

Child and adolescent mental and behavioural disorders

Session outline

- Introduction to child and adolescent mental and behavioural disorders
- Assessment of child and adolescent mental and behavioural disorders
- Management of child and adolescent mental and behavioural disorders
- Follow-up
- Review

Activity 1: Person's story

- Present the person's story of what it feels like to live with child and adolescent mental and behavioural disorders
- First thoughts

Local perspectives

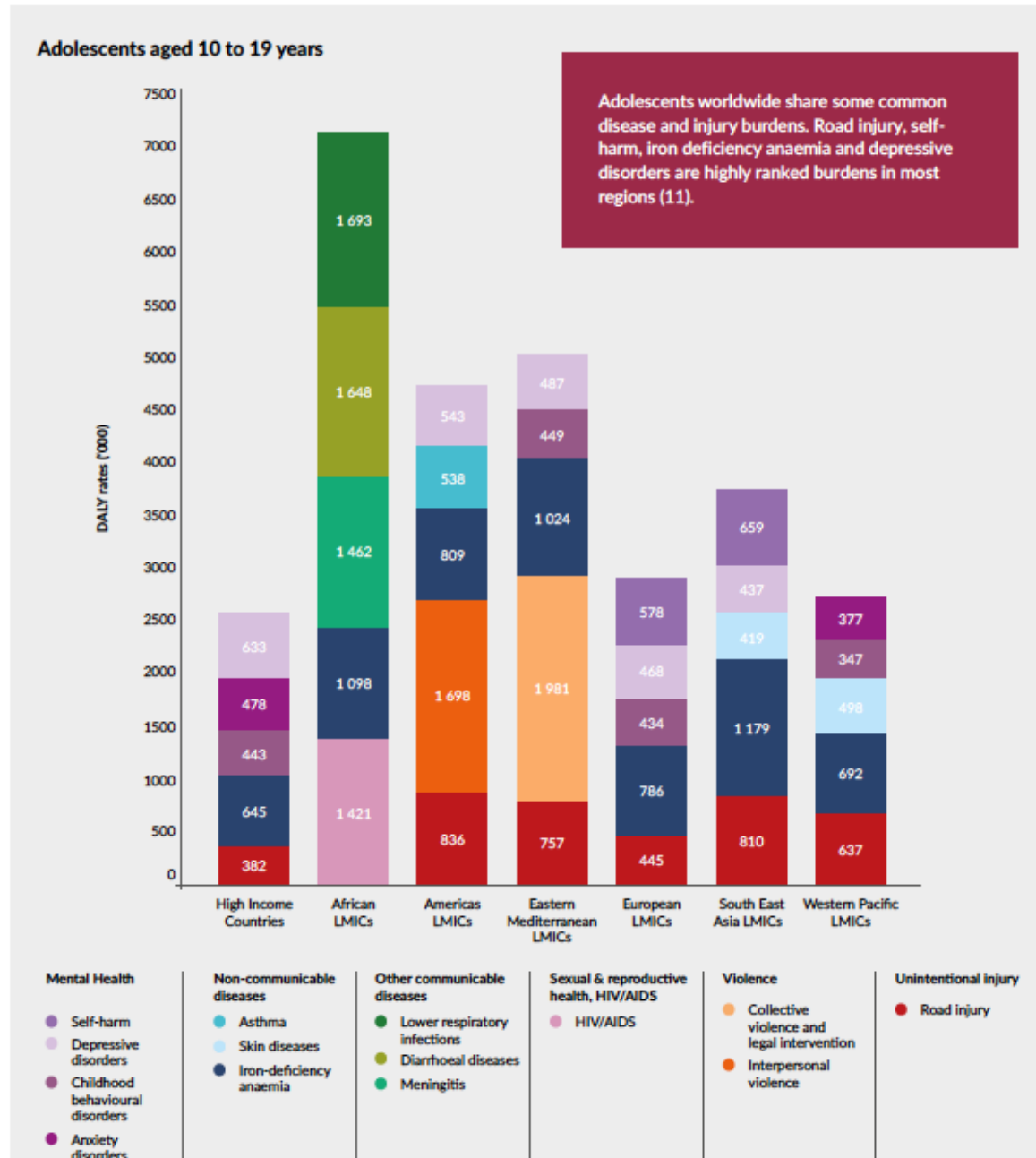
- How do the community perceive and understand children and adolescents with mental and behavioural disorders?
- What treatment and care do the children/adolescents receive? How does it impact on them?
- How are the families treated? How does it impact on them?

Child and adolescent mental health: A public health concern

- Mental health problems affect 10–20% of children and adolescents worldwide.
- Depression is the number one cause of illness and disability in young people aged 10–19 years old and suicide ranks number three among causes of death.



Figure 7. Estimated top five causes of adolescent disability-adjusted life years (DALYs) lost by Modified WHO Region, 2015.



Public health concern

- Some studies show that half of all people who develop mental disorders have their first symptoms by the age of 14, and 75% have had their first symptom by their mid 20s.
- If these early symptoms are left untreated they impact on:
 - Child/adolescent development.
 - Educational attainments.
 - Potential to live fulfilling and productive, healthy lives.

Early identification

- Early identification and early treatment can literally change the course of a person's entire life.
- Healthy early child development strongly influences well-being, obesity/stunting, mental health, heart disease, competence in literacy and numeracy, criminality and economic participation through out life.

Stigma and discrimination

- Children/adolescents with mental and behavioural disorders face major challenges with stigma, isolation and discrimination.
- They lack access to health care and educational facilities.

Forms of stigma and discrimination and abuse

- They may be bullied by siblings or others.
- They may be excluded from schools.
- They may not be brought for vaccination/essential health care.
- They may be tied up, abandoned or left alone in the house.
- They may receive less food in poor families.
- They may be subject to harmful forms of traditional healing (e.g. beating the spirit out).
- They may be harshly beaten by frustrated parents.

Social impact of stigma and discrimination

- Poor school performance.
- Reduced community participation.
- Impaired capacity to live independently.
- Limited employment opportunities.
- High carer burden (socially, financially, emotionally).
- Mothers or families may also be stigmatized or become isolated.

What challenges do you face in assessing and managing mental and behavioural disorders in children and adolescents?

- Carer/adolescent refuses to talk about mental health.
- Carer/adolescent has unrealistic expectations about management outcomes.
- Carers present mental health or substance abuse problems.
- Child/adolescent is being neglected or abused.
- Carers and their children are victims of stigma and isolation.

