COMMON PRESENTATIONS OF CHILD & ADOLESCENT MENTAL & BEHAVIOURAL DISORDERS

- ***Child/adolescent being seen for physical complaints or a general health assessment who has:***
  - *– Any of the typical presenting complaints of emotional, behavioural or developmental disorders (See **Table 1**)*
  - *– Risk factors such as malnutrition, abuse and/or neglect, frequent illness, chronic diseases (e.g. HIV/AIDS or history of difficult birth)*
- ***Carer with concerns about the child/adolescent's:***
  - *– Difficulty keeping up with peers or carrying out daily activities considered normal for age*
  - *– Behaviour (e.g. too active, aggressive, having frequent and/or severe tantrums, wanting to be alone too much, refusing to do regular activities or go to school)*
- ***Teacher with concerns about a child/adolescent***
  - *– e.g. easily distracted, disruptive in class, often getting into trouble, difficulty completing school work*
- ***Community health or social services worker** with concerns about a child/adolescent*
  - *– e.g. rule- or law-breaking behaviour, physical aggression at home or in the community*

1 ASSESS FOR DEVELOPMENTAL DISORDERS

Assess all domains – motor, cognitive, social, communication, and adaptive.

- **For toddlers and young children:** Has the child had any difficulties with age-appropriate milestones across all developmental areas?
- **For older children and adolescents:** Are there difficulties with school (learning, reading, and writing), communicating and interacting with others, self-care, and everyday household activities?

CLINICAL TIP

- Adolescents should always be offered the opportunity to be seen on their own, without carers present.
- Clarify the confidential nature of the discussion.
- Indicate in what circumstances parents or other adults will be given information.
- Explore the presenting complaint with the child/adolescent and carer.

NO → SKIP to STEP 2

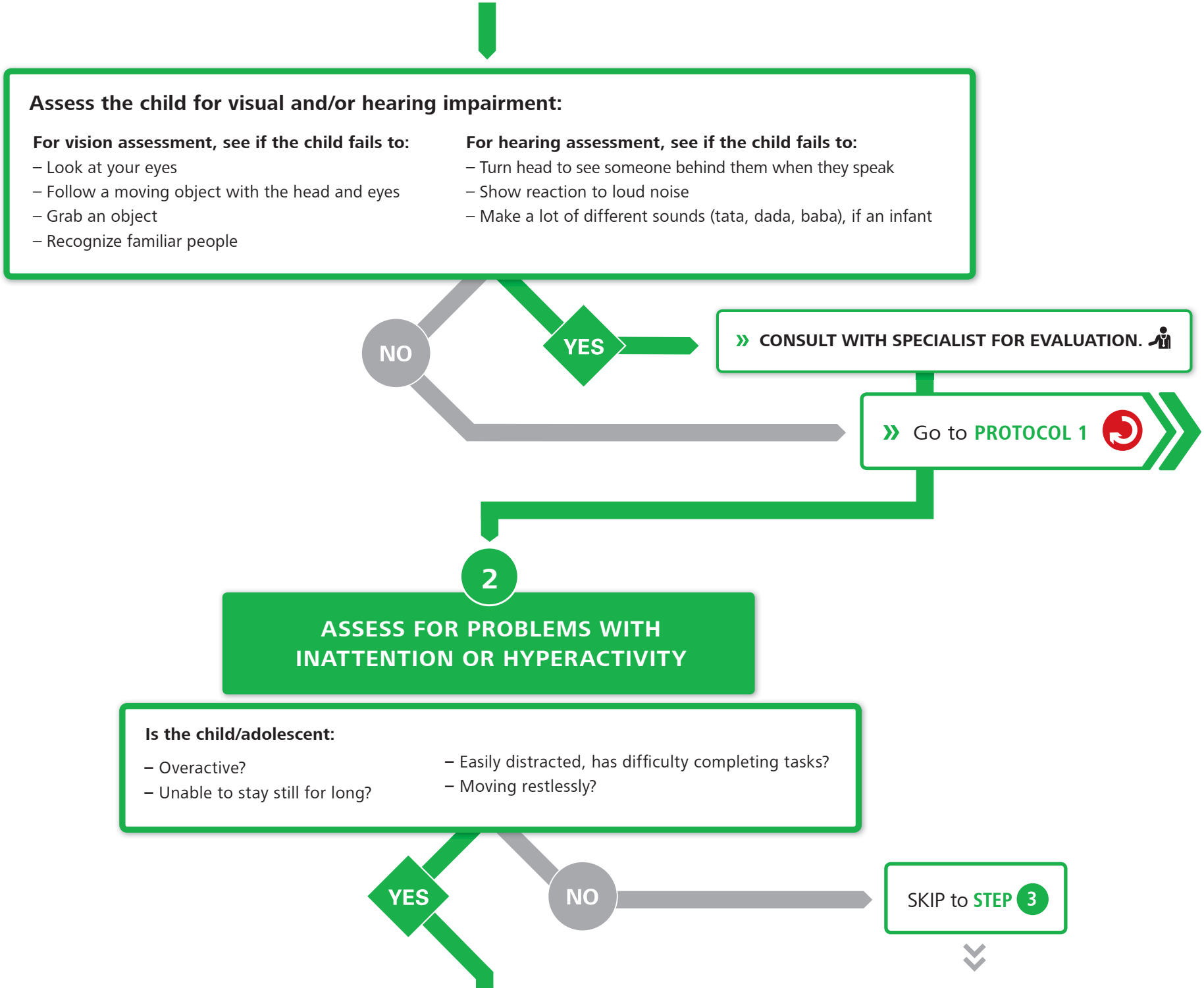
YES → **Suspect DEVELOPMENTAL DELAY/DISORDER**

