Child Mental Health CoP Session 2: Aggressive and challenging behaviours

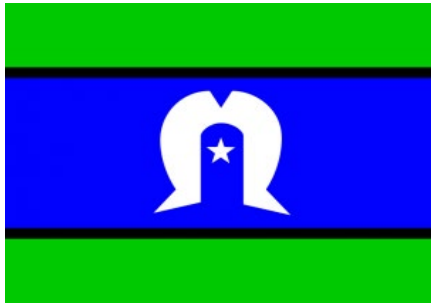
Tuesday 28 May 2024

The content in this session is valid at date of presentation

Acknowledgement of Country

North Western Melbourne Primary Health Network would like to acknowledge the Traditional Custodians of the land on which our work takes place, The Wurundjeri Woi Wurrung People, The Boon Wurrung People and The Wathaurong People.

We pay respects to Elders past, present and emerging as well as pay respects to any Aboriginal and Torres Strait Islander people in the session with us today.

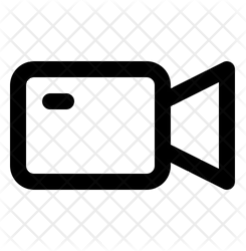


CoP guidelines
We agree to…

Stay on **mute** unless speaking

Raise your **hand** to speak

Keep conversations **confidential**



If possible, keep **camera on**

Introduce yourself and your role when speaking

Share **ideas** & promote everyone's **participation**

Acknowledge that we have **varied learning needs & interests**

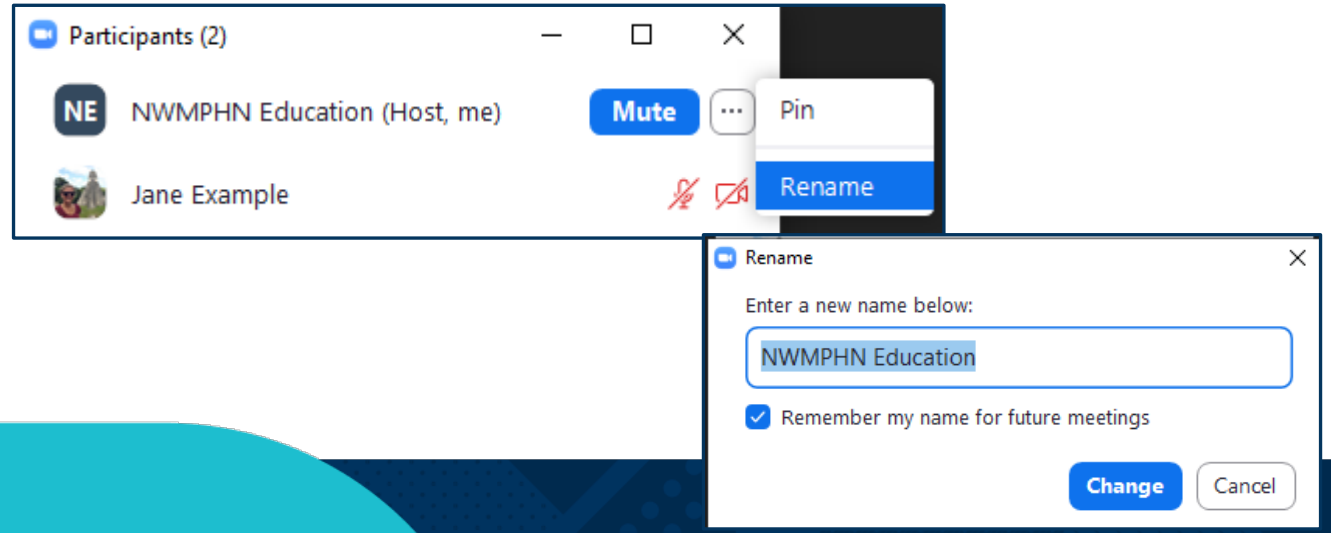
Ask **questions**

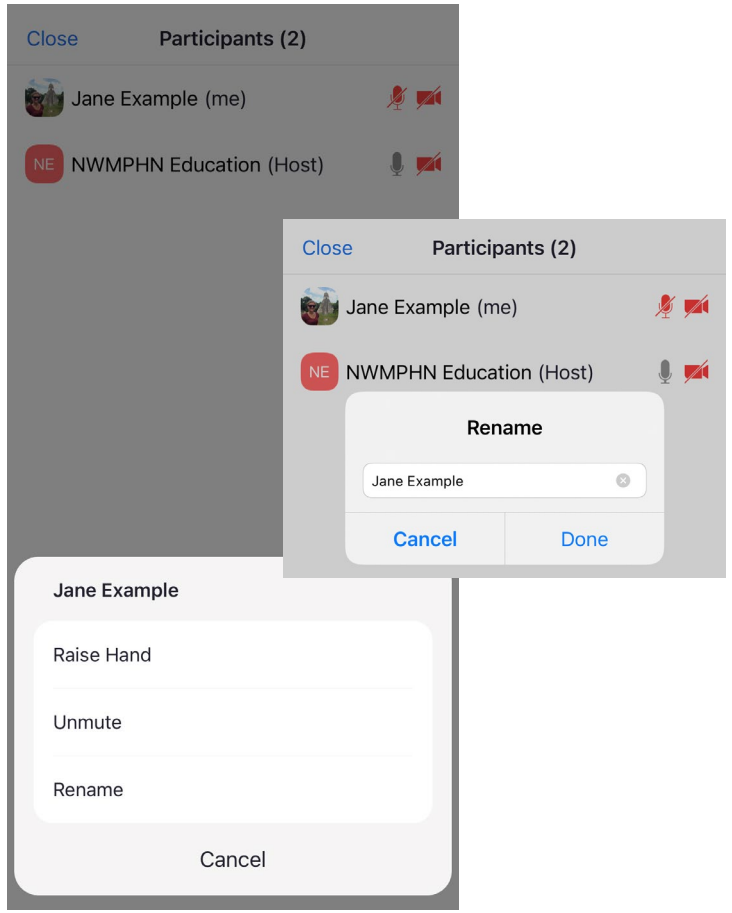
No question is silly