Special considerations for assessment of children

- Expectations about what is “normal” vary according to stage of development.
 - Symptoms for disorders may vary according to age and stage of development.
- The capacity to understand the problem and to participate in decision-making for treatment evolves with age.
 - It will be necessary to adapt your language to the developmental stage.
 - When talking to adults, never forget that the child is in the room! Be conscious of the child's level of understanding.
 - Allow opportunities for the child to express concerns in private and, if possible, express themselves in front of the carer.

Special considerations for assessment of children

- The mental health of children is closely related to the mental health of the carer. Assess carers' mental health needs.
- Explore available resources within the family, school and community. Carers and teachers are often your best allies!
- Explore negative factors affecting mental health and well-being.
- Children and adolescents are vulnerable to human rights violation. Ensure access to education and appropriate health care

Special considerations for assessment of adolescents

- It can be “normal” for adolescents to have distressing and disruptive emotions, thoughts and behaviours and are only a disorder when they persist over time and affect daily functioning.
- Adolescents may be difficult to reach as they often do not seek help.
 - Always offer adolescents the opportunity to be seen on their own without a carer present.
 - Clarify the confidential nature of the discussion.
 - Indicate in what circumstances parents of adults will be given information.
 - Explore the presenting complaint with the adolescent directly.

Activity 2: Group work: Common presentations

You are going to hear different case histories.

Use the mhGAP-IG to identify which child and adolescent mental and behavioural disorders are being described in the case histories.

Case history 1

My son is now five years old. I noticed that he was late in both sitting and walking compared with other children in the family.

He also started talking late and still is using very simple words to describe things that he wants.

When he is hungry he will rub his tummy and say “hungry” or “food” but finds it difficult to say complete sentences.

He is able to say his own name when asked, but often needs me to help him. He is a really loving child who likes to be hugged.

Case history 1 continued

Often he will forget where he put his toy, and then he will cry till I comfort him and find it for him.

He loves to go out to play with the children in the playground and kick the football around, but he is often left out of the games since he is not able to follow the rules.

Even now he needs help with all his daily activities including dressing and eating, though he can manage dry biscuits. He should have started in the local school. I feel he is not ready, since he is not yet toilet trained.

Developmental delay/disorder (intellectual disability)

Case history 2

Mother of three-year-old boy:

*I am concerned about my son. He is a bit of a slow learner...
(pause).*

I've been thinking about coming to the clinic for a while but it was really my sister-in-law who told me I should bring him in. It's taken him longer to learn things than his older brothers and sisters. He's three years old now but he's not talking much yet.

His younger sister is two and she can say things like, "More water mama" and "Come here", but he can't really speak. He does make sounds as if he's talking but he's not saying any real words. Sometimes, he will make sounds like "Aah-da-aah-da-aah-da" when he's excited. I can also tell that he's excited because he flaps his hands like this....

Case history 2 continued

He doesn't really like to play with other kids or even with his brother or sisters. He often plays by himself by rolling his toy cars back and forth on the ground. He also really likes to line up his cars in rows – he can do that for hours! Little cars and trucks are his favourite toys. He doesn't really play with any other toys and sometimes he doesn't even want to put them down to eat meals! He really likes toy cars but he doesn't play with them the same way as his brother.

He doesn't really try to get my attention like my other children. He seems not to notice the world around him. It's like he's in his own world.

Developmental disorder (autism spectrum disorder)

Case history 3

My daughter is 12 years old. This last month or so she has been crying about the smallest thing.

If you say anything to her, she is likely to snap back at you. A few times I've heard her being really grumpy with her friends when they call her to play. They don't call her any more.

She used to have many interests, like playing board games, helping with the housework, drawing. But now she's just not interested in any of it.

She just sits alone in the house. She won't wake up for school unless I ask her several times to get out of bed.

Case history 3 continued

She's stopped eating even her favourite meals, and she looks a lot thinner.

I don't know if it's due to being tired or eating less, but she doesn't have her usual energy any more.

Emotional disorder (depression)

Case history 4

He is all over the place – always on the move. He won't sit still at the table while we are eating – it's fidgeting the whole time. He'd get up between mouthfuls if I let him.

If there is some work that needs doing, he'll start willingly but within a few minutes he's been distracted and begun doing something else instead.

The teachers complain too that he is very naughty and disturbs other children. also, he doesn't do as well as he used to in his studies.

He breaks things in the house.

He has frequent falls and injuries.

Behaviour disorder (attention deficit hyperactivity disorder)

What is child development?

- The process of growing and acquiring new skills (i.e. walking and grasping objects, communicating, playing, interacting with others).
- It is a complex process, determined by the biological brain development, influenced in part by the quality of interactions with others (i.e. carers).
- Child development is not just about growing, but what happens to the child in the early years is critical for the child's development trajectory and life course.

Different domains of child development

Examples in each domain:

- Motor (movement) skills:
 - Sitting up, walking, skipping.
 - Picking up objects, using a spoon, drawing.
- Communication and speech:
 - Babbling (e.g. say “bababa”), pointing, using words.
- Social interaction:
 - Smiling, waving goodbye, taking turns with others.
- Play and learning (cognitive):
 - Problem-solving, exploring the environment, doing maths.

Developmental milestones

- By the age of one month the child should be able to.....
- By the age of six months the child should be able to.....
- By the age of 12 months the child should be able to.....
- By the age of 18 months the child should be able to.....
- By the age of 24 months the child should be able to.....

Developmental milestones

By the age of ONE MONTH a child should be able to:

- Bring both hands towards her or his mouth.
- Turn towards familiar voices and sounds.
- Suckle the breast.

By the age of SIX MONTHS a child should be able to:

- Reach for dangling objects.
- Sit with support.
- Smile.

Developmental milestones – cont'd

By the age of 12 MONTHS a child should be able to:

- Crawl on hands and knees and pull up to stand.
- Try to imitate words and sounds and respond to simple requests.
- Enjoy playing and clapping.
- Pick things up with thumb and one finger.

By the age of TWO YEARS a child should be able to:

- Walk, climb and run.
- Point to objects or pictures when they are named (e.g. nose, eyes).
- Scribble if given a pencil or crayon.
- Imitate the behaviour of others.
- Make sentences of two or three words.
- Learn to defecate in an appropriate place (18 months).

Developmental milestones - cont'd

By the age of THREE YEARS a child should be able to:

- Walk, run, climb, kick and jump easily.
- Say own name and age.
- Use make-believe objects in play.
- Feed herself or himself.