Are there signs/symptoms suggesting any of the following:

- Nutritional deficiency, including iodine deficiency
- Anaemia
- Malnutrition
- Acute or chronic infectious illness, including ear infection and HIV/AIDS

NO

YES → **Manage conditions using Integrated Management of Childhood Illness (IMCI)** (www.who.int/maternal_child_adolescent/documents/IMCI_chartbooklet) or other available guidelines.


Assess the child for visual and/or hearing impairment:
For vision assessment, see if the child fails to:
– Look at your eyes
– Follow a moving object with the head and eyes
– Grab an object
– Recognize familiar people
For hearing assessment, see if the child fails to:
– Turn head to see someone behind them when they speak
– Show reaction to loud noise
– Make a lot of different sounds (tata, dada, baba), if an infant
NO
YES
» CONSULT WITH SPECIALIST FOR EVALUATION.
» Go to PROTOCOL 1
2
ASSESS FOR PROBLEMS WITH INATTENTION OR HYPERACTIVITY
Is the child/adolescent:
– Overactive?
– Unable to stay still for long?
– Easily distracted, has difficulty completing tasks?
– Moving restlessly?
YES
NO
SKIP to STEP 3

Are symptoms persistent, severe, and causing considerable difficulty with daily functioning? Are ALL of the following true?

- Are symptoms present in multiple settings?
- Have they lasted at least 6 months?
- Are they inappropriate for the child/adolescent's developmental level?
- Is there considerable difficulty with daily functioning in personal, family, social, educational, occupational or other areas?

YES

NO

ADHD is unlikely

Consider PROBLEMS WITH BEHAVIOUR

» Go to **PROTOCOL 2**

SKIP to **STEP 3**

Consider ADHD

Rule out physical conditions that can resemble ADHD.
Does the child/adolescent have any of the following:

- Thyroid diseases
- Acute or chronic infectious illness, including HIV/AIDS
- Uncontrolled pain e.g. from an ear infection, sickle cell disease

NO

YES

» **Treat the physical condition**

» Go to **PROTOCOL 3**

3 ASSESS FOR CONDUCT DISORDER

Does the child/adolescent show repeated aggressive, disobedient, or defiant behaviour, for example:

