BEST PRACTICE

BEST PRACTICE 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.

BP6a (vii) Personality Disorders

Personality is the enduring pattern of social, emotional and behavioural traits that uniquely characterise each person. Personality disorders are enduring patterns which are maladaptive by deviating from cultural norms and causing distress and social disability. For communicative purposes these trait patterns are customarily clustered into a small number of recognisable types [Paranoid, Schizoid, Schizotypal, Antisocial, Borderline, Histrionic, Narcissistic, Avoidant].

In acknowledgment of the huge changes taking place during a young person's development, it has been customary to avoid stigmatising young people with diagnoses of personality disorder until beyond age 18. Nevertheless, many of the traits are firmly established before the age of 18. Early recognition of maladaptive traits and early treatment may be of major importance to the eventual outcome, irrespective of the formal use of the diagnostic category.

Two particular examples of patterns commonly seen in young people are Antisocial Personality Disorder and Borderline Personality Disorder.

ANTISOCIAL PERSONALITY DISORDER

'Externalising' childhood behavioural disorders are classified in a gradation from 'Disruptive Behaviour Disorder' to 'Oppositional-Defiant Disorder' and 'Conduct Disorder' before merging into the adult diagnostic category of 'Antisocial Personality Disorder'.

Although one half of conduct-problem children do not grow up to have antisocial personalities, the antisocial boys develop into adult men who are depressed, anxious, socially isolated, and have low-paid jobs. Thus, all conduct-disorder children warrant clinical attention.

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.

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. Children with Attention Deficit Hyperactivity Disorder (ADHD), a developmental disorder of the neurological impulse-control system, are at risk of developing disruptive behaviour disorders.

BORDERLINE PERSONALITY DISORDER

The main characteristics of BPD are instability and impulsivity, as described in PE6a(vii). The pattern of behaviour must be enduring, inflexible, pervasive across a broad range of personal and social situations and must cause significant impairment or distress.

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 include:

- Risk evaluation
- Mental state
- Level of psychosocial functioning
- Aims and motivation of the patient
- Social environment
- Comorbidity and
- Predominant symptoms.

The range of therapeutic modalities necessary for such case management includes family therapy, parent guidance (including behaviour modification) and child psychotherapies (including Cognitive Behavioural Therapies).

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