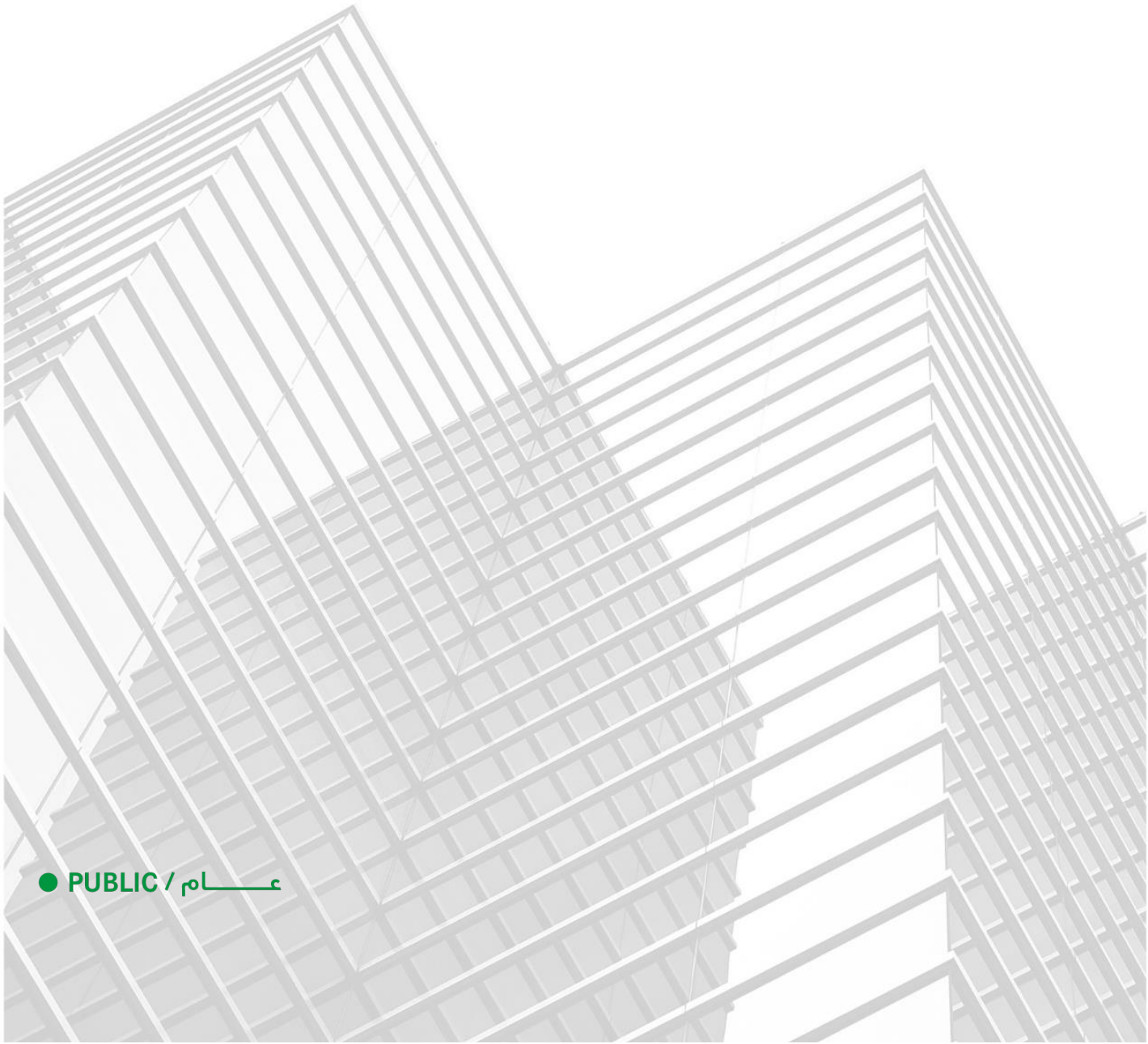
دائـــــرة الـصـــحـــة
DEPARTMENT OF HEALTH

Guideline for Mental Health of Children & Adolescents in Primary Care Settings



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1.Guideline Purpose and Brief

1.1. This guideline provides healthcare professionals in primary health centers (PHCs) interacting with children in various disciplines in Abu Dhabi with a basic understanding of children's mental health.

1.2. The guideline outlines:

1.2.1. Perspective on children's mental health including:

1.2.2. Risk factors

1.2.3. Protective factors

1.2.4. Impact of mental health issues on children and their families

1.2.5. Common mental health disorders in children

1.3. This guideline is intended for use by:

1.3.1. All healthcare professionals working with children

1.3.2. Secondarily, mental health professionals, for understanding the context of referrals they receive for more detailed diagnosis and treatment

1.4. Note: This guideline does not provide information on advanced diagnostics and treatment methods reserved for specialists.

2. Definitions and Abbreviations

No.	Term / Abbreviation	Definition
2.1	ADPHC	Abu Dhabi Public Health Center
2.2	ASQ	Ages and Stages Questionnaires
2.3	CBCL	Child Behavior Checklist
2.4	CSBS	The Communication and Symbolic Behavior Scales
2.5	CY-BOCS	Children's Yale-Brown Obsessive Compulsive Scale
2.6	DSM-5 TR	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition-Text Revision
2.7	GAD-7	Generalized Anxiety Disorder Scale
2.8	ICD-11	International Classification of Diseases: Classification and Mental and Behavioral Disorders Eleven's Revision
2.9	LSAS	Liebowitz Social Anxiety Scale
2.10	M-Chat	Modified Checklist for Autism in Toddlers
2.11	MFQ	Mood and Feelings Questionnaire
2.12	PCP	Primary Care Professional – this includes Family Physician and Paediatricians in this document
2.13	PHQ-9	Patient Health Questionnaire Nine
2.14	VADRS	Vanderbilt ADHD Diagnostic Rating Scale

3. Guideline Content

3.1. Professionals' roles & responsibilities

3.1.1. All professionals working with children must uphold and respect children's rights, ensuring they are treated with dignity, empathy, and fairness throughout all interactions and interventions.

Table 1. Professionals' Roles and Responsibilities

Professional Category	Role	Responsibility
Paediatric Primary Care	Family Physicians, Paediatricians	• Provide comprehensive evaluations of child health and screen for mental health concerns • Refer to mental health professionals when needed • Diagnose and establish treatment plans for mild to moderate mental health cases, when no complexities are present (e.g., anxiety, depression). ○ Prescribe medications, if required, in accordance with UAE laws and regulations • Conduct long-term, regular follow-ups with children and their families • Please note general practitioners' role with children and adolescents is limited to screening only
School Mental Health Professionals	Counsellors, Rehabilitation Professionals	• Identify and assess academic, emotional, and behavioral challenges in students, providing initial support where appropriate • Administer standardized screening tools for students with identified mental health concerns and communicate concerns and/or findings with parents • Refer students to specialized mental health or medical professionals when additional intervention is required
Child and Adolescent Mental Health Professionals	Child Psychiatrists, Child Psychologists, Educational Psychologists, Child Neuropsychologists, and Developmental and Behavioural Paediatricians	• Hold the sole authority to diagnose and treat mental health disorders and disturbances in children and adolescents in severe and/or complex cases

3.2. Overview mental health disorders in children and adolescents

3.2.1. Mental health is an important part of overall health for children. For a young person with symptoms of a mental disorder, early detection and treatment can:

3.2.1.1. Reduce severity of symptoms

3.2.1.2. Help develop coping mechanisms

3.2.1.3. Facilitate a more effective, quicker recovery

3.2.1.4. Reduce risk of lasting, long-term challenges including, but not limited to:

3.2.1.4.1. Academic and cognitive challenges

3.2.1.4.2. Health challenges

3.2.1.4.3. Socio-economic challenges

3.2.2. Understanding Risk and Protective Factors

3.2.2.1. Risk assessment includes weighing the risk and protective factors and evaluating their impact on the child.

3.2.2.2. Risk factors alone do not necessarily indicate a mental health issue; they simply increase the likelihood of challenges. Protective factors can mitigate these risks and support resilience.

Table 2. Risk and Protective Factors for Mental Health Disorders Among Children

Risk Factors	**Protective factors**
Challenging child temperament (challenges in emotional regulation, behavior management, and adapting to new situations)	Positive child temperament (effective emotional regulation, adaptability, resilience)
Child's physical health and disabilities	Secure attachment to parents
Child abuse and neglect	Family mental health literacy
Family history of mental disorders	Peer support
Family conflicts	Family cohesion
Adverse childhood experiences	Strong and supportive social networks
Limited education attainment in parents	Positive school environment
Discriminative social/cultural environments	Positive parenting practices
Low socio-economic status	
Bullying	
Parents with substance abuse	

3.2.2.3. When vulnerability occurs in any of the above-mentioned conditions, the physician screens for risk factors and then performs a primary evaluation of the child mental health. Whenever needed, the physician will refer the child and family to a mental health professional or social care professional.

3.2.3. Common mental health disorders in children and adolescents

3.2.3.1. To support early identification and intervention, the table below summarizes common mental health disorders in children and adolescents, including typical age ranges and validated screening tools applicable in primary care settings. If a child screens positive on any of these tools, or if clinical concerns persist despite a negative screen, the primary care practitioner should initiate a referral to a qualified mental health specialist for further evaluation and comprehensive management. Prompt referral is essential to ensure timely support, reduce long-term impairment, and coordinate care with families and schools where appropriate.