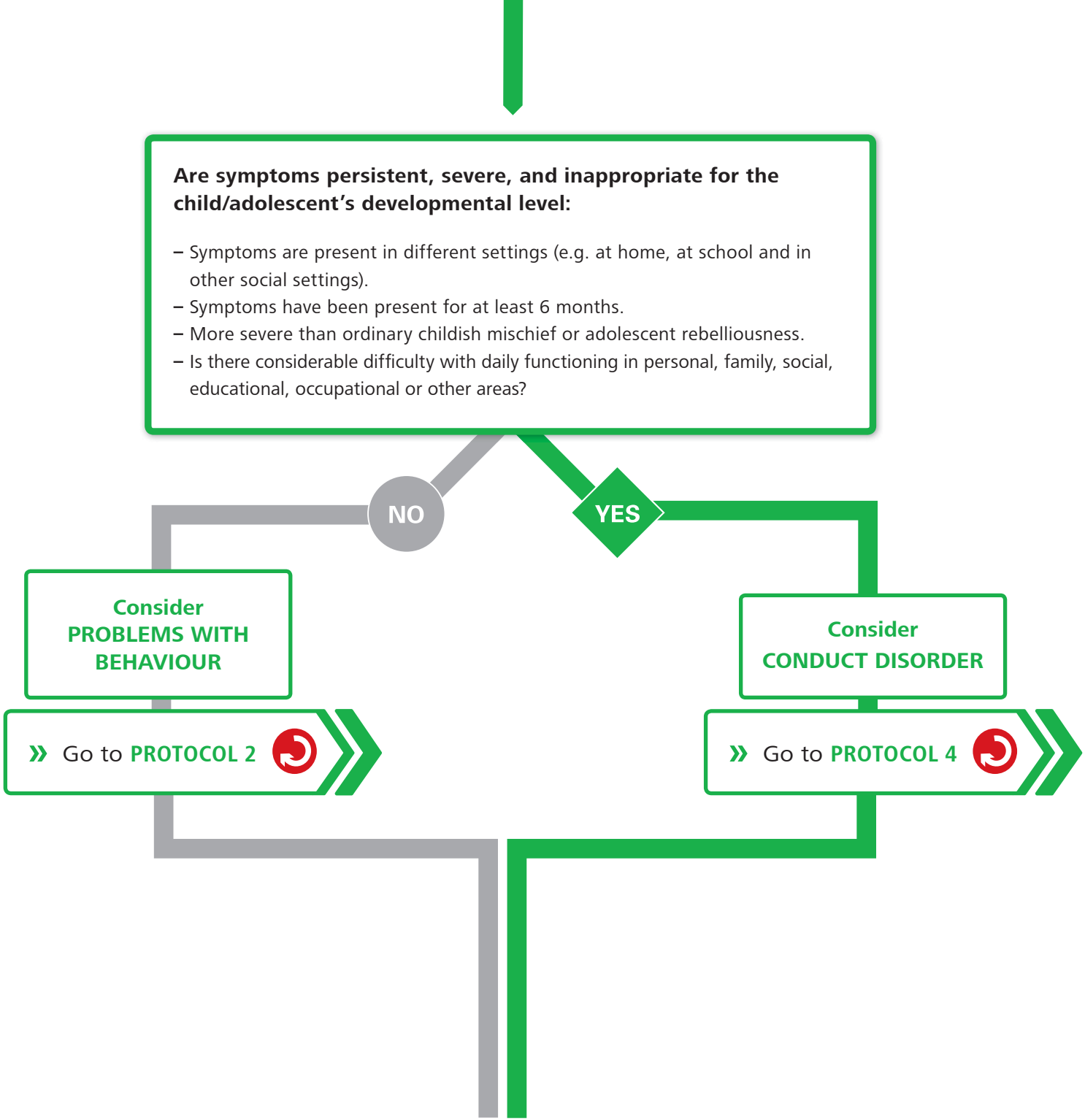
- Arguing with adults
- Defying or refusing to comply with their requests or rules
- Extreme irritability/anger
- Frequent and severe temper tantrums
- Difficulty getting along with others
- Provocative behaviour
- Excessive levels of fighting or bullying
- Cruelty to animals or people
- Severe destructiveness to property, fire-setting
- Stealing, repeated lying, truancy from school, running away from home