By the age of FIVE YEARS a child should be able to:

- Speak in sentences and use many different words.
- Play with other children.
- Dress without help.
- Answer simple questions.
- Count 5 to 10 objects.

What is developmental disorder?

- Not all children develop at the same rate; each child is unique.
- Only when there is a substantial delay in learning skills in more than one domain do we suspect a **developmental disorder**.
- Remember these are the four domains:
 - motor (movement) skills
 - communication and speech
 - social interaction
 - play and learning (cognitive).

Additional core signs of developmental disorder

- For older children, school performance or everyday household activities.
- Oddities in communication and behaviour, for example:
 - Use of non-meaningful words.
 - Repetition of words or sentences that someone else has said.
 - Repetitive movements like flapping hands, always playing with the same object.

Developmental disorders

- Substantial delay in development.
- Childhood onset, steady course, often persist into adulthood.
- Children with developmental disorders can learn new skills, but they develop much more slowly than other children.
- Development disorders include:
 - intellectual disability
 - autism and other pervasive developmental disorders.

Intellectual disability

- Substantial difficulty/delay in skills across most developmental domains:
 - motor (movement) skills
 - communication and speech
 - social interaction
 - play and learning (cognitive).
- There are different degrees of intellectual disability, ranging from mild to profound.

Autism and other pervasive developmental disorders

- Major delays and difficulties in communication, speech and social skills.
- Frequent preoccupation with a single object for long periods.
- Repetitive gestures (e.g. hand or finger flapping or twisting).
- Oddities in communication
 - inappropriate loudness, intonation, and rhythm
 - endless repetition of phrases
 - incomprehensible speech.

Main risk factors for developmental delay

Biological factors:

- Nutritional deficiencies (malnutrition, iron deficiency, iodine deficiency)
- Hearing and visual impairment
- Recurrent/chronic illness (HIV/AIDS)
- Alcohol use during pregnancy
- Certain complications during delivery
- Consanguinous parents (parents who are related to each by blood)

Psychosocial factors:

- Depression in mothers
- Insufficient child care/poorly stimulating environment
- Harmful traditional beliefs (e.g. not talking to small children)

Person's story

Hear what it is like to live with developmental disorders.

Problem behaviours and behavioural disorders

- Problems related to over-activity, inattention or dissocial behaviour are common among children and adolescents.
- Only when these behaviours are very severe and influence children's ability to perform daily activities (e.g. learning, playing and interacting with peers) they may be defined as “behavioural disorders”.

These problem behaviours can be defined as:

- **Excessive over-activity:**

Excessive running around, extreme difficulties remaining seated, excessive talking or making continuous movements with fingers or feet.

- **Excessive inattention:**

The child is often unable to complete one task and is frequently switching to others.

Behavioural disorder related to attention deficit and hyperactivity (attention deficit hyperactivity disorder – ADHD)

- The main features are impaired attention and over-activity that affect a child's functioning in daily life and learning.
- It is common: 5–8 %, especially in boys.
- What is the cause?
ADHD may have a genetic component, but it is not clear exactly what causes it.

What you need to know about ADHD?

- When children with ADHD are not recognized, they may be mislabelled naughty and irresponsible and be blamed and punished for their behaviours.
- Punishment can worsen their behaviour.
- When children with ADHD do not receive care and support, they may drop out from school.

Behavioural disorder related to dissocial, aggressive and disobedient behaviour (conduct disorder)

- Main features are repetitive and persistent dissocial, aggressive or defiant conduct.
- Is conduct disorder common?
4–10%, especially in boys.
- Caused by both genetic vulnerability and difficult psychosocial environments (exposure to violence, neglect, parents' mental or substance use disorder).

Why do you need to know about conduct disorder?

- When children/adolescents with conduct disorder do not receive appropriate care and support, they may drop out of school.
- They are at increased risk for depression.
- They are also at increased risk of having alcohol, drug use and criminal problems.

Why is treatment for behavioural disorders in young people important?

Early intervention is important to:

- Reduce suffering and disability.
- Improve educational and health outcomes.
- Improve the child's relationship with their family, teachers and peers, thus improving their outcomes.
- Help parents and teachers to better understand the behaviour of the child/adolescent with a behavioural disorder.

Person's story

Living with behavioural disorders.

Emotions and emotional disorders

- Feelings of fear, anxiety, sadness and or irritability in children and adolescents is normal and healthy as they grow and develop.
- Only when these emotions are felt for prolonged periods of time, cause disabling distress and impact on the child or adolescents ability to function in everyday life should it be considered a disorder.

Emotional disorders

Main features of emotional disorders are:

- Prolonged (intense emotions felt for prolonged period of time).
- Disabling: impedes the child/adolescents ability to function in everyday life.
- Distress: intensely feeling emotions such as sadness, fearfulness, anxiety and irritability.



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)

Early identification and intervention

- Globally depression is the number one cause of illness and disability in young people aged 10–19 years.
- Suicide ranks as the third leading cause of death among young people aged 10–19 years.
- Half of people who will develop MNS conditions will experience their first symptoms by age 14.
- If young people get the care they need early then it can prevent death and avoid suffering throughout adult life.

Depression in adolescence

- Core features of depression:
 - Feeling sad, irritable or down.
 - Lost interest or enjoyment in activities.
- Additional symptoms include:
 - Disturbed sleep, change in appetite, feeling worthless and excessive guilt, loss of energy, reduced concentration, problems making decisions, irritability, hopelessness, suicidal thoughts and acts.
 - These symptoms must be present **most of the day for at least two weeks.**