Table 3. Common Mental Health Disorders Among Children

Condition	Age of onset	Screening tools
Attention-Deficit/ Hyperactivity Disorder (ADHD)	Before age 12 No confirmed diagnosis before age 4	Vanderbilt ADHD Diagnostic Parent and Teacher Rating Scales. Conners' Rating Scales Ages and Stages Questionnaire, (ASQ-3) Strengths and Difficulties Questionnaire (SDQ)
Specific Learning Disorders (SLD)	Early childhood, precursors symptoms Diagnosis at age 6	No tools for GPs Poor achievement report from parent
Autism Spectrum Disorder (ASD)	Before age 3	Modified Checklist for Autism in Toddlers, Revised (M-CHAT-R) for children aged 16–30 months. Ages and Stages Questionnaire: Social-Emotional (ASQ:SE-2)
Intellectual Disability (ID)	Delays in early childhood (by age 3)	Ages and Stages Questionnaire, Third Edition (ASQ-3) Developmental Profile (DP-4)
Anxiety Disorders	Throughout the development	Screen for Child Anxiety Related Disorders (SCARED) for children aged 8–18 Generalized Anxiety Disorder 7-item scale (GAD-7) for children age 12 and above Strengths and Difficulties Questionnaire (SDQ) Pediatric Symptom Checklist (PSC)
Obsessive-Compulsive Disorder (OCD)	8 years and above	Children's Yale-Brown Obsessive-Compulsive Scale (CY-BOCS) Pediatric Symptom Checklist (PSC)

		Strengths and Difficulties Questionnaire (SDQ)
Major Depressive Disorder	Mainly in adolescence but can occur during childhood	Patient Health Questionnaire for Adolescents (PHQ-9) for children aged 12 and older Pediatric Symptom Checklist (PSC) Strengths and Difficulties Questionnaire (SDQ)
Post-Traumatic Stress Disorder (PTSD)	At any age	Child PTSD Symptom Scale (CPSS) PTSD Screen for DSM-5 (PC-PTSD-5
Oppositional Defiant Disorder (ODD)	Before age 8, mainly around 3-4 years	Strengths and Difficulties Questionnaire (SDQ) Child Behavior Checklist (CBCL) Pediatric Symptom Checklist (PSC)
Conduct Disorder (CD)	Mainly after age 10 but can appear earlier	Strengths and Difficulties Questionnaire (SDQ) Child Behavior Checklist (CBCL) Pediatric Symptom Checklist (PSC)
Eating Disorders (ED)	Throughout the development	SCOFF Questionnaire (adapted for children) Children's Eating Attitudes Test (ChEAT)
Substance Use Disorders (SUD)	During adolescence	CRAFFT Screening Tool Pediatric Symptom Checklist (PSC)
Child Abuse and Neglect (CAN) and Adverse Childhood Experiences (ACEs)	Throughout the development	Any major change in the child's development, behavior, achievement.

3.3. Primary Care Assessment Overview

3.3.1. The primary care practitioner should rule out medical causes through a physical examination including, but not limited to complete blood count, thyroid function, vitamin D, electrolytes (including calcium, phosphate, magnesium) before concluding to a hypothesis of mental health disorder and referring to the appropriate healthcare professionals.

3.3.2. The primary care practitioner (family physician or pediatrician) has the capacity to provide psychoeducation to the child and the family and reassure them at the time of the lab results, that mental health issues are not rare, and can affect children across different age groups, and can be treated.

3.3.3. Parental or guardian involvement is a critical component in the identification, treatment, and long-term management of mental health concerns in children and adolescents. They should be involved early in the care process, especially when concerns are first raised by teachers, primary care providers, or the child themselves. Their involvement is essential for shared decision-making, ensuring adherence to treatment plans, and providing emotional and

logistical support.

3.3.4. In the following sections, the most common mental health conditions in children and adolescents are presented as per the DSM-5 TR. For rare conditions, physicians are advised to refer to the international classifications.

3.4. Neurodevelopmental Disorders

3.4.1. Neurodevelopmental disorders (NDDs) are complex conditions arising from the interplay of genetic predispositions and environmental influences. Genetic factors, including inherited and de novo mutations, contribute significantly to the risk of NDDs. Environmental factors, such as prenatal exposure to pollutants, maternal immune activation, and other prenatal stressors, can also impact neurodevelopment. Symptoms of NDDs typically manifest in early childhood. Accurate diagnosis necessitates careful comparison of behavioral observations with typical developmental trajectories, ensuring that observed behaviors are not solely attributable to environmental factors

3.4.2. This section elaborates on neurodevelopmental disorders commonly encountered in primary care settings, aiming to enhance the understanding and capacity of primary care physicians (PCPs) in identifying and managing these conditions. Recommended screening tools are included to support preliminary evaluation and facilitate further management. It is important to note that while definitive diagnosis is typically the responsibility of specialty physician (e.g. psychiatrist, development and behavioral pediatrician), PCPs and pediatricians play a pivotal role in recognizing early signs and symptoms, ensuring timely screening, and initiating appropriate referrals to specialized care.

3.4.3. **Neuro Development Disorders can be of different types**:

3.4.3.1. Attention-Deficit/ Hyperactivity Disorder (ADHD)

3.4.3.2. Specific Learning Disorder (SLD)

3.4.3.3. Autism Spectrum Disorder (ASD)

3.4.3.4. Intellectual Disability (ID)

3.4.4. **Attention-Deficit/ Hyperactivity Disorder (ADHD) – (See Appendix A)**

3.4.4.1. Definition: ADHD, or Attention-Deficit/Hyperactivity Disorder, is a neurodevelopmental disorder characterized by persistent patterns of inattention, hyperactivity, and impulsivity that interfere with daily functioning or development.

3.4.4.2. Symptoms:

3.4.4.2.1. Signs and symptoms are categorized into two groups: inattention symptoms and hyperactivity symptoms.

3.4.4.2.2. Children may have symptoms of both inattentiveness and hyperactivity and impulsiveness, or they may have symptoms of just one of these types of behaviors.

3.4.4.2.3. Inattention Symptoms

3.4.4.2.3.1. Failure to pay attention

3.4.4.2.3.2. Difficulty in sustaining attention

3.4.4.2.3.3. Apparent inattentiveness when spoken to directly

3.4.4.2.3.4. Failure to follow instructions

3.4.4.2.3.5. Poor task organization

3.4.4.2.3.6. Inability to complete tasks

3.4.4.2.3.7. Avoidance or reluctance toward tasks requiring sustained mental effort

3.4.4.2.3.8. Frequent loss of items needed for tasks

3.4.4.2.3.9. Distraction by external stimuli

3.4.4.2.3.10. Forgetfulness in daily activities

3.4.4.2.3.11. Difficulty following directions and/or instructions

3.4.4.2.4. Hyperactivity and Impulsivity Symptoms

3.4.4.2.4.1. Excessive fidgeting or squirming

3.4.4.2.4.2. Difficulty remaining seated

3.4.4.2.4.3. Running or climbing in unsuitable situations

3.4.4.2.4.4. Difficulty engaging in quiet play or activities

3.4.4.2.4.5. Discomfort with remaining still for long periods

3.4.4.2.4.6. Excessive talking

3.4.4.2.4.7. Interrupting by blurting out answers

3.4.4.2.4.8. Difficulty waiting for turn

3.4.4.2.4.9. Frequent interruption or intrusion on others' activities

3.4.4.2.4.10. Difficulty managing frustrations

3.4.4.2.4.11. Hyperactivity is most observed in younger children, inattention and hyperactivity are most observed in elementary school children

3.4.4.2.5. Symptoms must be present for at least 6 months in at least two settings (e.g., home, school) and be inconsistent with the child's developmental level for consideration of a full diagnosis

3.4.4.2.6. In mild cases of ADHD, symptoms may not be detected until later in middle school when there is an increased demand in academic learning

3.4.4.3. <u>Screening</u>

3.4.4.3.1. Screening in primary care can be initiated based on concerns raised by parent or of inattention, hyperactivity, or impulsive behaviors affecting daily functioning.

3.4.4.3.2. Screening can be performed in Primary Care by family physicians, general practitioners or pediatricians and their nursing team

3.4.4.3.3. Screening should be performed using valid tools to identify ADHD symptoms including:

3.4.4.3.3.1. Vanderbilt ADHD Diagnostic Parent and Teacher Rating Scales to assess inattention, hyperactivity, and impulsivity across settings.

3.4.4.3.3.2. Conners' Rating Scales for evaluating ADHD symptoms and associated behaviors.

3.4.4.3.3.3. Ages and Stages Questionnaire, Third Edition (ASQ-3) for younger children to assess general developmental concerns.

3.4.4.3.3.4. Strengths and Difficulties Questionnaire (SDQ) to screen for emotional and behavioral problems, including ADHD.

3.4.4.3.4. Parent and teacher input is crucial to assess the presence of symptoms across home and school environments.

3.4.4.3.5. Positive screening results should prompt a referral to a developmental pediatrician, child psychologist, or psychiatrist for a comprehensive assessment and diagnosis.

3.4.4.4. <u>Diagnosis</u>

3.4.4.4.1. Diagnosis of ADHD should only be made by a mental health specialist (either a psychiatrist or psychologist)

3.4.4.4.2. Input from schools and parents is requested, and tools can be utilized such as the Strengths and Difficulties Questionnaire (SDQ) and, for greater specificity, the Vanderbilt ADHD Scale in both parent and school versions.