NO → CONDUCT DISORDER is unlikely → SKIP to STEP 4

YES

CLINICAL TIP: AGE-APPROPRIATE DISRUPTIVE OR CHALLENGING BEHAVIOUR IN CHILDREN/ADOLESCENTS

Toddlers and young children (age 18 months – 5 years)	– Refusing to do what they are told, breaking rules, arguing, whining, exaggerating, saying things that aren't true, denying they did anything wrong, being physically aggressive and blaming others for their misbehaviour. – Brief tantrums (emotional outbursts with crying, screaming, hitting, etc.), usually lasting less than 5 minutes and not longer than 25 minutes, typically occur less than 3 times per week. Developmentally typical tantrums should not result in self-injury or frequent physical aggression toward others, and the child can typically calm themselves down afterward.
Middle Childhood (age 6-12)	– Avoidance of or delay in following instructions, complaining or arguing with adults or other children, occasionally losing their temper.
Adolescents (age 13-18)	– Testing rules and limits, saying that rules and limits are unfair or unnecessary, occasionally being rude, dismissive, argumentative or defiant with adults.


Are symptoms persistent, severe, and inappropriate for the child/adolescent's developmental level:
– Symptoms are present in different settings (e.g. at home, at school and in other social settings).
– Symptoms have been present for at least 6 months.
– More severe than ordinary childish mischief or adolescent rebelliousness.
– Is there considerable difficulty with daily functioning in personal, family, social, educational, occupational or other areas?
NO
YES
Consider PROBLEMS WITH BEHAVIOUR
» Go to PROTOCOL 2
Consider CONDUCT DISORDER
» Go to PROTOCOL 4

4

ASSESS FOR EMOTIONAL DISORDERS
(prolonged, disabling distress involving sadness, fearfulness, anxiety or irritability)

Ask if the child/adolescent:

- Is often feeling irritable, easily annoyed, down or sad?
- Has lost interest in or enjoyment of activities?
- Has many worries or often seems worried?
- Has many fears or is easily scared?
- Often complains of headaches, stomach-aches or sickness?
- Is often unhappy, down-hearted or tearful?
- Avoids or strongly dislikes certain situations (e.g. separation from carers, meeting new people, or closed spaces)?

