BEST PRACTICE MODELS

BEST PRACTICE MODELS for Treatment of Mental Disorders

[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 service delivery facilities.

These are grouped under six headings: (1) anxiety disorders, (2) mood disorders, (3) substance abuse disorders, (4) behavioural and relationship disorders, (5) eating disorders, (6) psychotic disorders.

Where children have mental health problems, parents are involved in the process of noting the symptoms, probably working with schools, identifying appropriate treatment options and monitoring and reviewing the treatment. Guidelines for selecting appropriate treatments are set out below. In a general sense treatment is successful when symptoms abate and/or the child or adolescent is able to continue or resume daily living activities. Clarifying what type of treatment is best and what to do when one treatment doesn't work can be challenging.

Parents can be engaged in a psychoeducation model, where the treating practitioner will meet with the parent/s occasionally to update and seek feedback but the work will be mainly done with the child. Such meetings will be with the child's knowledge and preferably consent. Parent/s can be important in learning strategies to manage their children's symptomatic behaviour, as well as developing a narrative in the family for the behaviour.

Another model which includes parents is family therapy, where the family is the client. Reviews of effective use of family therapy include Carr (2000), Evidence based practice in family therapy and systemic consultation 1> Child focused problems Journal of Family Therapy 22: 29-60; Cottrell and Boston (2002) Practitioner review: the effectiveness of child and family therapy for children and adolescents. J of child psychology and psychiatry 43(5), 573-586….. many papers document the effectiveness of family therapy models with eating disorders and school refusal in particular.

Context is important when identifying symptoms or changes in behaviour in children.

1. **Family stress** and/or illness is an example. When one or both parents are in a high stress situation, they are struggling to cope with the stress. Therefore, it is difficult to be aware of the child's stress and patterns of coping, thereby, usually unwittingly, creating emotional distance, being unable to identify the child's stress and to assist the child. Common examples of this type of family stress include parents fighting and separating, family violence, financial stress and/or unemployment, illness in any family member, stress associated with caring responsibilities eg with aged parents or unwell person, migration, homelessness, post-natal depression.
2. **School / social issues** is another common example. These can be grouped in two broad categories
    a. Social / bullying concerns, where the child is uncomfortable in the social school community, feels alone and perhaps bullied, either by teachers or students.
    b. Academic performance issues, where the child feels or is made to feel s/he is underperforming at school. Often these issues require assessment to clarify whether there are learning patterns contributing to the

performance issues and appropriate help to be given to the child and teachers. Learning difficulties often present as bad behaviour because the child does not understand why s/he is not like the others. ADHD and ASD are also in this category of context.

BP6a (i) Anxiety Disorders,

The Royal Australian and New Zealand College of Psychiatrists and *the Australian Psychological Society* provide information and clinical practice guidelines for the treatment of anxiety disorders in children. The guidelines set out below are an amalgam of information put out by these two groups.

Childhood anxiety disorders involve excessive fear or anxiety that differs from normal developmental fears through its intensity or persistence beyond the appropriate developmental period. The fears or anxiety can be manifest by physical symptoms of distress (headaches, stomach aches, skin disorders), perfectionism, excessive reassurance seeking, great difficulty dealing with change, nightmares and difficulty going to sleep at the beginning of the night. Anxiety disorders in children can include separation anxiety disorder, specific phobias, social anxiety disorder and generalised anxiety disorder, and can also lead to school refusal.

Anxiety disorders in children have an ongoing, pervasive and negative impact on relationships, family life and school adjustment. Anxious children develop a pattern of avoidance of many family and school activities, which prevents them from enjoying developmentally appropriate activities. Many of the anxiety disorders that develop in childhood will persist into adulthood if not treated.

Various published studies have reported that one in five children and adolescents are identified with a range of elevated symptoms of anxiety throughout development.

Cognitive behavioural therapy (CBT) aimed at teaching children to identify and regulate their emotions is the gold standard for treating anxiety. However, when working with children it is essential that these skills are delivered in a developmentally appropriate way. Play therapy techniques and parenting skills training are highly valuable in ensuring children are engaged and understanding skills, and parents have the knowledge to reinforce coping at home. There are specific treatment components to give skills to families and teachers in order to maximise positive treatment gains. Both individual and group formats have proven to be effective, with the key target of normalisation, rather than stigmatisation, being emphasised in both formats.

Key targets for CBT treatments should include: increasing self-awareness; promoting empathy skills; relaxation skills and self-management training; mindfulness and attention training; challenging and replacing unhelpful thinking; increasing positive coping role models and support networks; building step plans and exposure exercises; problem-solving skills training; friendship skills; and maintenance and generalisation of skills. (Barrett 2014).