3.4.4.5. <u>Treatment</u>

3.4.4.5.1. Treatment is led by psychologists and psychiatrists; however, PCPs are involved in regular monitoring and coordination of care.

3.4.4.5.2. ADHD is best treated when combining medication, cognitive behavioral therapy, parenting, and psychoeducation for all primary caretakers (including nannies, if applicable)

3.4.4.5.3. Psychomotor therapy has emerging evidence of efficacy

3.4.4.5.4. Medication is rarely prescribed for children under the age of 6.

3.4.4.5.5. Coordination of care across school systems, ensuring academic accommodation such as individualized education plans (IEPs) and continued teacher collaboration should be explored and prioritized.

3.4.4.5.6. Monitoring treatment can be through repeating rating scales used in assessment or quality of life metric

3.4.4.5.7. Ensure engaging the family in child's treatment plan and monitoring treatment adherence

3.4.4.5.8. Ensure family's mental wellbeing and ability to support the child is considered

3.4.4.6. Reintegration

3.4.4.6.1. Support the incorporation of IEPs in schools and other accommodation (e.g., additional time for exams) when necessary

3.4.4.6.2. Coordinate access to community mental health services (e.g., support groups and peer support networks)

3.4.4.6.3. Offer vocational courses and alternative therapies (e.g., art, animals, music).

3.4.5. **Specific Learning Disorders (SLD)**

3.4.5.1. Definition: SLD are persistent impairment in reading, writing, or mathematics with no intellectual disability. SLD are not diagnosed before the age of 6 (i.e., when the child is asked to read and write).

3.4.5.2. Symptoms

3.4.5.2.1. Early Childhood Symptoms:

3.4.5.2.1.1. Language Delays: Challenges with language acquisition, including limited vocabulary or difficulty forming sentences.

3.4.5.2.1.2. Memory Challenges: Struggles with memorizing and repeating rhymes or sequences.

3.4.5.2.1.3. Motor Skills Issues: Difficulty with tasks requiring fine motor coordination, such as coloring or copying shapes.

3.4.5.2.1.4. Reading Difficulties: Problems with decoding, recognizing letters, or making specific reading errors.

3.4.5.2.2. Symptoms in Older Children:

3.4.5.2.2.1. Task Organization: Persistent difficulties in organizing tasks or following multi-step instructions.

3.4.5.2.2.2. Memory Retention: Struggles with retaining information, such as multiplication tables or spelling rules.

3.4.5.2.2.3. Reading and Writing Issues: Challenges in reading fluency, comprehension, or producing coherent written work.

3.4.5.2.2.4. Cognitive Organization: Difficulty structuring and articulating thoughts effectively in speech or writing.

3.4.5.3. Considerations for Diagnosis: Difficulties must persist for at least 6 months despite targeted interventions for a full diagnosis

3.4.5.4. Screening

3.4.5.4.1. Screening in primary care can be initiated based on concerns from parents, teachers, or school reports regarding academic difficulties.

3.4.5.4.2. Screening can be performed in Primary Care by family physicians, general practitioners or pediatricians and their nursing team

3.4.5.4.3. Screening should be performed using validated tools including:

3.4.5.4.3.1. Learning Disabilities Checklist for identifying observable learning challenges.

3.4.5.4.3.2. Teacher and Parent Questionnaires, such as Conners' Rating Scales, for detailed insights on classroom behaviors and academic performance.

3.4.5.4.3.3. Strengths and Difficulties Questionnaire (SDQ) to identify coexisting emotional or behavioral concerns.

3.4.5.4.3.4. Pediatric Symptom Checklist (PSC) to flag developmental or psychosocial concerns linked to learning challenges.

3.4.5.4.3.5. In cases of academic struggles, brief literacy or numeracy assessments (e.g., Wide Range Achievement Test) may also be performed.

3.4.5.4.4. Positive findings from these screenings should lead to referrals for educational psychologists, developmental pediatricians, or specialized learning services for further evaluation.

3.4.5.4.5. Diagnosis:

3.4.5.4.5.1. Diagnosis of SLD should only be made by a mental health specialist (either a child and adolescent psychiatrist or psychologist)

3.4.5.4.6. Treatment

3.4.5.4.6.1. Allied health specialists and educational professionals such as speech therapists, psychomotor therapists, special education teachers, and learning assistants or shadow teachers should be included in the treatment plan. They will have to conduct their own specific baseline assessment when they initiate their respective interventions.

3.4.5.4.6.2. Students with SLD need support throughout their academic journey

3.4.6. **Autism Spectrum Disorder (ASD)**

3.4.6.1. Definition: Neurodevelopmental disorder characterized by persistent deficits in social communication and social interaction across multiple contexts, alongside restricted, repetitive patterns of behavior, interests, or activities. These symptoms must be present in early childhood, cause clinically significant impairment in social, occupational, or other important areas of functioning, and are not better explained by intellectual disability or global developmental delay

3.4.6.2. Refer to DoH published Guideline on *Applied Behavioral Analysis for Autism Spectrum Disorder* for more details.

3.4.6.3. Symptoms

3.4.6.3.1. Social Communication and Interaction Symptoms

3.4.6.3.2. Deficits in social-emotional reciprocity, including:

3.4.6.3.2.1. Abnormal social approach

3.4.6.3.2.2. Failure of normal back-and-forth conversation

3.4.6.3.2.3. Reduced sharing of interests or emotions

3.4.6.3.2.4. Failure to initiate or respond to social interactions

3.4.6.3.3. Deficits in nonverbal communicative behaviors used for social interaction, such as

3.4.6.3.3.1. Poorly integrated verbal and nonverbal communication

3.4.6.3.3.2. Abnormalities in eye contact and body language

3.4.6.3.3.3. Deficits in understanding and use of gestures

3.4.6.3.3.4. Total lack of facial expressions and nonverbal communication

3.4.6.3.4. Deficits in developing, maintaining, and understanding relationships, such as:

3.4.6.3.4.1. Difficulties adjusting behavior to suit various social contexts

3.4.6.3.4.2. Difficulties in sharing imaginative play or in making friends

3.4.6.3.4.3. Absence of interest in peers

3.4.6.3.4.4. Restricted, repetitive patterns of behavior, interests, or activities

3.4.6.3.4.5. Stereotyped or repetitive motor movements, use of objects, or speech

3.4.6.3.5. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of behavior, including:

3.4.6.3.5.1. Extreme distress at small changes

3.4.6.3.5.2. Difficulties with transitions

3.4.6.3.5.3. Rigid thinking patterns, greeting rituals, or need to take the same route or eat the same food every day

3.4.6.3.6. Highly restricted, fixated interests that are abnormal in intensity or focus, such as:

3.4.6.3.6.1. Strong attachment to, or preoccupation with unusual objects

3.4.6.3.6.2. Excessively circumscribed or perseverative interests

3.4.6.3.7. Hyper- or hypoactivity to sensory input or unusual interests in sensory aspects of the environment, including:

3.4.6.3.7.1. Apparent indifference to pain or temperature

3.4.6.3.7.2. Adverse response to specific sounds or textures

3.4.6.3.7.3. Excessive smelling or touching of objects

3.4.6.3.7.4. Visual fascination with lights or movement

3.4.6.4. Considerations for Diagnosis: Symptoms must be present during the early developmental period (typically before age 3) and cause clinically significant impairment for a full diagnosis. ASD frequently co-occurs with intellectual disability.

3.4.6.5. Screening

3.4.6.5.1. Screening in primary care can be prompted by concerns from parents, teachers, or observations of developmental or social communication difficulties.

3.4.6.5.2. Screening can be performed in Primary Care by family physicians, general practitioners or pediatricians and their nursing team

3.4.6.5.3. Screening should be performed using validated tools to identify potential signs of ASD including:

3.4.6.5.3.1. Modified Checklist for Autism in Toddlers, Revised (M-CHAT-R) for children aged 16–30 months.

3.4.6.5.3.2. Ages and Stages Questionnaire: Social-Emotional (ASQ:SE-2) to assess social-emotional development.

3.4.6.5.3.3. Parent and teacher reports are crucial for gathering behavioral observations across multiple settings.

3.4.6.5.3.4. Positive screening results should prompt a referral to a developmental pediatrician, child psychologist, or psychiatrist for comprehensive assessment and diagnosis.

3.4.6.6. Diagnosis

3.4.6.6.1. Diagnosis of ASD should only be made by a mental health specialist (either a Child and Adolescent psychiatrist or psychologist)

3.4.6.6.2. A complete medical evaluation is recommended to eliminate sensory deficits, neurological disorders, and others prior to establishing a final diagnosis.

3.4.6.6.3. The assessment and diagnosis of ASD should be approached by a multi-disciplinary team (MDT) of professionals, all with formal professional training and experience in child development and neurodevelopmental and behavioral disorders, including those associated with ASD, as well as the common co-occurring conditions and their differential diagnosis (Applied Behavioral Analysis for Autism Spectrum Disorder Guidelines by the Abu Dhabi Department of Health).

3.4.6.7. Treatment

3.4.6.7.1. A combination of treatment modalities is commonly employed to address the diverse needs of individuals with Autism Spectrum Disorder (ASD), targeting sensory, motor, communication, and behavioral skills. These include:

3.4.6.7.1.1. Applied Behavioral Analysis (ABA): used in addressing communication skills and behavior

3.4.6.7.1.2. Special education: to design and adopt learning accommodations

3.4.6.7.1.3. Speech therapy: to address communication and language development

3.4.6.7.1.4. Psychomotor therapy: to address the enhancement of fine motor and gross motor skills as well as coordination

3.4.6.7.1.5. Psychotherapy: to support the journey of the parents and child

3.4.6.7.1.6. Medications: in case of severe behavioral problems (self-harm or aggression) or when co-occurring with ADHD.