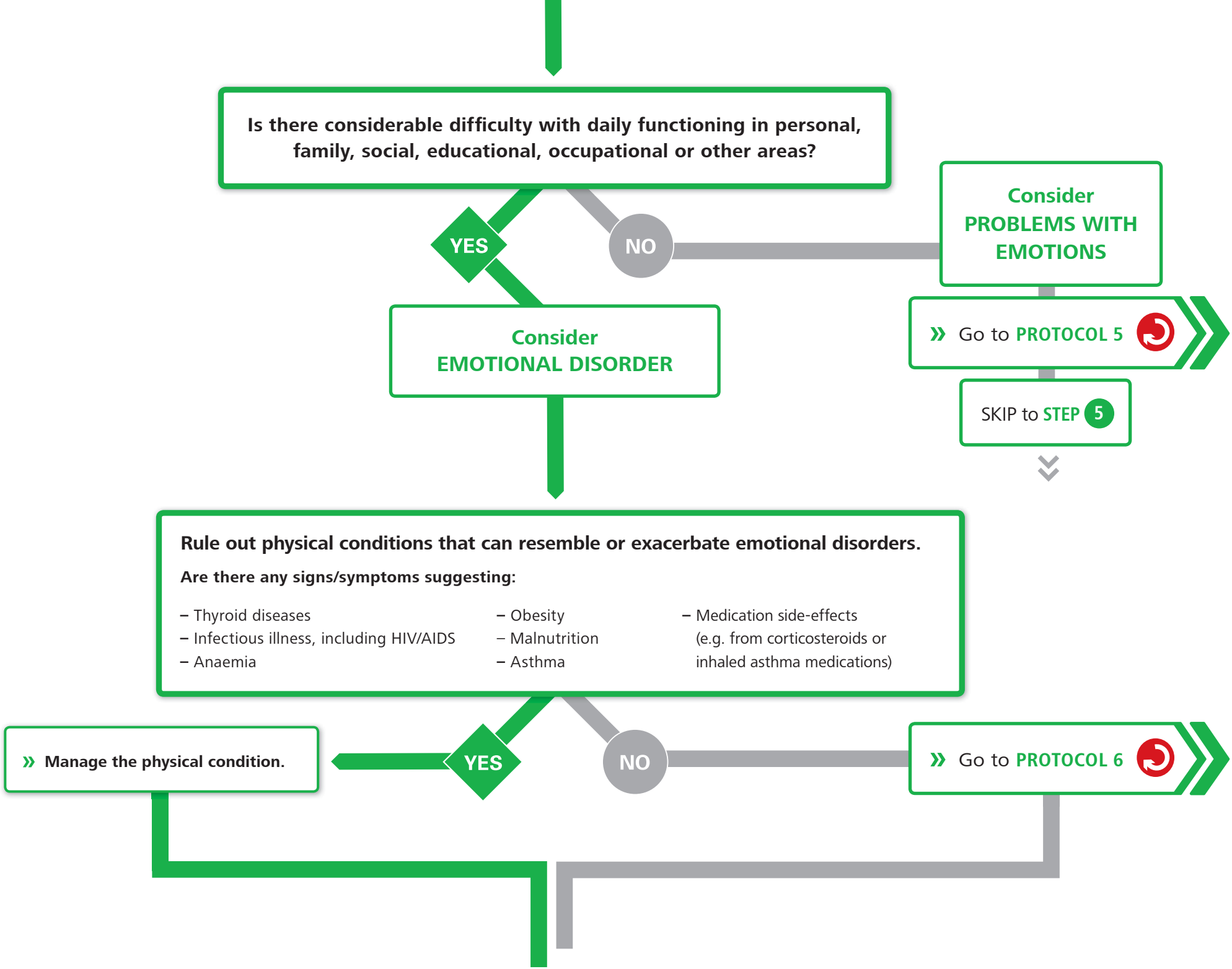
NO

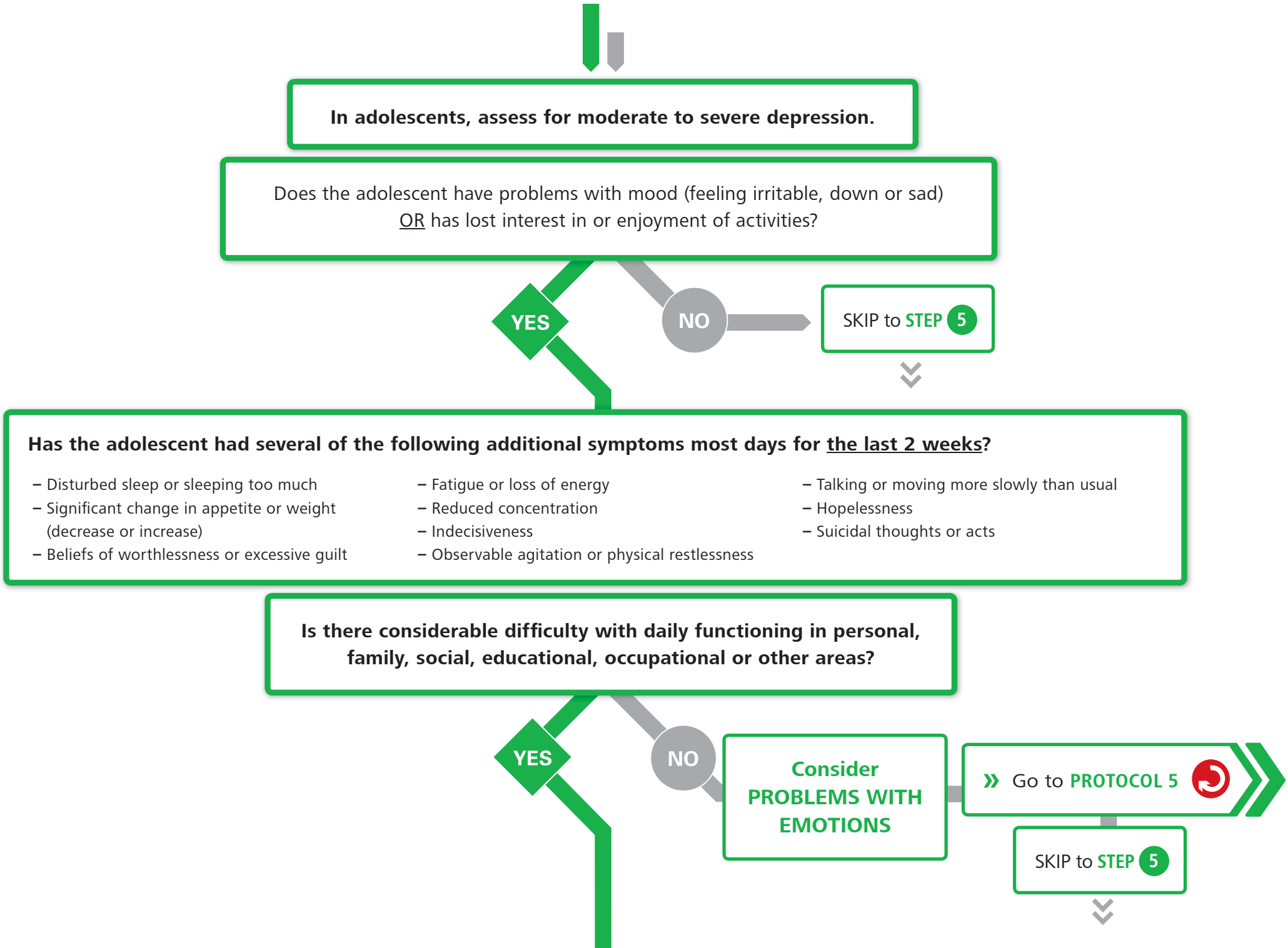
SKIP to STEP 5

YES

CLINICAL TIP: AGE-APPROPRIATE FEARS AND ANXIETIES IN CHILDREN AND ADOLESCENTS

Babies & Toddlers (age 9 months – 2 years)	– Fear of strangers, distress when separating from caregivers
Young Children (age 2-5)	– Fear of storms, fire, water, darkness, nightmares, and animals
Middle Childhood (age 6-12)	– Fear of monsters, ghosts, germs, natural disasters, physical illness, and being badly injured – Anxiety about school or about performing in front of others
Adolescents (age 13-18)	– Fear of rejection by peers, performing in front of others, physical illness, medical procedures, catastrophes (e.g. war, terrorist attack, disasters)


Is there considerable difficulty with daily functioning in personal, family, social, educational, occupational or other areas?
YES
NO
Consider PROBLEMS WITH EMOTIONS
» Go to PROTOCOL 5
SKIP to STEP 5
Consider EMOTIONAL DISORDER
Rule out physical conditions that can resemble or exacerbate emotional disorders.
Are there any signs/symptoms suggesting:
– Thyroid diseases
– Infectious illness, including HIV/AIDS
– Anaemia
– Obesity
– Malnutrition
– Asthma
– Medication side-effects (e.g. from corticosteroids or inhaled asthma medications)
» Manage the physical condition.
YES
NO
» Go to PROTOCOL 6