Please ensure you join the session using the same name you registered with and add your role next to your name

How to change your name in Zoom Meeting

1. Click on ***Participants***
2. **App:** click on your name
   Desktop: hover over your name and click the 3 dots
   Mac: hover over your name and click *More*
3. Click on ***Rename***
4. Enter the name you registered with and click
   Done / Change / Rename





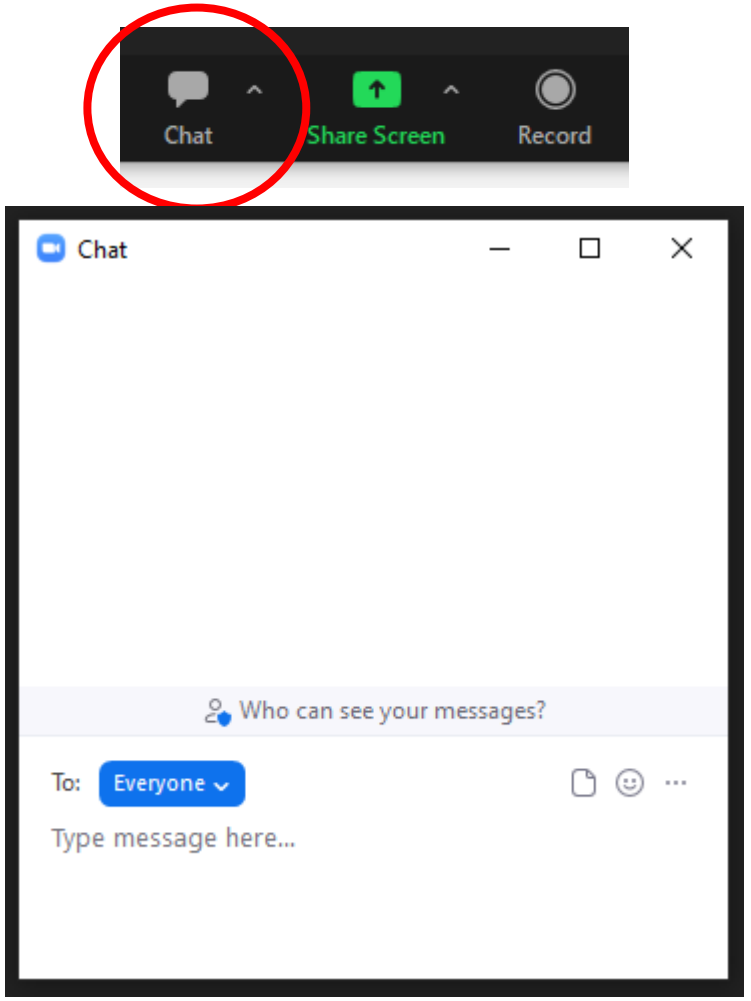
Housekeeping – Zoom Meeting

During the education component, please ask questions via the Chat box

This session is being recorded

Please ensure you join the session using the name you registered with so we can mark your attendance

Certificates and CPD will not be issued if we cannot confirm your attendance



Psychiatrist – Dr Chidambaram Prakash

- Dr Chidambaram Prakash is a senior consultant child and adolescent psychiatrist at the RCH with over 20 years' experience.
- Prakash has worked in, and managed, general and specialist clinics within child psychiatry in metropolitan and regional public mental health services.
- Prakash has worked with children and adolescents from 4 to 18 years of age assessing and managing a variety of mental health issues.