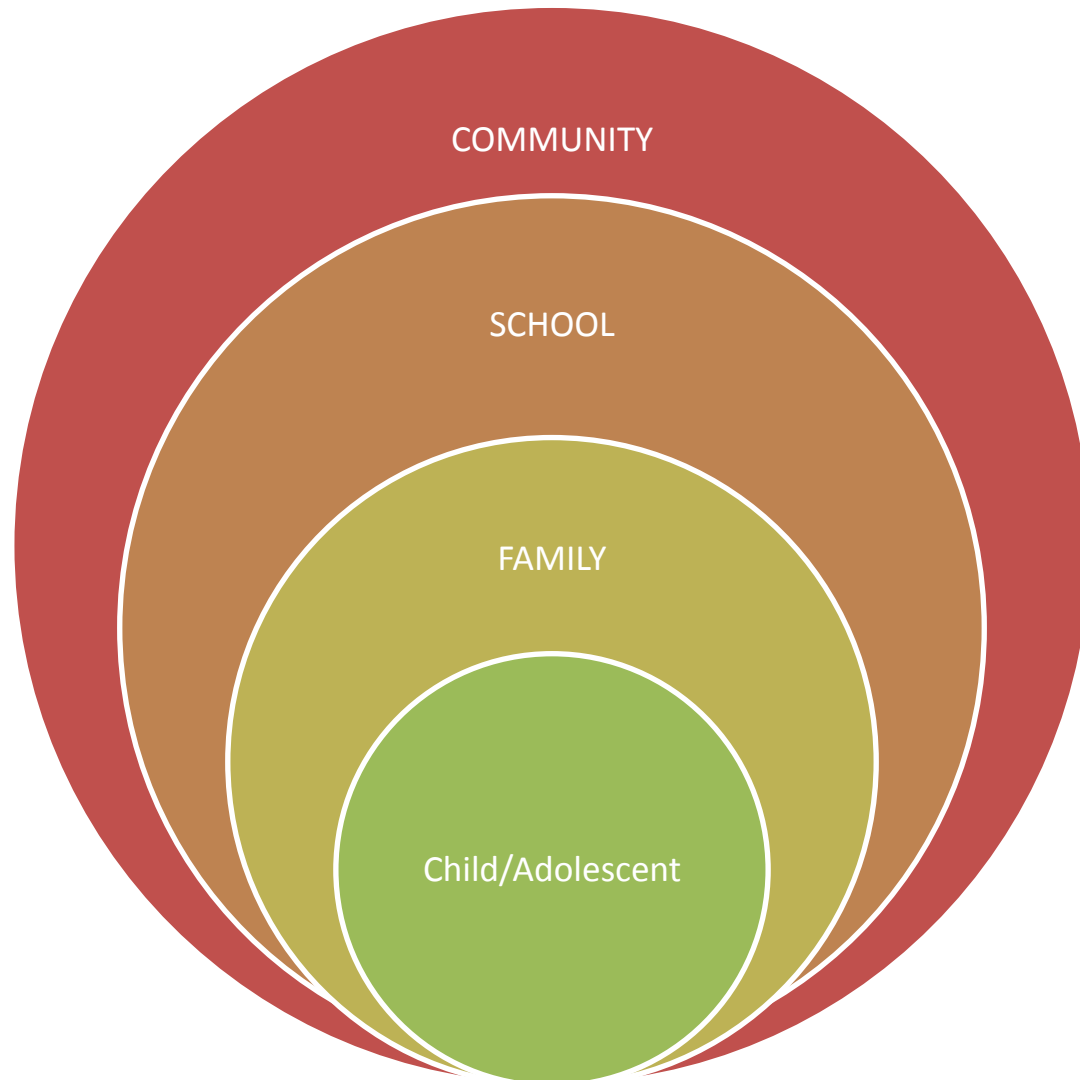
Emotional disorders in adolescents

Omar is a 14-year-old boy who lives with his parents and his two brothers and sisters. He has always been an active boy, doing well at school and interested in sports. His mother fell ill three months ago and has had to have an operation. She is unable to do much since she needs to rest for long hours. Omar has been helping his elder sister with household tasks. Since one month ago, his father reports that Omar has become withdrawn, preferring to stay at home rather than playing sports or visiting his friends, he has become irritable and quarrelsome with his siblings and cannot concentrate on his studies. He is worried about his forthcoming exams and does not think he will be able to do well, fearing failure. He cannot fall asleep at night and remains awake until late, making him very tired during the day. He blames himself for his mother's ill health and thinks he should have helped her more in the past.

Special considerations for assessment of children

Children do not grow and develop in isolation.

Their immediate and broader environment plays an important role



CMH » Quick Overview



ASSESSMENT

- » Assess for problems with development
- » Assess for problems with inattention or over-activity
- » Assess for problems with emotions. If an adolescent, evaluate for moderate to severe depression
- » Assess for repeated defiant, disobedient, and aggressive behaviour
- » Assess for presence of other priority MNS conditions
- » Assess the home environment
- » Assess the school environment



MANAGEMENT

» Management Protocols

1. Developmental Delay/Disorder
2. Problems with Behaviour
3. Attention Deficit Hyperactivity Disorder (ADHD)
4. Conduct Disorder
5. Problems with Emotions
6. Emotional disorders and Moderate to Severe Depression in Adolescents

» Psychosocial Interventions



FOLLOW-UP

CMH » Quick Overview



ASSESSMENT

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MANAGEMENT

» Management Protocols

1. Developmental Delay/Disorder
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» Psychosocial Interventions



FOLLOW-UP

Assess for developmental disorder

Three core pieces of information to learn at assessment:

1. Does the child/adolescent have problems/difficulties in different developmental domains (motor, cognitive, social, play and learning)?
2. Are there any physical conditions that could be contributing to that delay?
3. Are there any visual and/or hearing impairments?

Possible questions

- What questions could you ask to find out this information?
- Who could you ask to find out this information?

ASSESS FOR DEVELOPMENTAL DISORDERS

- 1) Motor (movement) skills
 - How does your child move her/his head, upper-body and legs (holding head up, sitting, walking)?
- 2) Communication and speech
 - How does your child communicate with you?
- 3) Social interaction
 - How does your child interact with you and others, how does he/she play?
- 4) Play and learning
 - What kinds of things can your child do alone now (like eating or dressing)?

Assess for problems with behaviours: Inattention and hyperactivity

1. Does the child/adolescent have problems with inattention or hyperactivity?
2. Do these problems remain in different settings, e.g. home, school, social etc?
 - a. Have they lasted for at least six months?
 - b. Are they appropriate for the child/adolescent's level of development?
 - c. Do they severely impact on the child/adolescent's ability to function in daily life (at school in the family etc.)?
3. Are there physical conditions that could resemble these symptoms?

Possible questions

- What questions could you ask to find out this information?
- Who could you ask to find out this information?

Assess for behavioural problems: Conduct disorder

1. Does the child/adolescent show repeated aggressive, disobedient or defiant behaviour?
2. Are those behaviours persistent, severe, and inappropriate:
 - a. Present across multiple settings (home, school, social groups etc.)?
 - b. Present for at least six months?
 - c. Age appropriate (more severe than childishness or rebelliousness)?
 - d. Severely impact on the child/adolescent's ability to function?