In adolescents, assess for moderate to severe depression.
Does the adolescent have problems with mood (feeling irritable, down or sad) OR has lost interest in or enjoyment of activities?
YES
NO
SKIP to STEP 5
Has the adolescent had several of the following additional symptoms most days for the last 2 weeks?
– Disturbed sleep or sleeping too much
– Significant change in appetite or weight (decrease or increase)
– Beliefs of worthlessness or excessive guilt
– Fatigue or loss of energy
– Reduced concentration
– Indecisiveness
– Observable agitation or physical restlessness
– Talking or moving more slowly than usual
– Hopelessness
– Suicidal thoughts or acts
Is there considerable difficulty with daily functioning in personal, family, social, educational, occupational or other areas?
YES
NO
Consider PROBLEMS WITH EMOTIONS
» Go to PROTOCOL 5
SKIP to STEP 5

Consider DEPRESSION

CLINICAL TIP

Delusions or hallucinations may be present. If present, treatment for depression needs to be adapted. **CONSULT A SPECIALIST**

Rule out a history of manic episode(s) and normal reaction to recent major loss. See » DEP.

» Go to **PROTOCOL 6**

5

ASSESS FOR OTHER PRIORITY MNS CONDITIONS

! IF THERE IS IMMINENT RISK OF SUICIDE, ASSESS AND MANAGE before continuing. Go to » SUI.

Are there any other concurrent MNS conditions? Assess according to the mhGAP-IG Master Chart. See » MC.