GP Facilitator - Dr Sahar Iqbal

- Practicing as a GP at Goonawarra Medical Centre for the past 11 years

- Sahar's areas of interest are child and adolescent mental health and chronic disease management

Agenda

Introduction and housekeeping	5 minutes
Education component: Aggressive and challenging behaviours *Psychiatrist Dr. Chidambaram Prakash*	30 minutes
Health Pathways	5 minutes
Case discussion Part 1 – Breakout room	15 minutes
Breakout room discussion	9 minutes
Case discussion Part 2 – Breakout room	15 minutes
Breakout room discussion	9 minutes
Conclusion	2 minutes

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Education component: Violence and aggression – a brief look at assessment and management

CHIDAMBARAM PRAKASH

HealthPathways – Anxiety in Children and Adolescents

melbourne.healthpathways.org.au

What is Aggression?

- Behavior intended to injure another
  - It is behavior (not angry feelings)
  - It is intended (not accidental harm)
  - It is aimed at hurting (not assertiveness or playfulness)
- It could be directed at self-deliberate self harm or suicide

Is Aggression an Instinct?

Hundreds of years of debate

- Jean-Jacques Rousseau: We are naturally gentle - restrictive society makes us hostile
- Thomas Hobbes: We are brutes and only law and government can help us
- Freud: Supports Hobbes. Argued that we had a powerful death instinct known as Thanatos – leads to aggressive actions

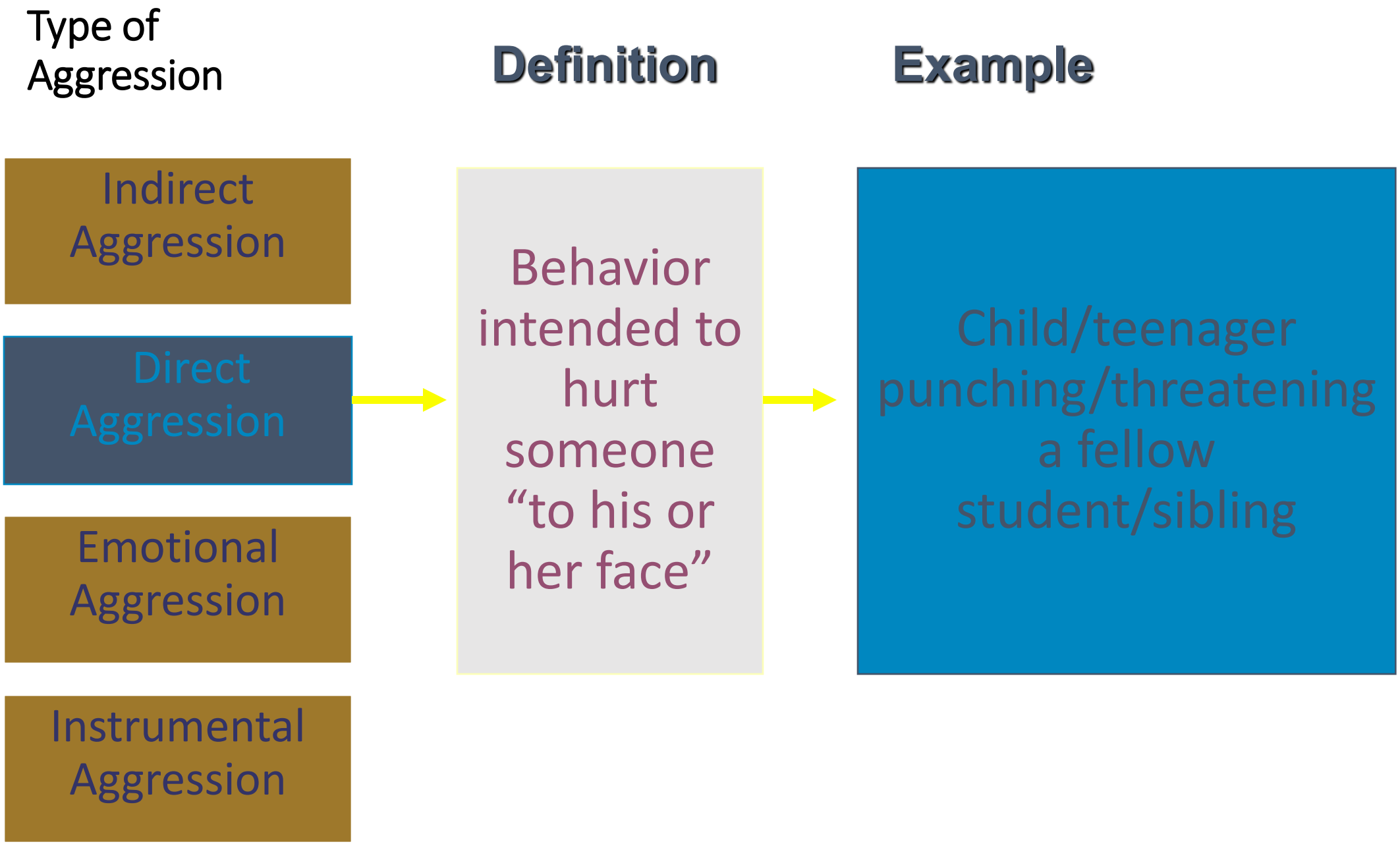
Freud and Aggression

- Believed that aggressive energy must be released – otherwise it builds up and causes illness.
  - A hydraulic theory
- Sublimation – society regulates this instinct. Helps people to turn destructive energy into useful behavior
  - E.g., danger seeking, competitive person becomes a race car driver

