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. See PE6a(ix) for a general outline of case management for young people.

BP6a (viii) Developmental Disorders and Intellectual Disability

The general principles of clinical assessment and case planning mentioned in the preceding paragraph are modified in the case of developmental disorders and intellectual disability because of the diverse range of specialist skills required for adequate management and the expectation of long-term shared involvement.

The additional principle is that management should be through a specialist multi-disciplinary team with capacity for continuity of care and ongoing partnership with the young person's family. The multi-disciplinary team should include contributions of specialists in all the relevant fields of the child's impairments (eg. Psychology, Speech pathology, Occupational therapy, Special education, etc).

INTELLECTUAL DISABILITY

The term 'intellectual disability' (ID) is defined as "a condition of arrested or incomplete development of the mind, which is especially characterized by impairment of skills manifested

during the developmental period, which contribute to the overall level of intelligence, i.e., cognitive, language, motor, and social abilities." (World Health Organization, WHO, 1992).

The etiology of ID is heterogeneous. It is an important part of assessment to ascertain the etiology. The immediate reason is to ensure that it is not a treatable ongoing cause (such as thyroid deficiency) that will further worsen if untreated. This generally requires a specialist paediatric medical assessment process.

On most occasions the developmental damage has been done and will remain unchanged and not specifically treatable. However, the impairment that produces a functional disability will result in a degree of handicap that is variable, depending upon management. It is a crucial part of assessment and management to minimise handicap and optimise developmental progress. Regardless of whether etiology can be treated, or even ascertained, a further important reason for diagnostic assessment is to add to the knowledge base about intellectual disability by which prevention and possible future treatment approaches may be promoted.

IQ measurement is mandatory in all cases in which ID is suspected. IQ should be measured using, if at all possible, widely accepted tests that have been standardized for the specific − or culturally similar − population. Widely used tests include the *Wechsler Intelligence Scale for Children* and the *Stanford-Binet Intelligence Scales*.

It is also useful to evaluate adaptive behaviour. To do that, professionals compare the functional abilities of a child to other children of similar age and education. There are many adaptive behaviour scales available, such as *Vineland Adaptive Behavior Scales* and *Adaptive Behavior Assessment System-II,* but an accurate assessment of children's adaptive behaviour requires clinical judgment as well.

Management

In all cases of ID, the crux of treatment is early detection and early intervention. The aim of treatment is to minimize symptoms and disability through reducing risk (e.g., helping individuals to be safe at home or school), teaching life skills, improve life quality and support families and carers. Detailed goals and modalities of treatment for each individual will largely depend on the cause and severity of ID and comorbid conditions.

The current trend is to educate children with ID as far as possible in normal rather than special schools (inclusive education). Whatever the approach, children with ID need education − even more so than other children − to maximize their development and chances in life. *Challenging behaviours* represent a wide range of problems that includes, among others, aggression, self-injury (such as head banging or ingestion or inhalation of foreign bodies), destroying objects, non-compliance, idiosyncratic habits (e.g., restricted range of foods), and socially inappropriate behaviour. These problems require specialist treatment programs within the educational and home settings as part of the case management plan. A further significant part of management should include measures to reduce stigma and discrimination.

AUTISM SPECTRUM DISORDERS

Autism spectrum disorder (ASD) refers to a neurodevelopmental condition defined by several behavioral features. The core clinical characteristics of ASD include impairments in two areas of functioning (social communication and social interaction), as well as restricted, repetitive patterns of behavior, interests or activities. These symptoms are present in the early developmental period but may not be fully manifest until social demands exceed the child's limited capacities or may be masked by learned strategies in later life. Despite its early unfolding, this condition is not necessarily diagnosed until a few years later.

In addition to the notes in PE6a(viii) there is a discussion in PE3a(ii) about Developmental Disorders including Autism Spectrum Disorders indicating that research has gradually changed the necessary and sufficient diagnostic criteria over the decades since initial description in scientific literature. The changed criteria have resulted in a greater acknowledged prevalence, about 1% of the child population. This increased identification of this disorder, its emotional impact on families and the challenging financial demands associated with its treatment and support currently make ASD an important illness at the scientific, clinic and public health levels.

The broad ranging patterns of functional impairments in ASD highlight the importance of careful clinical assessment by a multi-disciplinary team of the young person's strengths and limitations to arrive at optimal programs to maximise developmental progress in all domains.

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