Possible questions

- What questions could you ask to find out this information?
- Who could you ask to find out this information?

How to ask the child about conduct disorder

- Do you find yourself arguing with your parents?
- Do you get irritated if your parents ask you to do something?
- Have you been feeling extremely angry and irritable recently?
- Are you having difficulties getting on with other people?

How to ask a carer about conduct disorder

- Do they have severe temper tantrums?
- Do they repeatedly defy reasonable requests?
- Do they show provocative behaviour?
- Do they show excess bullying or excess levels of fighting?
- Do they show cruelty to other people and animals?
- Have they shown destructiveness to property?
- Have they been repeatedly truanting?

Assess for emotional disorders

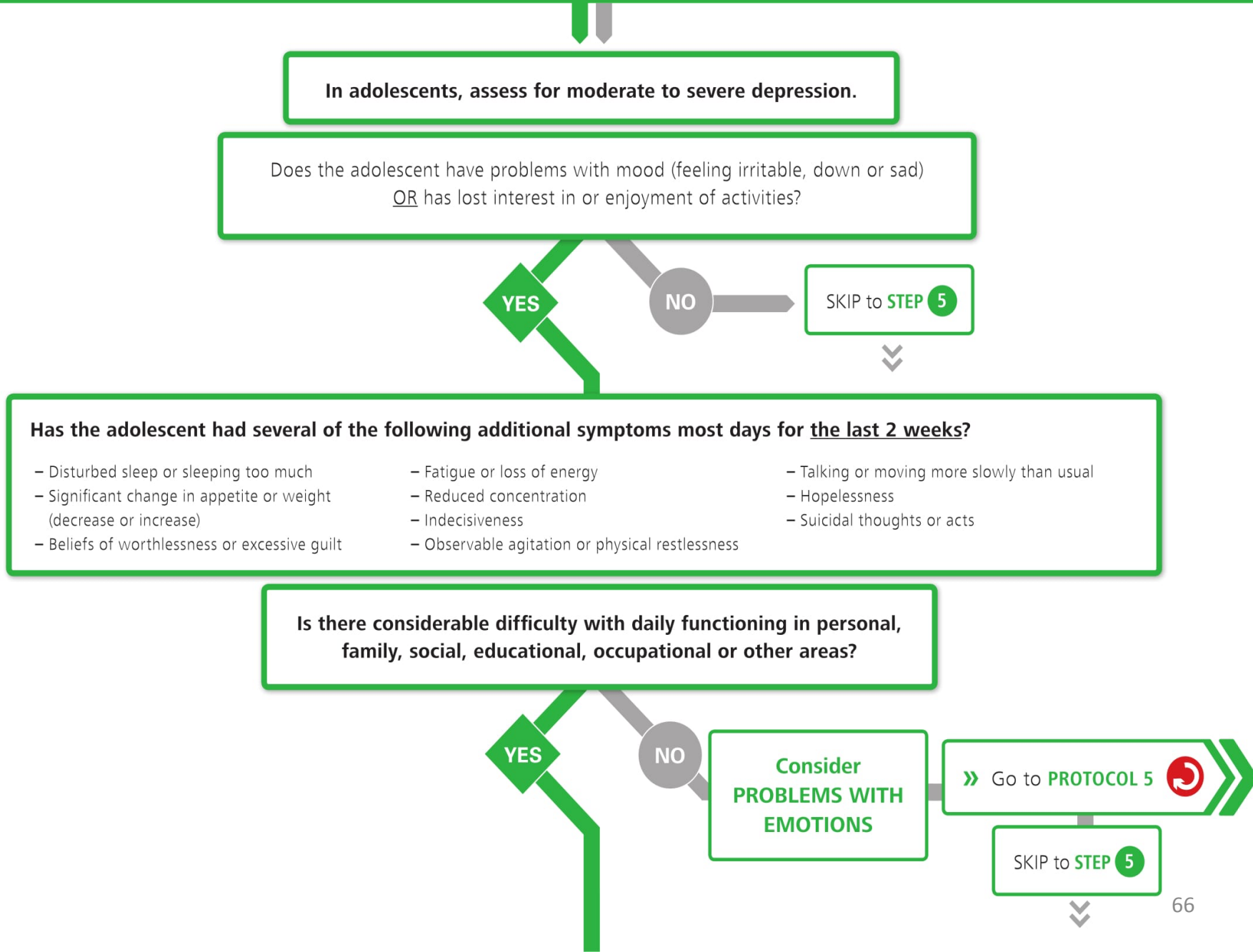
1. Is the child/adolescent experiencing prolonged, disabling distress involving sadness, fearfulness, anxiety and irritability?
2. Do these symptoms severely impact on the child/adolescent's ability to function in daily life?
3. Are there physical conditions that can resemble or exacerbate these emotional symptoms?

Possible questions

- What questions could you ask to find out this information?
- Who could you ask to find out this information?


Asking adolescents/carers about emotions

- Do they often feel irritable, sad, annoyed, down?
- Have they lost interest in activities they used to get enjoyment from?
- Do they have many worries or often seem worried?
- Do they have many fears and are they easily scared?
- Do they complain of headaches, stomach aches or sickness?
- Are they often tearful or down-hearted?
- Do they avoid or strongly dislike certain situations?



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.**

» **ASSESS AND MANAGE** concurrent MNS conditions 

YES

NO

What other priority MNS conditions occur in children and adolescents

- Depression (most common)
- Epilepsy
- Developmental disorders
- Behavioural disorders
- Psychoses
- Substance use disorder
- Self-harm/suicide
- Anxiety.

Activity 4: Video demonstration: Assessment

Show the videos of Rania and Aziz being assessed.

<https://www.youtube.com/watch?v=GKSTkyv3wAM&index=8&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v>

<https://www.youtube.com/watch?v=H6Nte7lxGlc&index=9&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v>

After the videos, discuss the assessments with participants.

Rania

- How did the health-care provider assess Rania's development? (Did she ask about all four developmental domains?)
- How did the health-care provider assess Rania's visual and/or hearing impairments?
- Why did the health-care provider refer Rania to a specialist?
- How did the health-care provider assess for any other problem behaviours?

Aziz

- How did the health-care provider assess Aziz for problems with inattention or hyperactivity?
- How did the health-care provider establish if Aziz's symptoms were present across multiple settings?
- How did the health-care provider rule out other physical conditions that resemble ADHD?