3.4.7. **Intellectual Disability (ID)**

3.4.7.1. Definition: Intellectual disabilities are characterized by intellectual deficits, which manifest in conceptual, social, and practical areas of functioning. These deficits should have an onset during childhood to be diagnosable. Generally, the more severe the condition, the earlier the delay appears.

3.4.7.2. Symptoms: The deficits in intellectual functioning include:

3.4.7.2.1. Reasoning: Difficulty analyzing information and making logical decisions

3.4.7.2.2. Problem Solving: Challenges in identifying solutions to everyday issues or complex situations

3.4.7.2.3. Planning: Struggles with organizing tasks, setting goals, and anticipating future needs.

3.4.7.2.4. Abstract Thinking: Limited ability to understand concepts not directly observable or tangible

3.4.7.2.5. Judgment: Poor decision-making abilities, often leading to inappropriate actions or choices

3.4.7.2.6. Academic Learning and Learning from Experience: Difficulty acquiring new knowledge, applying past experiences to new situations, and achieving age-appropriate educational milestones

3.4.7.2.7. The deficits in adaptive functioning significantly hamper conforming to developmental and sociocultural standards for the individual's independence and ability to meet their social responsibility.

3.4.7.3. Considerations for Diagnosis: Deficits in intellectual and adaptive functioning must be confirmed by clinical assessment and standardized testing for a full diagnosis

3.4.7.4. Screening

3.4.7.4.1. Screening in primary care can be initiated due to developmental concerns raised by parents, teachers, or early childhood educators.

3.4.7.4.2. Screening can be performed in Primary Care by family physicians, general practitioners or pediatricians and their nursing team

3.4.7.4.3. Screening should be performed using validated tools to assess developmental delays or cognitive functioning including:

3.4.7.4.3.1. Ages and Stages Questionnaire, Third Edition (ASQ-3) to identify general developmental delays in children up to 5 years.

3.4.7.4.3.2. Pediatric Symptom Checklist (PSC) to screen for psychosocial or developmental concerns.

3.4.7.4.3.3. Developmental Profile (DP-4) to assess adaptive functioning and intellectual development.

3.4.7.4.4. Parent and teacher input should be collected to evaluate functioning across settings.

3.4.7.4.5. Positive screening results should lead to referrals for developmental pediatricians, psychologists, or specialists for comprehensive assessment and diagnosis.

3.4.7.5. Diagnosis

3.4.7.5.1. ID is diagnosed through a neuropsychological assessment, typically conducted by a clinical psychologist or neuropsychologist, which evaluates IQ levels and the individual's learning profile. This process also includes an assessment of adaptive behaviors, often using tools like the ABAS (Adaptive Behavior Assessment System) test which focuses on adaptive behavior and should be measured along with IQ tests.

3.4.7.5.2. Medical Evaluation: Since ID can result from underlying medical conditions (e.g., genetic, endocrinological, or neurological disorders), a comprehensive medical evaluation is essential before any other diagnostic evaluation. This is typically performed by a neurodevelopmental pediatrician, psychiatrist, or other relevant medical specialist, depending on the suspected cause.

3.4.7.6. Treatment

3.4.7.6.1. A combination of treatment modalities are required for treatment of ID including, but not limited to:

3.4.7.6.1.1. Special Education and Rehabilitation: Evidence-based interventions, including speech therapy and psychomotor therapy, serve as the foundational approach to addressing developmental and functional challenges in individuals with ID

3.4.7.6.1.2. Vocational Services: Adolescents with ID should be provided with vocational training to enhance life skills and promote independence.

3.4.7.6.1.3. Parental Guidance: Structured guidance and support from psychologists are crucial to help parents navigate the challenges of caregiving and foster a supportive environment.

3.4.7.6.1.4. Psychotherapy: Targeted therapeutic interventions are necessary to support emotional adjustment, acceptance of the condition, and the management of co-occurring mental health disorders.

3.5. Anxiety Disorders – (See Appendix B)

3.5.1. Definition: Anxiety is defined as excessive worries and fears. Anxiety is part of a typical development in the child's journey:

3.5.1.1. At 6-9 months the infant expresses their fear of strangers and refuses to interact with unfamiliar adults.

3.5.1.2. At the age of 3-4 years, the child may manifest separation anxiety towards caregivers.

3.5.1.3. At the age of 9-10 years, the child becomes aware of danger and may manifest generalized anxiety.

3.5.1.4. Performance anxiety may be manifested by students particularly when exams determine their potential future achievements.

3.5.1.5. However, when symptoms are severe enough to impede the child's academic and social functioning, treating anxiety as a disorder is a necessity.

3.5.2. Symptoms

3.5.2.1. Generalized anxiety disorder: Excessive and general worries

3.5.2.2. Panic disorder: Recurrent and unexpected panic attacks

3.5.2.3. Separation anxiety disorder: Developmentally inappropriate anxiety or fear of separation from an attachment figure

3.5.2.4. Social anxiety disorder: Fear of being exposed to social demands and social situations

3.5.2.5. Specific phobia: Marked fear and avoidance of specific objects, or animals

3.5.2.6. Additional Symptoms of Anxiety Disorders

3.5.2.6.1. Emotional Symptoms

3.5.2.6.1.1. Excessive worry or fear that is challenging to manage

3.5.2.6.1.2. Persistent anxiety about events or activities, often coupled with catastrophic thinking

3.5.2.6.1.3. Increased irritability or signs of being overly tense

3.5.2.6.2. Physical Symptoms

3.5.2.6.2.1. Frequent headaches, stomach-aches, or other unexplained physical complaints

3.5.2.6.2.2. Fatigue or disrupted sleep patterns

3.5.2.6.2.3. Restlessness or the feeling of being constantly on edge

3.5.2.6.3. Behavioral Symptoms

3.5.2.6.3.1. Avoidance of activities, people, or places that cause anxiety

3.5.2.6.3.2. Difficulty focusing or being easily distracted

3.5.2.6.3.3. Emotional outbursts, such as crying or tantrums, especially under stress

3.5.2.6.4. Social Symptoms

3.5.2.6.4.1. Reluctance or refusal to attend school or participate in social activities

3.5.2.6.4.2. Extreme attachment behaviors, such as clinginess beyond what is typical for the child's age

3.5.2.6.4.3. Difficulty initiating or maintaining friendships

3.5.2.6.5. Academic Symptoms

3.5.2.6.5.1. Decline in school performance due to anxiety about tests, class participation, or completing assignments

3.5.2.6.5.2. Frequent visits to the school nurse for somatic complaints, such as headaches or nausea, linked to anxiety

3.5.3. Consideration for Diagnosis: Excessive anxiety and worry must occur, almost weekly, for at least 6 months for a full diagnosis.

3.5.4. Screening

3.5.4.1. Screening in primary care can be initiated based on concerns raised by parents, teachers, or reports of excessive worry, fear, or avoidance behaviors.

3.5.4.2. Screening can be performed in Primary Care by family physicians, general practitioners or pediatricians and their nursing team. They can also be self-administered by patients who are able to do so or supported by nursing staff

3.5.4.3. Screening should be performed using validated tools to identify anxiety symptoms including:

3.5.4.3.1. Screen for Child Anxiety Related Disorders (SCARED) for children aged 8–18 to identify anxiety symptoms

3.5.4.3.2. Generalized Anxiety Disorder 7-item scale (GAD-7) for children age 12 and above

3.5.4.3.3. Strengths and Difficulties Questionnaire (SDQ) for assessing emotional and behavioral difficulties

3.5.4.3.4. Revised Children's Anxiety and Depression Scale (RCADS) for screening anxiety and depression symptoms in children and adolescents

3.5.4.3.5. Pediatric Symptom Checklist (PSC) to detect emotional or psychosocial problems

3.5.4.4. Parent and teacher questionnaires are important for understanding anxiety symptoms in different settings

3.5.4.5. Positive screening results should lead to referrals to child psychologists, psychiatrists for further evaluation and intervention.

3.5.5. Diagnosis

3.5.5.1. Primary care physicians (PCPs), including family physicians and pediatricians, are equipped to conduct a full assessment, provide a diagnosis, and initiate treatment in accordance with established clinical standards and guidelines.

3.5.5.2. The PCP will conduct a clinical interview with both the child/adolescent and his or her family to evaluate symptoms and assess psychiatric history using DSM-5 criteria for diagnosing anxiety

3.5.5.3. The PCP should also rule out medical causes through a physical examination including, but not limited to: Complete blood count, Thyroid function, Vitamin D, Electrolytes (including calcium, phosphate, magnesium)

3.5.5.4. In In addition, the clinician will also assess risk factors, including but not limited to: Medical history, Family / Patient's history of mental illness, Severity of distress, Functional impairment (Impact of symptoms on academic and social functioning)

3.5.5.5. Based on the outcome of the PCP's comprehensive assessment, he or she will diagnose the patient with either Mild, Moderate or Severe disorder

3.5.6. Treatment

3.5.6.1. Psychotherapy is the first choice of treatment

3.5.6.2. Medical treatment may be prescribed based on the severity of the symptoms

3.5.6.3. Combining medical and psychological therapies in moderate to severe cases of anxiety is preferred

3.5.7. Reintegration

3.5.7.1. Offer educational support and accommodation (e.g., quiet room) in schools if necessary.

3.5.7.2. Enable the child to access community mental health services after securing the consent of the child's parents or legal guardian or custodian (e.g., support groups and peer support networks).