Where children are exhibiting anxiety symptoms it is important for parents to be involved in the process. It is increasingly documented that anxiety patterns run in families and where there is an anxious child it is likely that others in the family also have had to manage anxiety. Involving parents in the process of helping their children can be very reassuring for everyone in the family if it is done compassionately and cooperatively. The accepted wisdom is that anxiety is an instinct which is adaptive and that when it becomes clinically intrusive, needs to be managed rather than taken away. Management strategies for anxiety are a lifelong process and teaching them to children is important

Whilst initial treatment options for anxiety disorders are cognitive-behavioural therapy (face-to-face or delivered by computer, tablet or smart-phone application), cost and accessibility can be factors which hinder treatment.

Where access to these treatments is not possible and/or where the symptoms are severe and not responding to psychological treatments, pharmacotherapy (a selective serotonin reuptake inhibitor or serotonin and noradrenaline reuptake inhibitor together with advice about graded exposure to anxiety triggers), or the combination of cognitive-

behavioural therapy and pharmacotherapy can be offered. Whilst results of medication can be effective in terms of reduction of symptoms and enhanced capacity for daily living activities, review of side effects and plans to reduce of cease medication over a period of time are important.

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Andrews, Gavin et al., Australian & New Zealand Journal of Psychiatry 2018, Vol. 52(12) 1109-1172 DOI: 10. 1177/0004867418799453

Barrett,P. "Treatment guidance for common mental health disorders: Childhood anxiety disorders" InPsych 2014, Vol 36, October, Issue 5.

BP6a (ii) Mood Disorders,

Bipolar Disorder

The purpose of treatment is to protect the patient and others from the adverse effects of the illness while actively relieving distress and treating the core symptoms of the disorder, which comprise acute symptoms of mania, behavioural disturbance and cognitive disturbance.

Acute mania is a medical emergency, and often necessitates use of mental health legislation. Care should be provided in a low stimulus environment with support from health professionals. Treatment usually requires short-term use of a combination of benzodiazepines and antipsychotics, but delirious mania and mania with catatonic features (not attributable to an organic cause) also respond particularly well (and promptly) to ECT.

The pharmacotherapy of mania involves treatment with anti-manic agents. The fundamental goals of such medications are to reduce arousal, agitation and aggression, and begin the process of treating core manic symptoms including behavioural disturbances and psychosis, if it is present.

In long-term treatment, at the transition from acute treatment to continuation treatment it is important to begin withdrawal of adjunctive agents such as benzodiazepines that have been used to manage acute behavioural and cognitive disturbance associated with a mood episode.

The main goal of maintenance treatment is to prevent future episodes of illness (recurrence) and enhance resilience. In practice, even with optimal treatment, complete prophylaxis is seldom achieved; therefore, subsidiary goals warrant consideration. These include reducing the number, intensity and length of episodes and achieving functional mood stability with fewer inter-episode subsyndromal symptoms.

Major Depressive Disorder

In mild to moderate episodes of MDD, psychological management alone may be adequate, especially early in the course of illness. However, episodes of greater severity, and those that run a chronic course, are likely to require the addition of antidepressant medication, or some other combination of psychological and pharmacological treatment. In severe episodes of MDD pharmacotherapy is typically needed and, where there is a high risk of suicide or when the patient's welfare is threatened by a lack of nutrition or fluid intake, urgent intervention is sometimes necessary and may include electroconvulsive therapy (ECT).

There is consensus that CBT is as effective as antidepressant medication for depression of mild- moderate severity. However, if there is minimal response within a reasonable period of time, then pharmacotherapy should be

considered. Depending on the severity and symptom profile of the depressed patient, psychological treatment may be best administered after initiating pharmacotherapy, and in this context clinical features such as melancholic features that may predict better response to SSRIs than CBT should be taken into consideration.

It is recommended that some form of psychological intervention (at a minimum, psychoeducation) accompany pharmacotherapy whenever possible because sometimes where medications produce response but do not achieve remission, the addition of psychological interventions may enable remission.

BP6a (iii) Substance Abuse Disorders

if you are using substances to cope with life or escape personal problems, find other ways to manage the situation and deal with life's stress and pressures. By dealing with other problems in your life you can make it easier to recover and not relapse. Manage and treat substance misuse and addiction through counselling, medication, rehabilitation centres, self-help programs or support networks.

Two online sources of information and treatment options are:

https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services

https://www.lifeline.org.au

PE6a (iv) Behavioural and Relationship Disorders

There are varying degrees of disruptive behaviour disorders recognised by mental health services, with varying degrees of seriousness of outcomes and responsiveness to intervention. The whole life trajectory of the young person is at risk. The spectrum ranges from disruptive behaviour disorder, oppositional defiant disorder, and conduct disorder through to antisocial personality disorder. Early behavioural problems may reflect poor socialisation or responses to stressful environments but may also include other clinically significant predispositions such as mood and anxiety disorders, attention deficit hyperactivity disorder or developmental disorders of autism spectrum or language processing which impair the child's capacity to meet expectations. It is important to undertake proper assessment of underlying difficulties.