Evolutionary Arguments

- Lore and Schultz: argue that aggression has survival value.
  - However, most species seem to have developed inhibitory mechanisms that allow them to suppress aggression
  - Thus, aggression is an optional strategy
- Regional differences in aggression suggest “strategic” view of aggression

Type of Aggression	Definition	Example
Indirect Aggression	Attempt to hurt another without obvious face-to-face conflict	Spreading a false rumor that the child is being mistreated in school
Direct Aggression		
Emotional Aggression		
Instrumental Aggression		


Type of Aggression
Definition
Example
Indirect Aggression
Direct Aggression
Emotional Aggression
Instrumental Aggression
Behavior intended to hurt someone "to his or her face"
Child/teenager punching/threatening a fellow student/sibling

Type of Aggression

Definition

Example

Indirect Aggression

Direct Aggression

Emotional Aggression

Instrumental Aggression

Hurtful behavior that stems from angry feelings

A child displaying aggression after a painful procedure or being held in hospital

Type of Aggression

Definition

Example

Indirect Aggression

Direct Aggression

Emotional Aggression

Instrumental Aggression

→

Hurting another to accomplish another (non-aggressive) goal

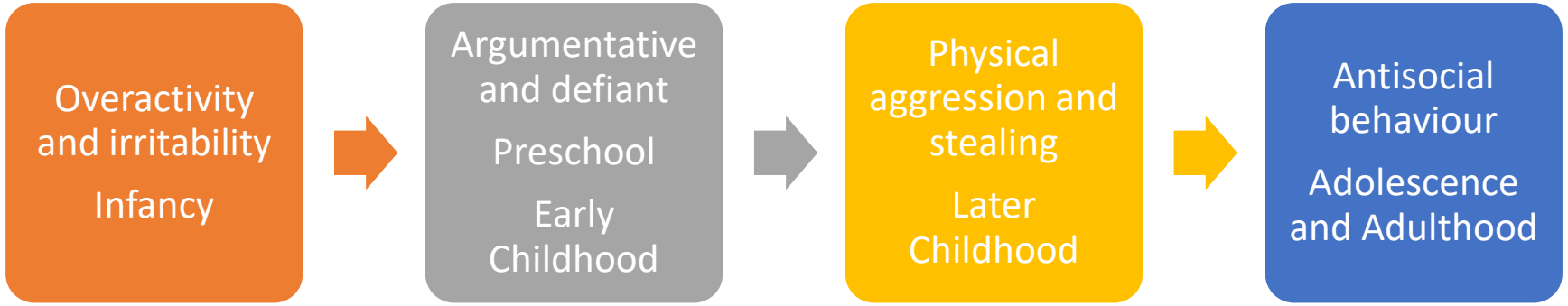
→

A child hitting out at staff at school or at the parents at home to avoid a punishment

A Cumulative Model for Understanding Aggression in hospital

- Genes
- Gender
- Social learning
- Cognitive Reasoning
- Illness & response
- Environment-hospital
- Some neurosciences findings

Progression over time



But there is desistance at every stage.

While virtually every case of childhood CD had earlier ODD, most of those with earlier ODD don't develop CD

While virtually every case of adult antisocial personality disorder (APD) had CD as a youth, most of those with CD don't develop APD

Around 10% of children with ODD eventually develop APD

Comprehensive assessment of children and young people with antisocial behaviour and conduct disorders

- A comprehensive assessment of a child or young person with a suspected conduct disorder should be undertaken by a health or social care professional who is competent to undertake the assessment and should:
  - offer the child or young person the opportunity to meet the professional on their own
  - involve a parent, carer or other third party known to the child or young person who can provide information about current and past behaviour
  - if necessary involve more than 1 health or social care professional to ensure a comprehensive assessment is undertaken.

NICE Guideline 158

Comprehensive assessment of children and young people with antisocial behaviour and conduct disorders

The standard components of a comprehensive assessment of conduct disorders should include asking about and assessing the following:

- core conduct disorders symptoms including:
    - patterns of negativistic, hostile, or defiant behaviour in children aged under 11 years
    - aggression to people and animals, destruction of property, deceitfulness or theft and serious violations of rules in children aged over 11 years
- current functioning at home, at school or college and with peers
- parenting quality
- history of any past or current mental or physical health problems.
    - learning difficulties or disabilities
    - neurodevelopmental conditions such as ADHD and autism
    - neurological disorders including epilepsy and motor impairments
    - other mental health problems (for example, depression, post-traumatic stress disorder and bipolar disorder)
    - substance misuse
    - communication disorders (for example, speech and language problems).