Assess the home environment

Aim of the home environment assessment is to understand:

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

How can you assess this?

6

ASSESS THE HOME ENVIRONMENT



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.


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

NO

- » 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 

CLINICAL TIP:

WARNING FEATURES OF 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

Example questions for the child/adolescent

- How are things at home?
- Has anything stressful or difficult been happening recently?
- Has anyone at home or outside the home hurt or upset you in anyway?
- What happens when you do something your parent/carer doesn't like?
- What happens in your home when people get angry?

Example questions for carers

- Are there any difficult or painful situations at home that may be affecting how your child/adolescent feels or behaves? These could be situations happening now or that have happened in the past.
- Has anyone at home been hurt or upset by anything recently?
- Did the child/adolescent's difficulties begin after a new or stressful event?
- How do you discipline your child?
- How do other family members discipline your child?

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6

ASSESS THE HOME ENVIRONMENT

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- 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

Assess the home environment

If the home environment is **not** aggravating or causing the problems then:

- Ensure that the child can be properly supported at home. Does the carer have priority MNS conditions? Can they care for the child/adolescent?
- Is the child getting adequate opportunities for play/social interaction/communication?

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.

Assess the school environment

- Establish if the child/adolescent is attending school? **If not why not?**
- Is the child/adolescent being bullied, not able to participate in learning, refusing to attend?

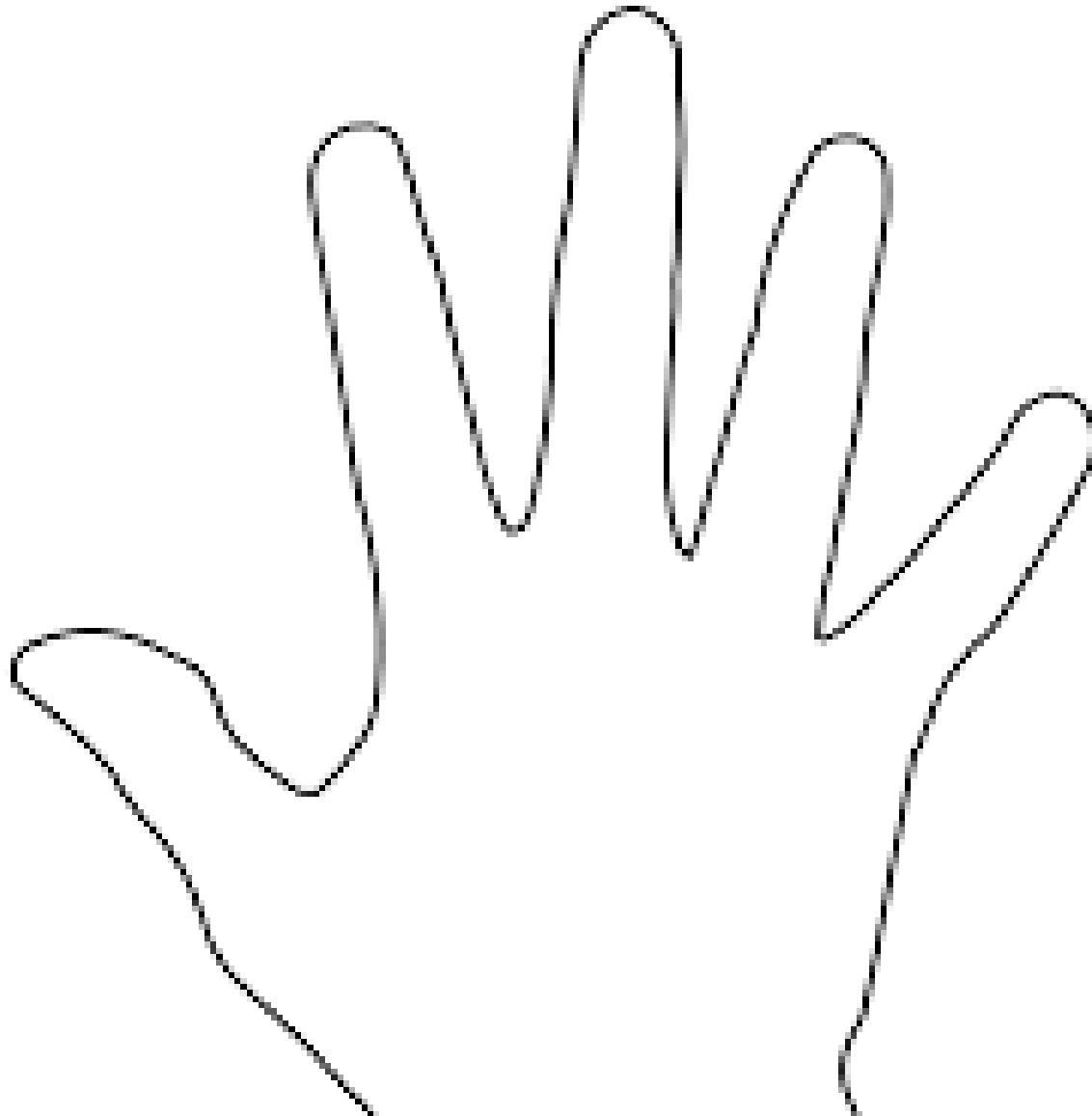
If the answer to these is **yes** then (with consent) talk to the teachers. Find out what is happening. Support the staff to help manage the child/adolescent.

Assess the school environment

- How practical would it be to carry out an assessment of school environment in your setting?
- How would the school and teachers respond?
- What could they do to strengthen those links?

Activity 5: Demonstration role play (conduct disorder)

- Does John have a conduct disorder? If so, why?
- How the health-care provider assessed for any repeated aggressive, disobedient or defiant behaviours?
- How did the health-care provider assess for those symptoms across multiple settings?
- Were the symptoms present for at least six months?
- Was there considerable difficulty in daily functioning in personal, family, social, educational and occupational life? If so, what was that?