! *Do not forget to assess for disorders due to substance use.* **See » SUB.**

! *For children with developmental delay/disorders, do not forget to assess for epilepsy.* **See » EPI.**

YES

NO

» **ASSESS AND MANAGE concurrent MNS conditions**

CLINICAL TIP

- Ask the child/adolescent directly about these exposures when developmentally appropriate and safe to do so (e.g. not in the presence of a carer who may have committed the maltreatment).
- Adolescents should always be offered the opportunity to be seen on their own, without carers present.

6

ASSESS THE HOME ENVIRONMENT

Are the emotional, behavioural or developmental problems a reaction to or aggravated by a distressing or frightening situation?

Assess for:

- Clinical features or any element in the clinical history that suggest maltreatment or exposure to violence (see CLINICAL TIP).
- Any recent or ongoing severe stressors (e.g. illness or death of a family member, difficult living and financial circumstances, being bullied or harmed).

YES

- Refer to child protection services if necessary
- Explore and manage stressors
- Ensure child/adolescent's safety as a first priority
- Reassure the child/adolescent that all children/adolescents need to be protected from abuse
- Provide information about where to seek help for any ongoing abuse
- Arrange additional support including referral to specialist
- Contact legal and community resources, as appropriate and as mandated
- Consider additional psychosocial interventions
- Ensure appropriate follow-up

NO

CLINICAL TIP:
RED FLAGS FOR CHILD MALTREATMENT

CLINICAL FEATURES

- **Physical abuse**
  - Injuries (e.g. bruises, burns, strangulation marks or marks from a belt, whip, switch or other object)
  - Any serious or unusual injury without an explanation or with an unsuitable explanation
- **Sexual abuse**
  - Genital or anal injuries or symptoms that are medically unexplained
  - Sexually transmitted infections or pregnancy
  - Sexualised behaviours (e.g. indication of age-inappropriate sexual knowledge)
- **Neglect**
  - Being excessively dirty, unsuitable clothing
  - Signs of malnutrition, very poor dental health
- **Emotional abuse and all other forms of maltreatment**

  Any sudden or significant change in the behaviour or emotional state of the child/adolescent that is not better explained by another cause, such as:
  - Unusual fearfulness or severe distress (e.g. inconsolable crying)
  - Self-harm or social withdrawal
  - Aggression or running away from home
  - Indiscriminate affection seeking from adults
  - Development of new soiling and wetting behaviours, thumb sucking

ASPECTS OF CARER INTERACTION WITH THE CHILD/ADOLESCENT

- Persistently unresponsive behaviour, especially toward an infant (e.g. not offering comfort or care when the child/adolescent is scared, hurt or sick)
- Hostile or rejecting behaviour
- Using inappropriate threats (e.g. to abandon the child/adolescent) or harsh methods of discipline

Do the carers have any priority MNS condition that could impact their ability to care for the child/adolescent?

Consider especially depression and disorders due to substance use.

CLINICAL TIP

» Depressive disorder in carers can worsen emotional, behavioural or developmental disorders in their children/adolescents.

NO

YES

» **Assess and manage for carer MNS conditions.**

» **Go to Management 2.6** (Carer support)

Is the child getting adequate opportunities for play and social interaction/communication at home?

Consider asking:

» With whom does the child spend most of their time?
» How do you/they play with the child? How often?
» How do you/they communicate with the child? How often?

NO

YES

» Provide advise on age-appropriate stimulation and parenting. Refer to Care for Child Development http://www.who.int/maternal_child_adolescent/documents/care_child_development/en/

» Consider need for additional support for the child including referral to child protection services where available.

7 ASSESS THE SCHOOL ENVIRONMENT

Is the child/adolescent in school?

YES

NO

» Provide information regarding educational services and educate carer on importance of keeping the child/adolescent in school as much as possible.

Is the child/adolescent:

- » Being bullied, picked on or made fun of?
- » Not able to participate and learn?
- » Not wanting/refusing to attend school?

CLINICAL TIP

» Ask the child/adolescent directly about these exposures when developmentally appropriate and safe to do so.

NO

» Go to **CMH 2 (Management)**

YES

» After getting consent, liaise with teachers and other school staff. Go to Management **(2.7)**.

» If there has been an absence from school, try to help the child/adolescent return to school as soon as possible and explore reasons for absence.