NICE Guideline 158

Comprehensive assessment of children and young people with antisocial behaviour and conduct disorders

- Assess the risks faced by the child or young person and if needed develop a risk management plan for self-neglect, exploitation by others, self-harm or harm to others.

- Assess for the presence or risk of physical, sexual and emotional abuse in line with local protocols for the assessment and management of these problems.

NICE Guideline 158

Comprehensive assessment of children and young people with antisocial behaviour and conduct disorders

- Conduct a comprehensive assessment of the child or young person's parents or carers, which should cover:
  - positive and negative aspects of parenting, in particular any use of coercive discipline
  - the parent–child relationship
  - positive and negative adult relationships within the child or young person's family, including domestic violence
  - parental wellbeing, encompassing mental health, substance misuse (including whether alcohol or drugs were used during pregnancy) and criminal behaviour.

NICE Guideline 158

Formulation-Risk Status factors

- **Risk status factors: Static factors:** *These factors cannot be changed during the episode of management/treatment*. *These are factors that increase the likelihood that this young person is more likely to be aggressive than others currently admitted to the ward.* They include:
- Forensic history with general offences, substance use history, history of violence whilst intoxicated or withdrawing from substances, history of violence when not affected by substances, male gender, a history of aggression, mental illness symptoms of psychosis, major depression, significant anxiety disorder, ADHD, Oppositional defiant disorder, conduct disorder, exposure to violence in peer groups, preoccupation with violence on TV or video games, antisocial peers, Low IQ, exposure to family violence.

Formulation-Risk State factors

Risk state factors: Dynamic factors: *These are the changeable factors: These are the factors that are like to indicate either 1. That the young person is more likely to be aggressive now than at any time in their past historical time periods i.e.: past 24 hours, 48 hours, 1 week, 2 weeks, 2 months, longer than 2 months OR 2. That they are likely to be at the same level of risk of being aggressive as the last time they displayed aggression*.

- The factors include:
- Ongoing symptoms of the underlying mental illness: e.g. 2nd person command auditory hallucinations urging the young person to harm others, paranoid and persecutory delusions, withdrawing from substances, remains unhappy and angry with being in hospital.

Formulation-Risk State factors-cont’d

Warning signs of impending aggression

- Huffing and puffing, Pacing up and down - rapid movements, Facial indicators: staring - frowning - rubbing forehead - reddened complexion, Raised voice, Aggressive body language/actions - pointing - clenched fists hitting things – throwing magazines, pens and other objects down in frustration, Words expressing threats - including swearing, Argumentative and belligerent - won’t follow advice of the adults. The following acronym ‘S.T.A.M.P.’ can be used to best describe the behaviours exhibited by a person who is becoming agitated and potentially aggressive and violent:
- S - STARING -prolonged glaring at staff
- T - TONE -sharp, sarcastic, loud, argumentative
- A - ANXIETY -flushed face, heavy breathing, rapid speech, reaction to pain
- M - MUTTERING -talking under breath, criticising staff to self or others, mimicking staff
- P - PACING -walking around in confined space, walking into areas that are off limits

Formulation- Protective factors and available resources

- *<u>These are factors that are likely to decrease the risk of aggression</u>*
- Individual factors: Female gender, High IQ, intolerance towards deviant behaviours, positive social orientation, Family factors: close relationship with parents, warm supporting parental stance, an absence of violence in the family, absence of criminal history. Peer and social factors: Prosocial peers, peers who have a commitment to the rule of law, to learning and education.
- Response to medications: Improvement in psychosis, improvement in arousal regulation in a child or adolescent with a Neurodev disorder and reduction of symptoms that fuelled the aggression,

Care Plan

- Develop a care plan with the child or young person and their parents or carers that includes a profile of their needs, risks to self or others, and any further assessments that may be needed.
- This should encompass the development and maintenance of the conduct disorder and any associated behavioural problems, any coexisting mental or physical health problems and speech, language and communication difficulties, in the context of:
  - any personal, social, occupational, housing or educational needs
  - the needs of parents or carers
  - the strengths of the child or young person and their parents or carers.

NICE Guideline 158

Identifying effective treatment and care options

- When discussing treatment or care interventions with a child or young person with a conduct disorder and, if appropriate, their parents or carers, take account of:
  - their past and current experience of the disorder
  - their experience of, and response to, previous interventions and services
  - the nature, severity and duration of the problem(s)
  - the impact of the disorder on educational performance
  - any chronic physical health problem
  - any social or family factors that may have a role in the development or maintenance of the identified problem(s)
  - any coexisting conditions.