3.5.7.3. Engage family in child's treatment plan and monitoring treatment adherence.

3.6. Obsessive-Compulsive Disorder (OCD)

3.6.1. Definition: A person with OCD experiences either or both:

3.6.1.1. Obsessions: Uncontrollable and recurring thoughts and unwanted experiences that occur repeatedly and feel beyond the child's control, typically causing significant worry, anxiety, and distress

3.6.1.2. Compulsions: Repetitive behaviors that the child/adolescent feels they "must do" to prevent bad things from happening and/or to relieve the distress caused by obsessions.

3.6.1.3. People with OCD have time-consuming symptoms that can cause significant distress or interfere with daily life.

3.6.2. Symptoms:

3.6.2.1. Observed Thoughts: Common obsessions include:

3.6.2.1.1. Thoughts: Worrying about germs or getting sick

3.6.2.1.2. Images: Visualizing disturbing scenes or feared situations

3.6.2.1.3. Urges: Feeling the need to shout or harm someone inappropriately

3.6.2.2. Observed Behavior: Common compulsions include:

3.6.2.2.1. Excessive checking: Repeatedly checking locks

3.6.2.2.2. Cleaning and washing: Washing hands frequently or in a specific way

3.6.2.2.3. Counting or repeating actions: Touching objects a certain number of times

3.6.2.2.4. Arranging or organizing objects: Placing items in a particular order

3.6.3. Consideration for Diagnosis: Obsessions and compulsions must be time-consuming (taking more than 1 hour per day) or cause significant distress or impairment for a full diagnosis.

3.6.4. Screening

3.6.4.1. Screening in primary care can be initiated based on concerns raised by parents, teachers, or reports of repetitive behaviors, intrusive thoughts, or compulsions interfering with daily life.

3.6.4.2. Screening can be performed in Primary Care by family physicians, general practitioners or pediatricians and their nursing team

3.6.4.3. Screening should be performed using validated tools including:

3.6.4.3.1. Children's Yale-Brown Obsessive-Compulsive Scale (CY-BOCS) to assess the severity and presence of OCD symptoms

3.6.4.3.2. Pediatric Symptom Checklist (PSC) to screen for emotional and behavioral concerns, including OCD

3.6.4.3.3. Strengths and Difficulties Questionnaire (SDQ) to evaluate comorbid emotional or behavioral challenges

3.6.4.4. Parent and teacher input should be gathered to assess the impact of symptoms across settings

3.6.4.5. Positive screening results should prompt a referral to a child psychologist or psychiatrist for comprehensive assessment and treatment planning

3.6.5. Diagnosis

3.6.5.1. Clinical assessment should be undertaken by a mental health professional – child and adolescent psychiatry/psychology specialists.

3.6.5.2. Treatment

3.6.5.2.1. Psychotherapy is the main form of treatment

3.6.5.2.2. Medication is an option for severe cases but must be combined with therapy

3.7. Major Depressive Disorder

3.7.1. Definition: Depression is a mood disorder that affects the way a child or adolescent views themselves and the world. Feelings of sadness and loss of purpose and interest are prevalent in those with depression. When transient, these emotions are part of the personality growth. However, when the symptoms persist, mental health interventions are needed

3.7.1.1. Depression is not grief and sadness due to a specific loss. Grief is a normal reaction where sadness comes in waves and the person's self-esteem remains intact

3.7.1.2. Risk factors for depression include, but are not limited to:

Table 4. Risk Factors for Major Depressive Disorder

Risk Factor	Description
Bullying and Cyberbullying	Experiencing or perpetrating bullying, including online harassment, leading to emotional distress and social isolation.
Chronic Low Self-Esteem	Persistent feelings of inadequacy, shame, or worthlessness, increasing vulnerability in challenges.
Interpersonal Difficulties	Struggles in forming or sustaining healthy relationships, resulting in limited social support and isolation.
Academic Challenges	Poor academic performance, learning disabilities, or unmet academic expectations exacerbating stress and failure.
Rejection or Social Exclusion	Experiences of rejection by family, peers, or social groups, leading to feelings of abandonment and reduced self-worth.
Trauma and Adverse Experiences	Exposure to stressors such as abuse, parental loss, chronic illness, or violence impacting psychological well-being.
Genetic and Biological Factors	Family history of depression or mental health conditions increasing vulnerability due to genetics or neurobiology.
Environmental Stressors	Unstable living conditions, financial hardships, or community violence contributing to heightened stress.
Chronic Illness or Health Challenges	Ongoing health conditions or physical limitations causing frustration, isolation, and emotional distress.

3.7.2. Symptoms

3.7.2.1. Emotional Dysregulation:

3.7.2.1.1. Pronounced irritability, persistent sadness, or frequent tearfulness without identifiable triggers

3.7.2.1.2. A marked loss of interest or pleasure in previously enjoyed activities and relationships

3.7.2.2. Physiological Changes:

3.7.2.2.1. Noticeable alterations in appetite, leading to significant weight loss or increased cravings for unhealthy foods

3.7.2.2.2. Disrupted sleep patterns, including insomnia or hypersomnia, often accompanied by neglect of personal grooming and hygiene

3.7.2.3. Cognitive and Behavioral Decline:

3.7.2.3.1. Impaired concentration, diminished motivation, and a subsequent decline in academic performance and engagement

3.7.2.4. High-Risk Indicators:

3.7.2.4.1. Expressions of hopelessness, including death wishes or suicidal ideation, ranging from passive thoughts to active planning

3.7.2.4.2. Self-injurious behaviors such as cutting, burning, or hair-pulling, reflecting profound emotional distress and an elevated suicide risk

3.7.3. Screening

3.7.3.1. Screening in primary care can be initiated based on concerns raised by parents, teachers, or observations of mood changes, withdrawal, or behavioral issues or sudden changes in grades. In addition, complaints of fatigue or modifications of body mass index (BMI) without physical explanations need to be further investigated

3.7.3.1.1. Screening can be performed in Primary Care by family physicians, general practitioners or pediatricians and their nursing team. They can also be self-administered by patients who are able to do so or supported by nursing staff

3.7.3.2. Screening should be performed using validated tools including:

3.7.3.2.1. Patient Health Questionnaire for Adolescents (PHQ-9) for children aged 12 and older

3.7.3.2.2. PHQ-2 as a quick screen for mood and interest changes.

3.7.3.2.3. Pediatric Symptom Checklist (PSC) to identify emotional and behavioral concerns, including depression.

3.7.3.2.4. Strengths and Difficulties Questionnaire (SDQ) to assess emotional distress and social relationships.

3.7.3.3. Parent and teacher input is valuable for identifying changes in behavior and mood across settings.

3.7.3.4. Positive screening results should lead to referrals to a child psychologist or psychiatrist for further evaluation and treatment.

3.7.3.5. Urgent referral to psychiatrist or Emergency Department is required if suicidal ideation or self-harm is identified.

3.7.4. Consideration for Diagnosis: Symptoms must be present nearly every day for at least 2 weeks for a full diagnosis

3.7.4.1. In younger children, depression manifests in crankiness and anger outburst most of the time

3.7.4.2. In older children, anger outbursts, feeling guilty, emotional dysregulation, social isolation and the symptoms listed above may be observed

3.7.4.3. Some adolescents present Major Depressive Episodes where the abovementioned symptoms are severe, impeding their functioning

3.7.5. Diagnosis

3.7.5.1. Primary care physicians (PCPs), including family physicians and pediatricians, are equipped to conduct a full assessment, provide a diagnosis, and initiate treatment in accordance with established clinical standards and guidelines

3.7.5.2. The PCP will conduct a clinical interview with both the child/adolescent and his or her family to evaluate symptoms and assess psychiatric history using DSM-5 criteria for diagnosing depression

3.7.5.3. In In addition, the clinician will also assess risk factors, including but not limited to: Medical history, Family / Patient's history of mental illness, Severity of distress, Functional impairment (Impact of symptoms on academic and social functioning)

3.7.5.4. Based on the outcome of the PCP's comprehensive assessment, he or she will diagnose the patient with either Mild, Moderate or Severe disorder

3.7.6. Treatment

3.7.6.1. Psychotherapy is the main form of treatment

3.7.6.2. Medication is an option for severe cases but must be combined with therapy

3.7.7. Reintegration

3.7.7.1. Offer educational support and accommodation (e.g., quiet room) in schools if necessary

3.7.7.2. Enable access to community mental health services (e.g., support groups and peer support networks)

3.7.7.3. Engage family in child's treatment plan and monitoring treatment adherence

3.8. Post-Traumatic Stress Disorder (PTSD)

3.8.1. Definition: PTSD occurs after a major stressor, direct exposure or witnessing the traumatic event, such as being exposed to death, threatened death, actual or threatened serious injury, or actual or threatened sexual assault.