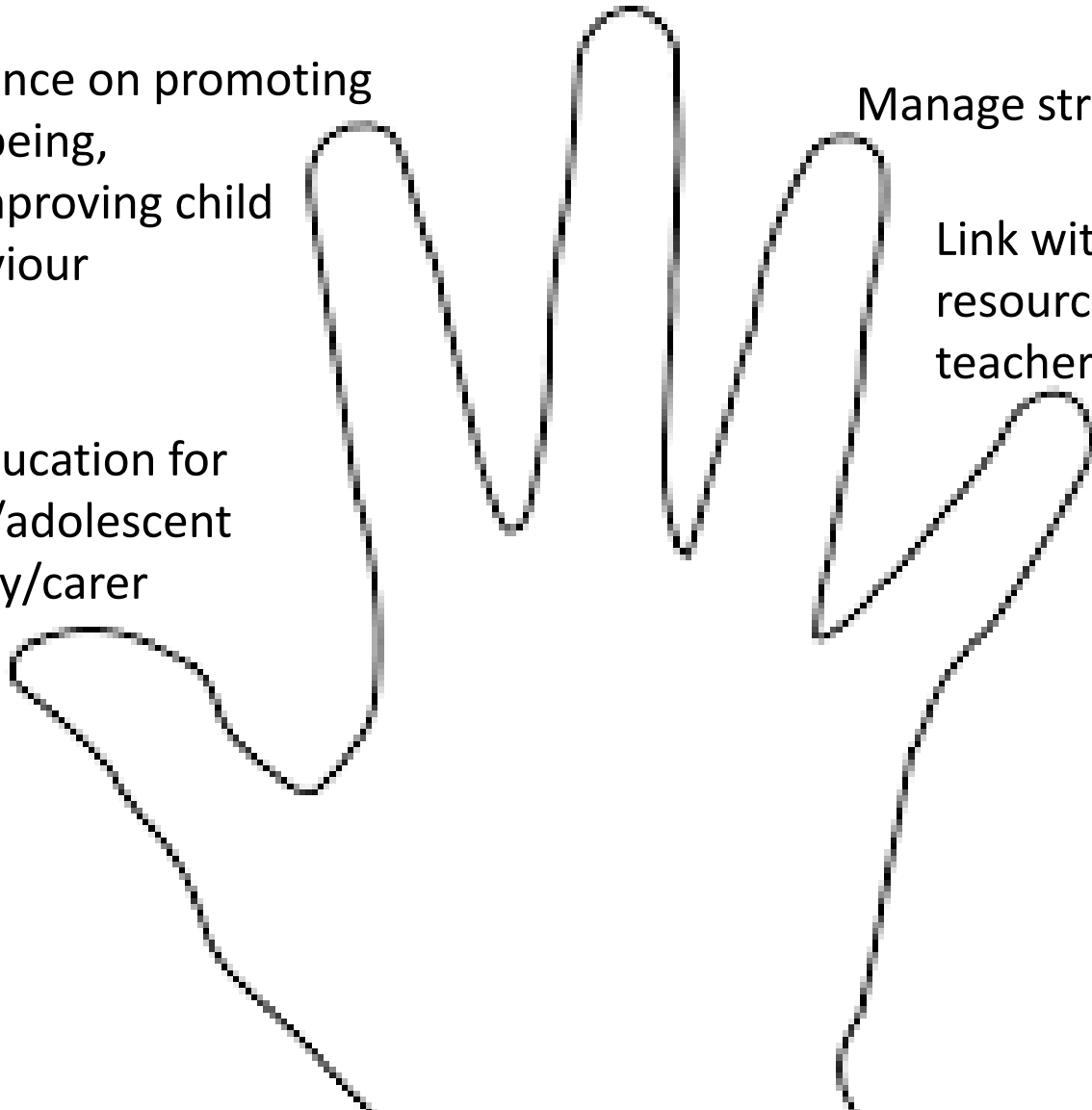
Carer support

Guidance on promoting well-being, i.e. improving child behaviour

Manage stressors

Link with community resources, Liaise with teachers

Psychoeducation for the child/adolescent and family/carer



mhGAP recommendations

Psychosocial interventions for treatment of behavioural disorders	Behavioural interventions for children and adolescents, and caregiver skills training.
Psychosocial interventions, treatment of emotional disorders	Psychological interventions, such as CBT, IPT for children and adolescents with emotional disorders, and caregiver skills training focused on their caregivers
Caregiver skills training for the management of developmental disorders	Caregiver skills training should be provided for management of children and adolescents with developmental disorders, including intellectual disabilities and pervasive developmental disorders
Antidepressants among adolescents with moderate-severe depressive disorder for whom psychosocial interventions have proven ineffective	Fluoxetine (but not other Selective Serotonin Reuptake Inhibitors or Tricyclic Antidepressants) may be offered. The intervention should only be offered under supervision of a specialist.

Psychosocial interventions

- Psychoeducation can be given to all carers even if their children/adolescents do not have mental and behavioural disorders.
- Guidance on improving behaviour can be given to all carers.
- The more people that are aware of the importance of healthy childhood development the better the outcomes for children and adolescents.