A CASEA (CAMHS and schools early action) program for children with disruptive behaviour has been trialled in some Victorian state primary 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. The future costs to the community of a behaviourally-impaired life trajectory can be immense, and the savings by a favourable improvement far outweigh the costs of the program. This is an extremely important health initiative not only because it can improve the life of individuals but also the lives of current and future families and friends.

Relationship difficulties are discussed on the Relationships Australia website, found on
https://www.relationships.org.au

Some conflict in relationships is inevitable, but there are ways to handle it so it is not destructive to you individually or as a couple. Relationships can become stronger if partners can talk about differences and stress as a normal part of their relationship. Conflict can often be resolved and serious matters dealt with through respectful communication and a bit of give and take.

The key questions are

- how can you manage not to hurt each other or your relationship when you have a row? and
- how can you learn from the conflict?

Avoiding conflict, or agreeing not to talk about the issue that caused the conflict, might provide short-term peace. However, it's better to sort out important relationships issues.

Conflict is a symptom – if you patch things up without finding out what's at the bottom of your differences, you'll probably find yourselves in conflict again. If you want to find out more about Relationships Australia courses that focus on managing anger phone 1300 364 277.

BP6a (v) Eating Disorders

Anorexia Nervosa

The Clinical Practice Guidelines recommend treatment as an outpatient or day patient in most instances (i.e. in the least restrictive environment), with hospital admission for those at risk of medical and/or psychological compromise. A multi-axial and collaborative approach is recommended, including consideration of nutritional, medical and psychological aspects, the use of family based therapies in younger people and specialist therapist-led manualised based psychological therapies in all age groups and that include longer-term follow-up. A harm minimisation approach is recommended in chronic AN.

Bulimia Nervosa and **Binge Eating Disorder**

The Clinical Practice Guidelines recommend an individual psychological therapy for which the best evidence is for therapist-led cognitive behavioural therapy (CBT).
There is also a role for CBT adapted for internet delivery, or CBT in a non-specialist guided self-help form. Medications that may be helpful either as an adjunctive or alternative treatment option include an antidepressant, topiramate, or orlistat (the last for people with comorbid obesity).

Avoidant restrictive food intake disorder (ARFID)

No specific treatment is recommended for ARFID as there are no trials to guide practice.

BP6a (vi) Psychotic Disorders

Before the emergence of positive psychotic symptoms most people show a prolonged period of symptoms and increasing disability. This 'prodrome' or 'at-risk mental state' is associated with evidence of changes in brain structure. The potential benefits of identifying and proactively treating individuals at risk of psychosis are significant because much of the psychosocial disability that becomes entrenched in the subthreshold period, prior to First Episode Psychosis, is difficult to reverse even when the core symptoms remit with effective treatment.

FEP is defined as one week or more of sustained positive symptoms above the psychosis threshold for delusions and hallucinations in particular. The purposes of early intervention in FEP are to ensure the safety of the young person and others, to reduce the duration of untreated psychosis as much as possible and to preserve and restore function, thereby reducing the disability associated with psychotic illness. Management of FEP requires a holistic, systematic approach which involves a comprehensive range of pharmacological and psychosocial interventions.

A significant proportion of people who have one episode of psychosis will go on to have more episodes or continuing disability. It is essential that high-quality, intensive care is continuously and assertively provided during this period. Recovery from an acute relapse can take longer than after the initial episode.

Interventions essential to community-supported recovery include supporting people in early prodromal or symptomatic stages, responding quickly to requests for assistance, providing meaningful support, planning together with individuals and carers, listening to family members, facilitating connections with peer support networks and professional advocates, ready access to suitable facilities and helping people stay in their own accommodation.

Antipsychotic medicines treat the symptoms of schizophrenia but not its underlying causes. In the absence of new treatments, these medicines remain the cornerstone of both acute and maintenance therapy for schizophrenia. All antipsychotic medicines derive their effect on positive symptoms of psychosis from the blocking of dopamine receptors.

Families of people with schizophrenia experience tremendous distress, grief and chronic day-to-day stress, which can be extreme and result in significant risks to their health and wellbeing. These issues have generally been neglected by services and by many health professionals - yet effective support for families is crucial, since for many people with schizophrenia, survival and recovery depend on their family relationships.

Notes from:

Galletly, C. et al. “RANZCP clinical practice guidelines for the management of schizophrenia and related disorders” ANZ J Psychiat 2016 : 50 (5): 1-117.

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