3.8.2. Symptoms

3.8.2.1. Intrusion symptoms in which the traumatic event is persistently re-experienced in upsetting memories, nightmares, flashbacks

3.8.2.2. Avoidance of trauma related stimuli after the trauma

3.8.2.3. Negative alterations in cognitions and mood such as:

3.8.2.4. Overly negative thoughts and assumptions about oneself or the world

3.8.2.5. Exaggerated blame of self or others

3.8.2.6. Decreased interest in activities

3.8.2.7. Alterations in arousal and activity such as:

3.8.2.8. Irritability or aggression

3.8.2.9. Risky or destructive behavior

3.8.2.10. Hypervigilance

3.8.2.11. Difficulty concentrating and sleeping

3.8.2.12. Additionally in children, particularly the younger ones, symptoms can manifest as:

3.8.2.12.1. Regression in development: such as bedwetting, loss of language skills, or a return to earlier behaviors (like thumb-sucking)

3.8.2.12.2. Attachment issues: excessive clinging to others and/or showing familiarity with strangers

3.8.2.12.3. Somatic complaints: Frequent unexplained headaches or stomach aches

3.8.3. Screening

3.8.3.1. Screening in primary care can be initiated based on concerns raised by parents, teachers, or observations of trauma-related symptoms such as intrusive thoughts, avoidance, or emotional dysregulation

3.8.3.2. Screening in primary care can be performed by family physicians, general practitioners, or pediatricians and their nursing team.

3.8.3.3. Screening should be performed using validated tools including:

3.8.3.3.1. Child PTSD Symptom Scale (CPSS) to assess PTSD symptoms specifically in children and adolescents

3.8.3.3.2. Primary Care PTSD Screen for DSM-5 (PC-PTSD-5), adapted for children, as a brief tool for identifying probable PTSD cases in primary care settings

3.8.3.4. Parent and teacher input should be collected to evaluate symptoms across different environments and contexts

3.8.3.5. Positive screening results should prompt a referral to a child psychologist or psychiatrist for comprehensive evaluation and treatment

3.8.4. Consideration for Diagnosis:

3.8.4.1. The symptoms need to be present for more than one month.

3.8.4.2. The onset of the disorder may occur 6 months after the traumatic event

3.8.5. Diagnosis

3.8.5.1. Clinical assessment should be performed by mental health professional – child and adolescent psychiatry/psychology specialists.

3.8.6. Treatment

3.8.6.1. Evidence based psychotherapy and associated therapeutic approaches

3.8.6.2. Medical treatment may be needed to address severe symptoms of anxiety and depression associated with PTSD

3.9. Oppositional Defiant Disorder (ODD)

3.9.1. Definition: ODD is a persistent pattern of anger, irritability, frequent arguing, defiance towards parents and authority figures such as teachers and school coordinator.

3.9.1.1. In some cases, children with ODD can be vindictive or on the contrary, feel extreme guilt

3.9.2. Symptoms

3.9.2.1. Consistent angry or irritable mood: persistent irritability and emotional volatility, often reacting with anger over minor issues when interacting with peers, family, or authority figures

3.9.2.2. Argumentative behavior: Frequent arguments with adults and challenges to rules, especially regarding routine tasks or reasonable requests, often accompanied by a lack of respect for authority

3.9.2.3. Defiant and noncompliant behavior: consistent refusal to follow instructions or comply with directives from parents, teachers, or other authority figures, demonstrating a pattern of deliberate disobedience

3.9.2.4. Vindictiveness and intentional annoyance: deliberately seeking to annoy or provoke others, engaging in petty acts of revenge, and showing disregard for social norms, often leading to repeated conflicts

3.9.2.5. Frequent loss of temper: easily angered by small frustrations or setbacks, often responding with aggressive behaviors such as yelling, throwing objects, or physical aggression

3.9.2.6. Sensitivity and easily annoyed: highly reactive to criticism or perceived provocations, often responding with rude, defensive, or aggressive behavior

3.9.2.7. Blaming others for mistakes or misbehavior: habitually deflects responsibility for actions, assigning blame to others rather than acknowledging personal accountability

3.9.2.8. The disturbance in behavior is associated with distress in the individual or others in his or her immediate social context or it impacts negatively on social, educational, occupation or other areas of functioning

3.9.3. Screening

3.9.3.1. Screening in primary care can be initiated based on concerns raised by parents, teachers, or observations of persistent defiance, irritability, or argumentative behavior in children

3.9.3.1.1. Screening can be performed in Primary Care by family physicians, general practitioners or pediatricians and their nursing team

3.9.3.2. Screening should be performed using validated tools including:

3.9.3.2.1. Strengths and Difficulties Questionnaire (SDQ) to assess behavioral and emotional problems, including oppositional behaviors.

3.9.3.2.2. Child Behavior Checklist (CBCL) to identify externalizing behaviors such as defiance and aggression.

3.9.3.2.3. Pediatric Symptom Checklist (PSC) to screen for psychosocial and behavioral concerns in primary care settings.

3.9.3.3. Input from parents and teachers is crucial to understand the child's behavior across multiple environments.

3.9.3.4. Positive screening results should lead to a referral to a child psychologist or psychiatrist for further evaluation and development of a management plan.

3.9.4. Diagnosis

3.9.4.1. If concerns arise or symptoms consistent with ODD are observed for a period of at least 6 months, a referral to a mental health professional—such as a child and adolescent psychiatrist or psychologist—is strongly recommended for formal diagnosis. These specialists are equipped to conduct a comprehensive clinical assessment, confirm the diagnosis, and develop an appropriate treatment plan.

3.9.4.2. Typically, this diagnosis is made for children between 7-8 years of age.

3.9.5. Treatment

3.9.5.1. Individual psychotherapy with the child

3.9.5.2. Working with parents on strategies to manage child's behavior

3.9.5.3. Coordinating with teachers and school personnel to apply a behavioral plan that includes self-reflection and close monitoring

3.10. Conduct Disorder (CD)

3.10.1. Definition: Conduct Disorder (CD) is characterized by a repetitive and persistent pattern of behavior that violates the basic rights of others or disregards major age-appropriate societal norms and rules.

3.10.1.1. CD is marked by aggressive and hurtful behaviors, as well as a lack of empathy and consideration for others, often accompanied by self-centered emotions.

3.10.1.2. This condition is more severe and harmful than Oppositional Defiant Disorder (ODD) and is typically diagnosed in adolescents Individuals with CD often exhibit a lack of remorse for their actions, including violations of norms and harm caused to others

3.10.2. Symptoms

3.10.2.1. Aggressive behaviors:

3.10.2.1.1. Bullying, threatening, or intimidating others

3.10.2.1.2. Initiating physical fights

3.10.2.1.3. Being physically cruel to people or animals

3.10.2.2. Violation of Laws and Social Norms:

3.10.2.2.1. Engaging in illegal activities such as stealing, vandalism, or destruction of property

3.10.2.2.2. Use of weapons to intimidate or harm others

3.10.2.2.3. Involvement in sexual abuse or other serious offenses

3.10.2.3. Deceptive Behaviors:

3.10.2.3.1. Frequently lying to obtain goods, Favors, or to avoid obligations

3.10.2.4. Rule Violations:

3.10.2.4.1. Staying out late despite parental prohibitions

3.10.2.4.2. Persistent disregard for rules and expectations

3.10.2.5. Lack of Remorse:

3.10.2.5.1. Acting deliberately with no guilt or remorse for actions, even when harm is caused to others

3.10.2.6. Functional Impairment:

3.10.2.6.1. Behavior causes significant disruption in social, academic, or occupational settings, negatively affecting daily life and relationships

3.10.3. Consideration for Diagnosis: At least 3 criteria must be met in the past 12 months, with at least one in the past 6 months, for a full diagnosis.

3.10.4. Screening

3.10.4.1. Screening in primary care can be initiated based on concerns raised by parents, teachers, or observations of aggressive, defiant, or rule-breaking behaviors in children.

3.10.4.2. Screening can be performed in Primary Care by family physicians, general practitioners or pediatricians and their nursing team

3.10.4.3. Screening should be performed using validated to identify symptoms of Conduct Disorder including:

3.10.4.3.1. Strengths and Difficulties Questionnaire (SDQ) to assess emotional and behavioral problems, including conduct issues.

3.10.4.3.2. Child Behavior Checklist (CBCL) to evaluate a wide range of behavioral and emotional problems, including oppositional and aggressive behaviors.

3.10.4.3.3. Pediatric Symptom Checklist (PSC) to screen for emotional and behavioral difficulties in primary care settings.

3.10.4.3.4. Parent and teacher questionnaires should be utilized to gather information on the child's behavior across settings (home, school, etc.).

3.10.4.3.5. Positive screening results should prompt a referral to a child psychologist or psychiatrist for further evaluation and intervention.

3.10.5. Diagnosis

3.10.5.1. Clinical assessment by mental health professional – child and adolescent psychiatry/psychology specialists.

3.10.6. Treatment

3.10.6.1. Psychotherapy: Individual and family therapy to address behavioral and emotional challenges

3.10.6.2. Behavioral Therapy: Teaches anger management, impulse control, and prosocial skills

3.10.6.3. Community Support: Involvement in structured activities and support groups

3.10.6.4. Parent Training: Equips caregivers with effective behavior management strategies

3.10.6.5. Educational Support: Collaboration with schools for tailored interventions

3.10.6.6. Medication: Used for co-occurring conditions or severe aggression, if necessary

3.11. Eating Disorder (ED)

3.11.1. Definition

3.11.1.1. Eating disorders are characterized by persistent and severe disturbance in eating behaviors, as well as high level of stress when an activity involves eating (regular meal intakes, restaurants, and outings, etc.). There are different types of ED. The main ones are presented below.