NICE Guideline 158

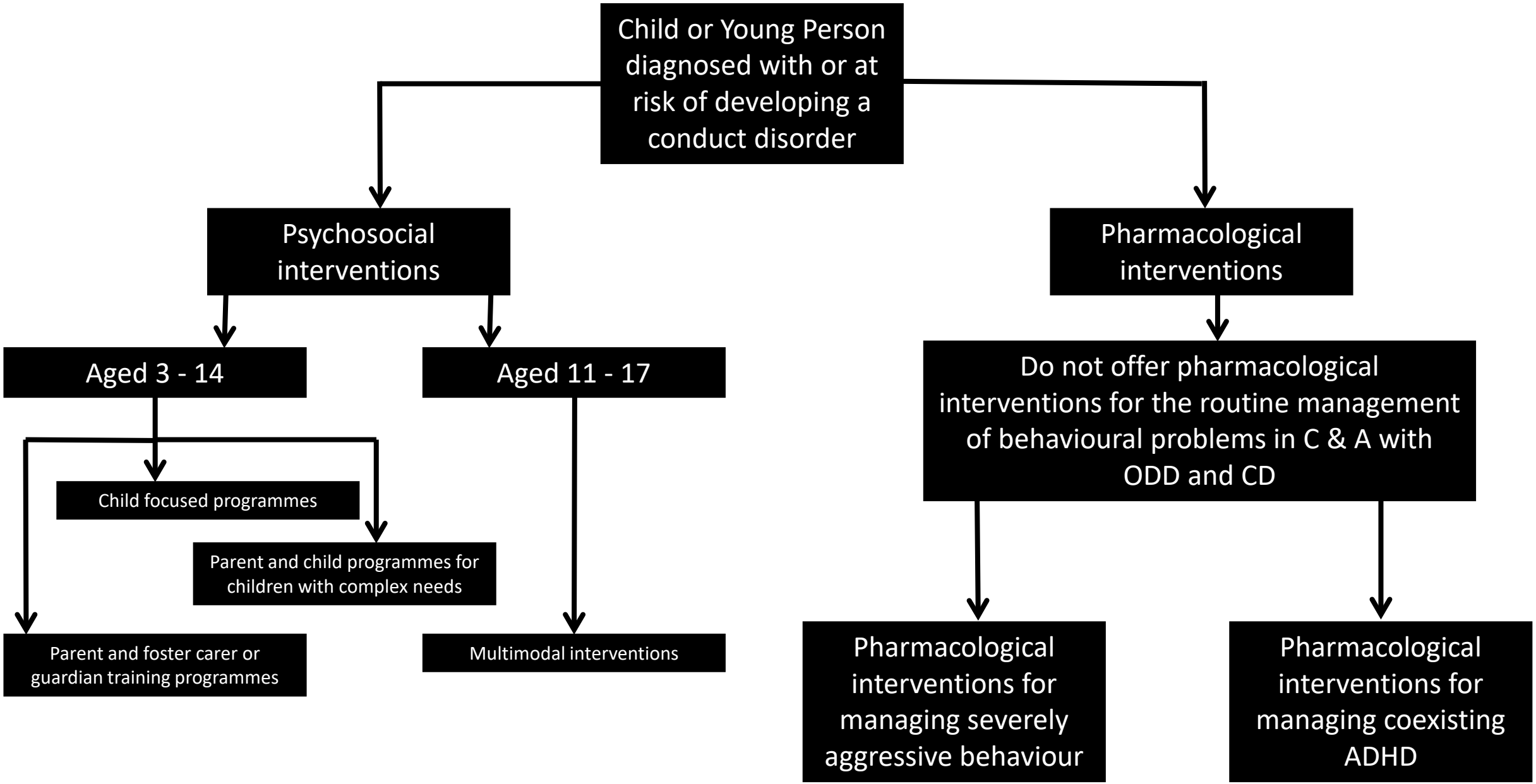
Identifying effective treatment and care options

When making a referral for treatment or care interventions for a conduct disorder, take account of the preferences of the child or young person and, if appropriate, their parents or carers when choosing from a range of evidence-based interventions.

NICE Guideline 158

Disruptive Mood Dysregulation Disorder (DMDD)

- Severe temper outbursts at least three times a week
- Sad, irritable or angry mood almost every day
- Reaction is bigger than expected
- Child must be at least six years old
- Symptoms begin before age ten
- Symptoms are present for at least a year
- Child has trouble functioning in more than one place (e.g., home, school and/or with friends)



NICE Guideline 158

Medications with some evidence for use in treating CD / Reducing aggression

- Antipsychotics ✓
  - Typicals (Haloperidol, Molindone) ✓ ✓ (ID)
  - Risperidone
  - Olanzapine ?
  - Quetiapine
  - Aripiprazole

Open label only

- Stimulants ✓
- SNRI X
  - Atomoxetine
  - Reboxetine

- Mood stabilizers
  - Lithium Carbonate ✓ low quality
  - Carbamazepine X
  - Divalproax Sodium (sodium Valproate) ?
- Antidepressants X
  - SSRI
  - Trazodone ?

