of encopresis. A useful booklet for child and parents is "Beating Sneaky Poo", which can be viewed on the 'Library Resources' page of this website.

(a) For encopresis with constipation.

In children with *constipation*, toilet training is combined with laxatives: first *disimpaction*, then maintenance treatment. Disimpaction is necessary to evacuate fecal masses at the beginning of treatment. This can be performed rectally or orally. In rectal disimpaction, enemas are applied. An alternative is oral disimpaction with polyethylenglykol. Sufficient oral fluids are required for this osmotic laxative to be effective.

(b) For encopresis without constipation.

Toilet training is the main aspect of treatment, combined with psychotherapy. Laxatives are not indicated.

SEXUAL DISORDERS

Gender dysphoria is a clinical diagnosis and requires in depth and longitudinal evaluation of these youth. The evaluation of gender, in addition to the usual developmental and mental health evaluation of a child, needs to include a thorough chronological history of the child's gender expression and identity from parents and caregivers as well as a developmentally informed evaluation of the child's gender individually. The evaluator may use tools such as toys, books, drawing or playing materials to assist in the evaluation and gather information about behavior at school, with peers and at home. Several scales have also been developed to help with the assessment of gender nonconforming youth (The Utrecht Gender Dysphoria Scale, The Gender Identity/Gender Dysphoria Questionnaire for Adolescents and Adults, among others), though none of these alone can establish a diagnosis. Because inferior management can be harmful, it is essential for assessment and management to be undertaken only by reputable specialist services (such as the Royal Children's Hospital).

ATTENTIONAL DISORDERS

The diagnosis of ADHD is a clinical one, defined by the presence of a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with normal functioning or development. An important aspect of assessment is to exclude other disorders producing similar attentional problems. These include lead toxicity, frontal lobe impairments from Foetal Alcohol Syndrome or acquired brain injury, also some medical conditions such as thyrotoxicosis, fragile-X syndrome, and psychiatric conditions such as bipolar disorder and generalised anxiety disorder. The most common comorbid conditions in children are oppositional defiant disorder (ODD), conduct disorder (CD), intellectual disability, learning disorders, language disorders, sleep disorders, enuresis, developmental motor

coordination disorders, depressive and anxiety disorders, tic disorders, and autism spectrum disorders.

Best practice assessment clearly requires both paediatric medical appraisal and psychological appraisal. Equally, case management requires consideration of both domains. Medication alone, without psychological intervention, is malpractice.

MOTOR DISORDERS

Tic Disorders

The clinical assessment (see PE4) should include a thorough physical and neurological examination, including an EEG. The main purpose for this is to exclude other possible illnesses that could cause the symptoms. Psychoeducation involves providing detailed information to the relevant persons, in the case of young people this usually will involve parents and teachers.

Cognitive behavioural methods are the most effective psychotherapeutic intervention. This treatment should be administered by trained professionals well versed in the complexities of the disorder.

Stuttering

Stuttering is a clinical syndrome involving abnormal and persistent dysfluencies that result in the speaker's perception of a loss of control over speech, which is often accompanied by affective and behavioural reactions. Assessment should be undertaken by a specialist Speech Pathologist.

In general, speech therapy is used both to shape fluent speech and help the client to stutter with less tension, avoidance, and interruption of the flow of communication. Psychotherapy alone has not been shown to be an effective treatment for stuttering, but counselling is often helpful for overcoming the secondary effects of stuttering on self-concept, thoughts, and feelings.

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Last updated 10/2/2022