3.11.2. Symptoms

3.11.2.1. Avoidant/Restrictive Food Intake Disorder (ARFID)

3.11.2.1.1. Lack of interest in eating or food

3.11.2.1.2. Avoidance based on sensory characteristics of food

3.11.2.1.3. Behavior is not attributable to a concurrent medical condition or better explained by another mental disorder

3.11.2.1.4. Significant weight loss and nutritional deficiency may occur

3.11.2.2. Anorexia Nervosa

3.11.2.2.1. Restriction of food intake leading to significantly low body weight for age, sex, developmental stage, and physical health

3.11.2.2.2. Intense fear of gaining weight or becoming fat, or persistent behavior that interferes with weight gain

3.11.2.2.3. Disturbance in self-perception of body weight and shape

3.11.2.2.4. Persistent lack of recognition of the seriousness of low body weight

3.11.2.3. Binge-Eating Disorder

3.11.2.3.1. Recurrent episodes of binge eating characterized by:

3.11.2.3.1.1. Eating, within a discrete period of time, an amount of food larger than what most individuals would eat under similar circumstances

3.11.2.3.1.2. A sense of lack of control over eating during the episode

3.11.2.3.2. Binge-eating episodes are associated with three or more of the following:

3.11.2.3.2.1. Eating very rapidly

3.11.2.3.2.2. Eating until feeling uncomfortably full

3.11.2.3.2.3. Eating large amounts of food when not physically hungry

3.11.2.3.2.4. Eating alone due to embarrassment about eating habits

3.11.2.3.2.5. Feeling disgusted with oneself, depressed, or guilty after overeating

3.11.2.4. Bulimia Nervosa

3.11.2.4.1. Recurrent episodes of binge eating characterized by:

3.11.2.4.1.1. Eating, within a discrete period, an amount of food that is significantly larger than what most individuals would eat under similar circumstances

3.11.2.4.1.2. A sense of lack of control overeating during the episode

3.11.2.4.1.3. Recurrent inappropriate compensatory behaviors to prevent weight gain, such as:

3.11.2.4.1.3.1. Self-induced vomiting

3.11.2.4.1.3.2. Misuse of laxatives, diuretics, or other medications

3.11.2.4.1.3.3. Excessive exercise or fasting

3.11.3. Screening

3.11.3.1. Screening in primary care can be initiated based on concerns from parents, teachers, or observations of changes in eating habits, weight, or body image concerns.

3.11.3.2. If at physical examination, the primary care practitioner notices signs of purging such as erosion of the tooth enamel because of recurrent exposure to gastric acidity and skin lesions on the fingers, this should prompt an assessment of eating disorders, including targeted questions about bingeing, vomiting, laxative use, and body image concerns, followed by appropriate referral to a mental health specialist

3.11.3.3. Screening can be performed in Primary Care by family physicians, general practitioners or pediatricians and their nursing team

3.11.3.4. Screening should be performed using validated tools including:

3.11.3.4.1. SCOFF Questionnaire (adapted for children): A brief screening tool with questions targeting eating behaviors and weight concerns.

3.11.3.4.2. Eating Disorder Examination Questionnaire (EDE-Q): Assesses disordered eating attitudes and behaviors.

3.11.3.4.3. Children's Eating Attitudes Test (ChEAT): Evaluates disordered eating patterns and attitudes in younger populations.

3.11.3.5. Additional indicators to assess:

3.11.3.5.1. Unexplained weight loss, frequent dieting, or restrictive eating.

3.11.3.5.2. Behavioral signs such as avoiding meals, excessive concern with body image, or over-exercising.

3.11.3.5.3. Physical signs like fatigue, fainting, or changes in menstrual cycles (in adolescents).

3.11.3.6. Positive screening results should prompt a referral to a child psychologist or psychiatrist for comprehensive evaluation and management.

3.11.4. Diagnosis

3.11.4.1. Clinical assessment is required by a mental child and adolescent psychiatrist and/ or psychology specialists.

3.11.5. Treatment

3.11.5.1. Evidence based psychotherapy, along with nutritional counseling, and medical care.

3.11.5.2. The PCP can request a general medical check-up

3.11.5.3. In severe cases, hospitalization in a specialized clinic may be required

3.12. Substance Use Disorder (SUD)

3.12.1. Definition

3.12.1.1. Repeated and prolonged use of one or more substances (e.g., alcohol, opioids, other narcotics) at high doses or frequencies can lead to health and social problems, including functional and clinical impairment or distress. Substance Use Disorder is a mental health condition characterized by a problematic pattern of substance use that causes significant distress and/or impairs an individual's daily life.

3.12.1.2. Some children use glue for example, adolescents may use cigarettes, alcohol, and/or drugs

3.12.1.3. Substance misuse may lead to serious and irreversible damage to the brain.

3.12.1.4. The most frequently substance used in older children and adolescents are:

3.12.1.4.1. **Alcohol**: Often the most accessible and commonly abused substance among youth.

3.12.1.4.2. **Tobacco**: Including cigarettes, chewing tobacco, shisha, pipes and increasingly e-cigarettes or vaping products.

3.12.1.4.3. **Cannabis**: Including Marijuana, Pot, Grass, Hash use among youth has become more prevalent.

3.12.1.4.4. **Prescribed medications**: Misuse of prescription drugs, particularly pain relievers, sedatives, and stimulants, is a growing concern.

3.12.1.4.5. **Inhalants**: Substances like glue, paint thinners, or nitrous oxide, which are inhaled for their psychoactive effects.

3.12.2. Symptoms

3.12.2.1. Substance Use Disorder can present with both behavioral and physical signs. These symptoms may help primary care physicians (PCPs) identify the condition and facilitate timely intervention.

3.12.2.2. Behavioral Signs:

3.12.2.2.1. Irritability

3.12.2.2.2. Anger

3.12.2.2.3. Intense rush of need

3.12.2.2.4. Inability to stop substance use despite awareness of harm

3.12.2.2.5. Deterioration in school attendance and performance

3.12.2.2.6. Decreased concentration

3.12.2.2.7. Changes in sleep patterns

3.12.2.2.8. Changes in eating habits

3.12.2.3. Mood and Behavioral Changes:

3.12.2.3.1. Frequent arguments or fights with parents

3.12.2.3.2. Social isolation

3.12.2.3.3. Disruptive behavior

3.12.2.3.4. Frequent lying

3.12.2.3.5. Poor hygiene and noticeable changes in appearance

3.12.2.3.6. Stealing or becoming involved in dealing substances

3.12.2.3.7. Self-harm

3.12.2.4. Physical Signs:

3.12.2.4.1. Sweating of palms

3.12.2.4.2. Increased heart rate

3.12.2.4.3. Glazed or bloodshot eyes

3.12.2.4.4. Needle marks on the skin

3.12.2.4.5. Tremors or shaking

3.12.2.4.6. Self-harm

3.12.2.4.7. Nasal symptoms (for patients inhaling stimulants)

3.12.3. Consideration for Diagnosis

3.12.3.1. The child must show a pattern of substance use that causes significant problems in their daily life, with at least 2 specific symptoms present over a 12-month period for a full diagnosis.

3.12.4. Screening

3.12.4.1. Screening in primary care can be initiated based on concerns from parents, teachers, or observations of behavioral changes, poor academic performance, or risky behaviors.

3.12.4.2. Screening can be performed by family physicians, general practitioners, or pediatricians and their nursing team.

3.12.4.3. Screening should be performed using validated tools including:

3.12.4.3.1. CRAFFT Screening Tool: A widely used tool designed for adolescents to assess substance use and its impact on their lives.

3.12.4.3.2. Pediatric Symptom Checklist (PSC): To identify emotional, behavioral, or psychosocial problems that may co-occur with substance use.

3.12.4.4. Additional considerations:

3.12.4.4.1. Ask direct but nonjudgmental questions about substance use and exposure.

3.12.4.4.2. Assess for signs such as mood changes, withdrawal from family, or unexplained health issues.

3.12.4.5. Positive screening results should prompt a referral to a child psychologist, psychiatrist, or substance use specialist for further evaluation and intervention.

3.12.5. Diagnosis

3.12.5.1. The abovementioned symptoms may manifest in other mental health disorders or problems which makes the diagnosis of substance use complex. Yet, any unexplainable change in a child or adolescent behavior raises the suspicion of substance use.

3.12.5.2. Diagnosis of SUD can be made by a PCP with adequate training

3.12.6. Treatment

3.12.6.1. The PCP can:

3.12.6.1.1. Provide brief interventions including counseling and motivational interventions for mild or early stages of SUD.

3.12.6.2. Monitor and support the aftercare of SUD patients after discharge from inpatient facilities or daycare programs

3.12.6.3. Further treatment of SUD requires referral to a psychiatrist including but not limited to, Medication Assisted Treatment (MAT) and detoxification

3.12.6.4. Addiction psychiatrists should lead MAT where possible.

3.13. Child Abuse and Neglect (CAN) and Adverse Childhood Experiences (ACEs)

3.13.1. Definition

3.13.1.1. Child abuse and neglect (CAN) and Adverse Childhood Experiences (ACEs) are events that the child may witness or experience. Domestic violence, sexual harassments or assaults, physical and emotional abuse, neglect, natural disasters, human made disasters are events creating acute stress and trauma.

3.13.1.2. CAN and ACEs are not mental health diagnosable disorders; they are not included in the international classifications of mental disorders (DSM5-TR; ICD-11).