Medication for severely aggressive behaviours

Consider risperidone for the short-term management of severely aggressive behaviour in young people with a conduct disorder who have problems with explosive anger and severe emotional dysregulation and who have not responded to psychosocial interventions.

- Provide young people and their parents or carers with age-appropriate information and discuss the likely benefits and possible side effects of risperidone including:
  - metabolic (including weight gain and diabetes)
  - extrapyramidal (including akathisia, dyskinesia and dystonia)
  - cardiovascular (including prolonging the QT interval)
  - hormonal (including increasing plasma prolactin)
  - other (including unpleasant subjective experiences).

NICE Guideline 158

Risperidone for aggression

Record the following baseline investigations:

- weight and height (both plotted on a growth chart)
- waist and hip measurements
- pulse and blood pressure
- fasting blood glucose, HbA_{1c}, blood lipid and prolactin levels
- assessment of any movement disorders
- assessment of nutritional status, diet and level of physical activity.

Monitor and record systematically throughout treatment, but especially during titration:

- efficacy, including changes in symptoms and behaviour
- the emergence of movement disorders
- weight and height (weekly)
- fasting blood glucose, HbA_{1c}, blood lipid and prolactin levels
- adherence to medication
- physical health, including warning parents or carers and the young person about symptoms and signs of neuroleptic malignant syndrome.

Review the effects of risperidone after 3–4 weeks and discontinue it if there is no indication of a clinically important response at 6 weeks.

Effect size for selected medications in Conduct Disorder

Medication	Effect size
Risperidone	0.9
Typical antipsychotics	0.7 – 0.8
Stimulants (primarily MPH)	0.7 - 0.8
Lithium	0.4
SSRI	0.3 (but mostly ADHD samples not CD)

Components of a behavioural plan

- **What are the Drivers (motivators)? –** (gains/benefits). What was the person trying to accomplish? What made violence seem more attractive or rewarding? e.g. • Reaction to perceived rejection, to achieve distance from other young people• Affiliation: to achieve proximity (victim or others) • Justice/revenge • Profit • Control • Status/Esteem • Emotional release/expression • Emotional arousal/stimulation dysregulation problem
- **What are the Disinhibitors?** – e.g. Negative or nihilistic attitudes in a young person with irritable depression, alienation – nothing more to lose, lack of insight/awareness due to psychosis, impulsivity due to partially treated ADHD or undiagnosed ADHD, remorselessness as part of a personality trait, absence of guilt/lack of empathy, Lack of anxiety for the consequences, due to withdrawing from substances.

Components of a behavioural plan

- **Are there Destabilisers?** - impair decision making e.g. • Psychosis • Disturbed cognitive function • Perseverative thoughts • Intoxication
- Strategies to manage each of the above factors including sensory techniques, behavioural techniques informed by the understanding of the function of the aggressive behaviour and medication including regular medication and PRN medications.
- Review date and a rationale for review of the plan (not working, needs more information added on drivers and strategies to manage them etc).

Pathways are written by GP clinical editors with support from local GPs, hospital-based specialists and other subject matter experts

- clear and concise, evidence-based medical advice
- Reduce variation in care
- how to refer to the most appropriate hospital, community health service or allied health provider.
- what services are available to my patients

Relevant and Related Pathways

Relevant Pathways

ADHD in Children and Youth
Anxiety in Children and Adolescents
Child and Youth Mental Health
Depression in Children and Adolescents
Psychological Trauma in Children
Self-harm
Suicide Prevention