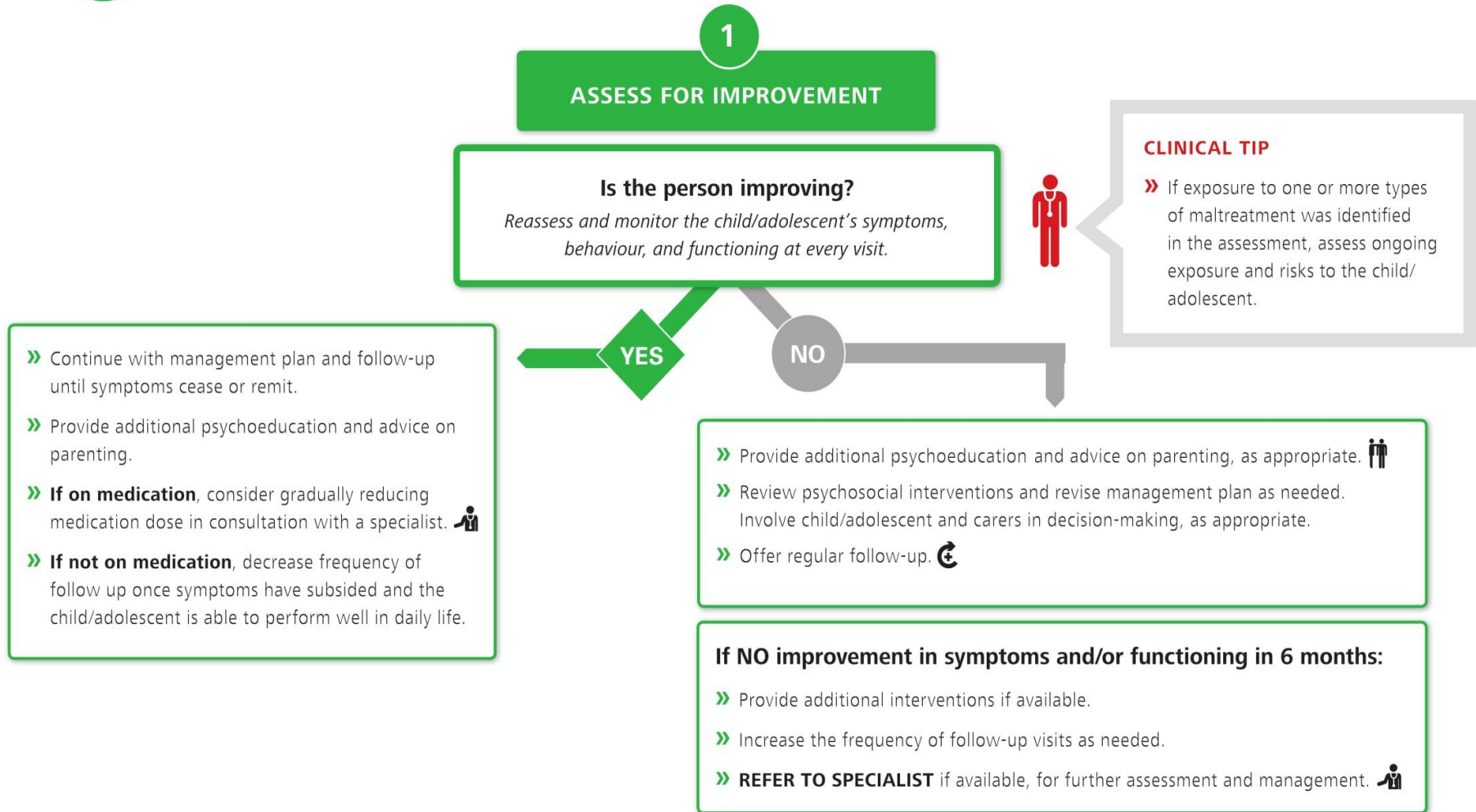
Psychoeducation messages to the carer

- Strongly emphasize that the child/adolescent should not be blamed for their disorder and/or behaviour.
- It is not their fault, nor is it because they are cursed or evil.
- Acknowledge how hard and stressful it is for the carer.
- But stress that the child/adolescent needs kindness, patience, love and support.

Activity 6: Role play: Psychosocial interventions

- Read through and familiarize yourself with the psychosocial interventions in the mhGAP-IG (pages 87–89).
- Aziz (six) and his mother Fatima have just heard that Aziz has ADHD.
- The health-care provider will develop a treatment plan and deliver psychosocial interventions to Aziz and his mother, including psychoeducation.

CMH 3 » Follow-up



CLINICAL TIP

- » For adolescents, plan to see the adolescent separately from their parent/carer for part of the follow-up visit. Clarify the confidential nature of the health care discussion, including in what circumstances parents or other adults will be given information.



DEVELOPMENTAL DISORDERS

If no improvement, further deterioration, predicted danger to the child, or physical health is affected (such as nutritional problems),

- » REFER TO SPECIALIST for further assessment and advice on management plan. 
- ❌ **DO NOT** consider pharmacological treatment.

ADHD

If no improvement and the child is at least 6 years old and has received psychosocial treatment for at least 6 months

- » Refer to or consult SPECIALIST for methylphenidate use. 

CONDUCT DISORDERS

If no improvement or predicted danger to the adolescent

- » REFER TO SPECIALIST for further assessment and advice on management plan. 
- ❌ **DO NOT** consider pharmacological treatment.

EMOTIONAL DISORDERS

If no improvement and the child/adolescent has received psychosocial treatment for at least 6 months

- » REFER TO SPECIALIST. 
- ❌ **DO NOT** initiate pharmacological treatment.

DEPRESSION

If no improvement and the adolescent is 12 years or older and has received psychosocial treatment for at least 6 months

- » Refer to or consult SPECIALIST for fluoxetine (but not other SSRIs or TCAs). 

2

CONDUCT ROUTINE ASSESSMENTS

At every visit:

- » For children under 5 years, monitor child development.
- » Assess for the presence of any new problem or symptom related to mood, behaviour or development/learning. For adolescents, assess for the presence of worsening mood (irritable, easily annoyed or frustrated, down or sad) or suicidal thoughts. Go back to Assessment Step 4 for worsening mood. Go to »SUI for suicidal thoughts.
- » Explore and address psychosocial stressors in the home, school or work environment, including exposure to violence or other forms of maltreatment.
- » Assess opportunities for the child/adolescent to participate in family and social life.
- » Assess carers' needs and support available to the family.
- » Monitor attendance at school.
- » Review management plan and monitor adherence to psychosocial interventions.
- » If on medication, review adherence, side-effects, and dosing.


3

MONITOR PHARMACOLOGICAL TREATMENT AS APPLICABLE

Additional monitoring if the adolescent has been prescribed fluoxetine

- » Record prescription and administration details.
- » **Weekly for the first month, then every month:** monitor for reported side-effects and changes in mood and other symptoms.
- » Consult specialist if you identify severe medication side-effects or adverse events (e.g. new or worsening suicidal thoughts, suicidal or self-harming behaviour, agitation, irritability, anxiety or insomnia). 
- » Advise the adolescent to continue the medication even if they feel better. The medication should be continued for 9-12 months after the symptoms have resolved to reduce the risk of relapse.
- » Advise against suddenly stopping the medication.
- » **If symptoms have been resolved for 9-12 months:** Discuss with adolescent and carer risks and benefits to taper off medication. Reduce treatment gradually over minimum 4 weeks, monitor closely for symptom recurrence.

Additional monitoring if the child has been prescribed methylphenidate

- » Record prescription and administration details.
- » Monitor potential for misuse and diversion.
- » **Every three months:** monitor/record height, weight, blood pressure, reported side-effects, and changes in behaviour.
- » Consult specialist if you observe medication side-effects (e.g. failure to make expected gains in weight and height, increased blood pressure, agitation, anxiety, and severe insomnia). 
- » **After one year of treatment:** Consult specialist regarding the continuation of methylphenidate.

Activity 7 Role play: Follow-up

- An adolescent was diagnosed with depression three months ago.
- After trying to get the adolescent to return for a follow-up visit for six weeks they finally agree to attend.
- This is the first time they have seen a health-care provider in three months.

Review

- Administer MCQs.