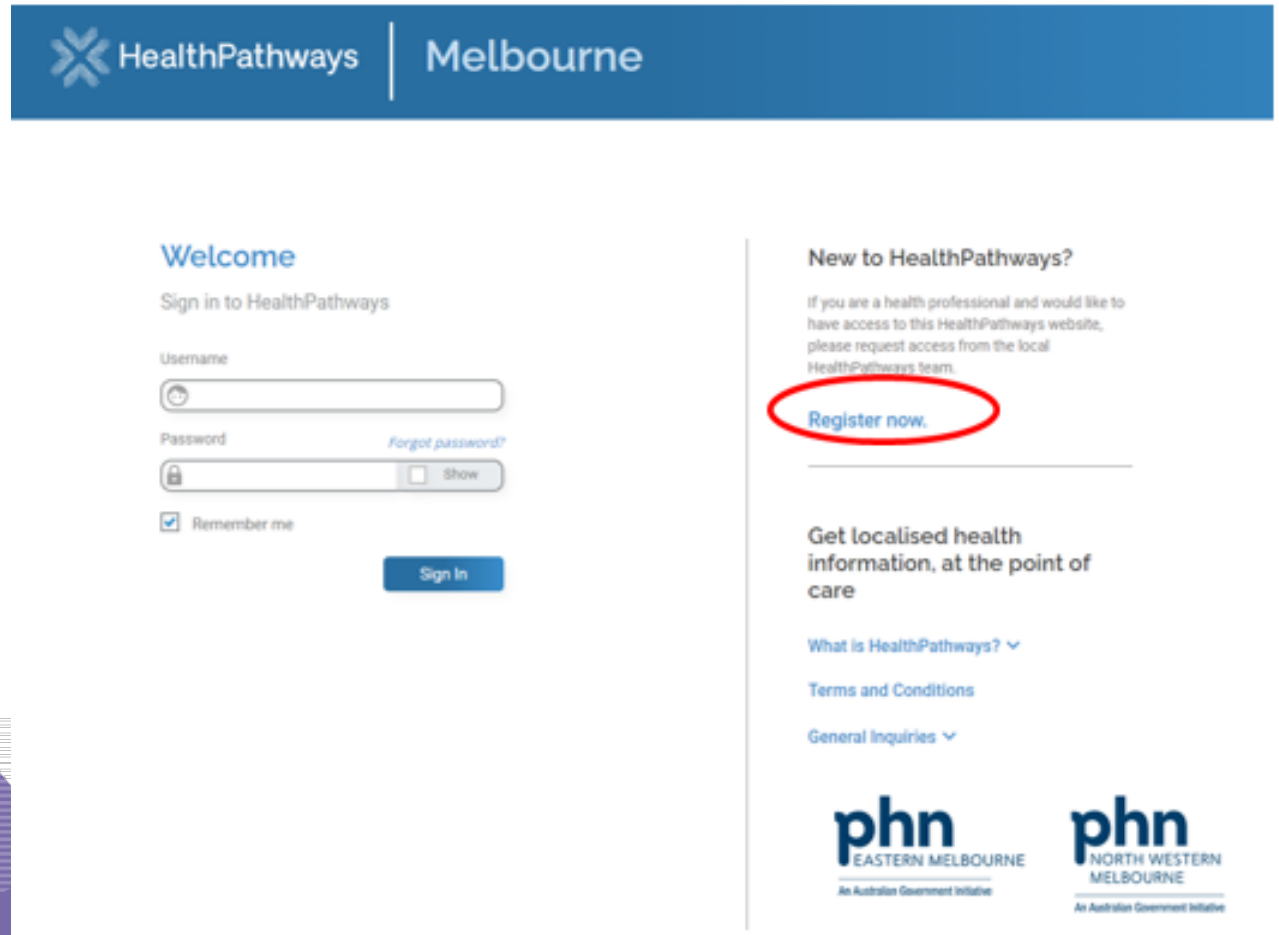
Referral Pathway

Acute Child and Adolescent Psychiatry Referral or Admission (Same-day)
Child and Youth Mental Health Support Services
Non-acute Child and Adolescent Psychiatry Referral (> 24 hours)
Paediatric Psychology and Counselling Referral

Related Pathways

Carer Support - Mental Health
E-Mental Health Services
GP Mental Health Treatment Plan
Mental Health Community Support Services

Accessing HealthPathways: Go to melbourne.healthpathways.org.au



Register via QR code

info@healthpathwaysmelbourne.org.au

Disclaimer: For presentation purposes only

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Case studies

Breakout 1 – Case study

Mitchell is a 15 year old male who has a history of increasing aggression and violence that affects his family members, the property at home and also at school. He has been suspended numerous times from his alternative school where he is currently enrolled. He has been asked to stay away for a month whilst the services discuss next steps with his educational placement and care. Mitchell has been expelled from his previous school. He has broken and entered into homes, been in gang fights and held a knife to an elderly lady who was taking money out of an ATM.

What additional information would you like to obtain?
What do you think is possibly going on with Mitchell?
How can the school support Mitchell?

Take a photo

Breakout 2 – Case study

Mitchell is one of 3 siblings and is the youngest. Developmentally, he was born 4 days early, had limited imaginative play, a slight speech delay and has some ongoing expressive verbal problems and articulation deficits. Socially, he was described as a child who was quite controlling and could not keep his friendships. He continues to be that way and is often impulsive in his actions. Mitchell likes to take risks, uses many different substances intermittently and was exposed to significant family violence until recently by his father towards his mother. His father was removed from home and an IVO is in place. Child protection are trying to work with Mitchell and his mother who is at her wits end with his behaviours.

How can we support Mitchell's mum with his behaviour?
How can we support Mitchell to ensure his safety and what strategies/tools can be employed in management of his risk-taking behaviours?

Take a photo

Session Conclusion

Next session on depression, suicidality and self-harm

– Tuesday 25th June (same time)

You will receive a post session email within a week which will include slides and resources discussed during this session.

Attendance certificate will be received within 4-6 weeks.

RACGP CPD hours will be uploaded within 30 days.

To attend further education sessions, visit,

https://nwmphn.org.au/resources-events/events/

This session was recorded, and you will be able to view the recording at this link within the next week.

https://nwmphn.org.au/resources-events/resources/

We value your feedback, let us know your thoughts.

Scan this QR code