3.13.1.3. The major impact of these on the child physical and mental health, education, future life makes it extremely important to screen for these issues, identify them early, and refer children to treatment.

3.13.2. Signs & Symptoms

3.13.2.1. Age-specific signs such as:

3.13.2.1.1. For infants and toddlers: Being frightened especially when separated from primary caregivers

3.13.2.1.2. For preschoolers: Re-enacting the traumatic event in play or being more withdrawn.

3.13.2.1.3. For older children aged 6-12 years: Feeling guilty or feeling they caused the traumatic event

3.13.2.1.4. For teenagers aged 13-18 years: Impulsive behaviors, substance use, self-harm or suicidality

3.13.2.2. Sleep disruptions or disruptive behaviors

3.13.2.3. Behavioral signs such as:

3.13.2.3.1. Regression to earlier developmental stages

3.13.2.3.2. Withdrawal from friends, family, or usual activities

3.13.2.3.3. Regression in school performance

3.13.2.4. Emotional signs such as:

3.13.2.4.1. Excessive fear or anxiety

3.13.2.4.2. Sadness or mood swing

3.13.2.4.3. Feelings of guilt or shame, which may be related to the trauma

3.13.2.4.4. Decreased interest in previously enjoyed activities

3.13.2.5. Physical signs such as:

3.13.2.5.1. Unexplained aches and pains.

3.13.2.5.2. Changes in appetite or eating patterns

3.13.2.6. Cognitive signs such as:

3.13.2.6.1. Difficulty concentrating or paying attention

3.13.2.6.2. Memory problems, especially regarding the traumatic event.

3.13.2.7. Relationship signs such as:

3.13.2.7.1. Difficulty forming attachments

3.13.2.7.2. Maintaining relationships

Screening & Diagnosis

3.13.3.1. Healthcare providers should routinely screen for trauma and child abuse exposure by observing, examining, and interviewing the child and their parents.

3.13.3.2. PCPs should also observe the child's hygiene, adherence to vaccination schedules, and look for bruising or signs of injury or for atypical behavior for age

Treatment

3.13.4.1. Primary care staff should always reach out to Child Protection Officers when dealing with CAN cases

3.13.4.2. The legal component is to be carefully considered, and local laws implemented, in addition to hospital policy

3.13.4.3. Referral to social worker

3.13.4.4. Referral to psychologist for psychotherapy using different techniques and modalities, including but not limited to:

3.13.4.4.1. CBT

3.13.4.4.2. TF-CBT

3.13.4.4.3. Family therapy

3.13.4.4.4. Play therapy

3.13.4.4.5. EMDR

3.13.4.5. Communication with children and family: effective communication provides the ground for trusted and open relation between physician, parents, and children.

3.13.4.6. Healthcare providers should foster a collaborative, shared decision-making process with parents and children by:

3.13.4.6.1. Engaging in active listening, validating emotions, promoting shared decision-making, and adopting a patient-centered approach

3.13.4.6.2. Using developmentally appropriate language and providing language support, especially for children with disabilities

3.13.4.6.3. Respectfully acknowledging parents' concerns to ensure they feel heard and valued

3.14. Parental Mental Health

3.14.1. A child with neurodevelopmental disorder, emotional and/or behavioral disorder creates difficult emotions in parents including but not limited to: as guilt, anxiety, fatigue, and hopelessness

3.14.2. These are aggravated in cases where parents suffer from existing mental health disorders or are psychologically vulnerable either for environmental stressors or for deeper concerns

3.14.3. When detecting, assessing or treating mental health disorders in children or adolescents, the family physician, general practitioner or pediatrician should also consider screening the parents for mental health disorders including, but not limited to:

3.14.3.1. Depression: using PHQ-9

3.14.3.2. Anxiety: using GAD-7

4.Relevant References Documents			
No.	**Reference Date**	**Reference Name**	**Relation Explanation / Coding / Publication Links**
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3	2019	González-Carrasco, M., Vaqué, C., Malo, S., et al. A Qualitative Longitudinal Study on the Well-Being of Children and Adolescents. Child Indicators Research, 12, 479–499.	https://doi.org/10.1007/s12187-018-9534-7
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11	2020	Strathearn, L., Giannotti, M., Mills, R., Kisely, S., Najman, J., Abajobir, A. Long-term Cognitive, Psychological, and Health Outcomes Associated With Child Abuse and Neglect. Pediatrics, 146(4), e20200438.	https://pmc.ncbi.nlm.nih.gov/articles/PMC7786831/
12	2021	Morris, A. S., Hays-Grudo, J., Zapata, M. I., et al. Adverse and Protective Childhood Experiences and Parenting Attitudes: The Role of Cumulative Protection in Understanding Resilience. Advances in Research Science, 2, 181–192.	https://doi.org/10.1007/s42844-021-00036-8
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19	2024	Standard for Specialized Mental Healthcare Services	https://www.doh.gov.ae/en/resources/standards
20	2025	Standard of Care for Depression and Anxiety Disorders	https://www.doh.gov.ae/en/resources/standards
21	2021	Standard for the Management of Narcotics and Controlled Medicinal Products	https://www.doh.gov.ae/en/resources/standards
22	2022	Scope of Practice Guidelines for Licensed Healthcare Professionals- Family Medicine	https://www.doh.gov.ae/en/resources/standards
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25	2021	Ministerial Resolution No. (14) of 2021 on the Patient Rights and Duties Charter	https://uaephl.mohap.gov.ae/en/health-policies-and-legislations-advocacy/health-legislations?itemId=57c4ff8d-648c-4811-8830-5c3724b7fdd6
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27	2025	Unified Healthcare Professional Qualification Requirements	https://www.doh.gov.ae/en/pqr
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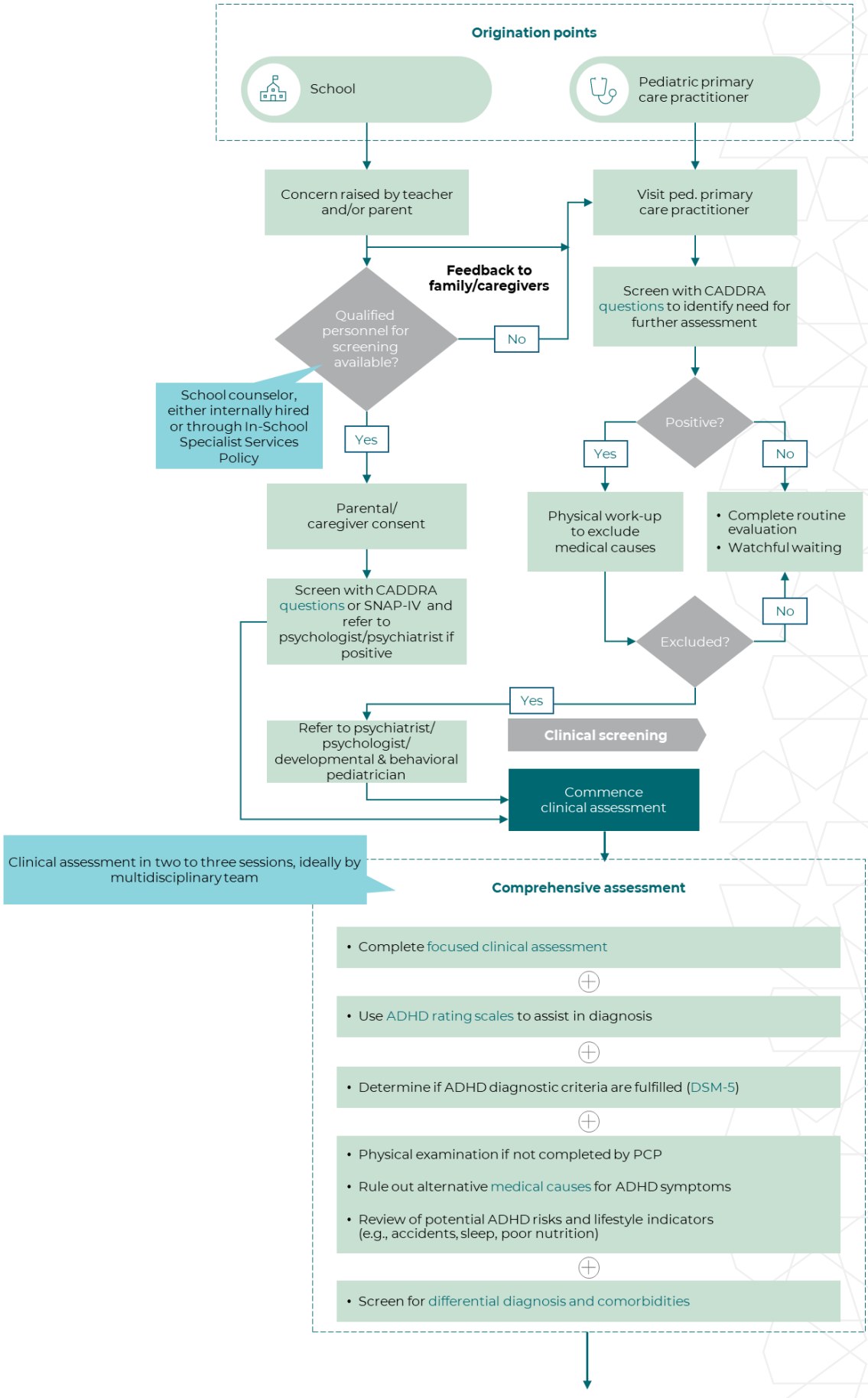
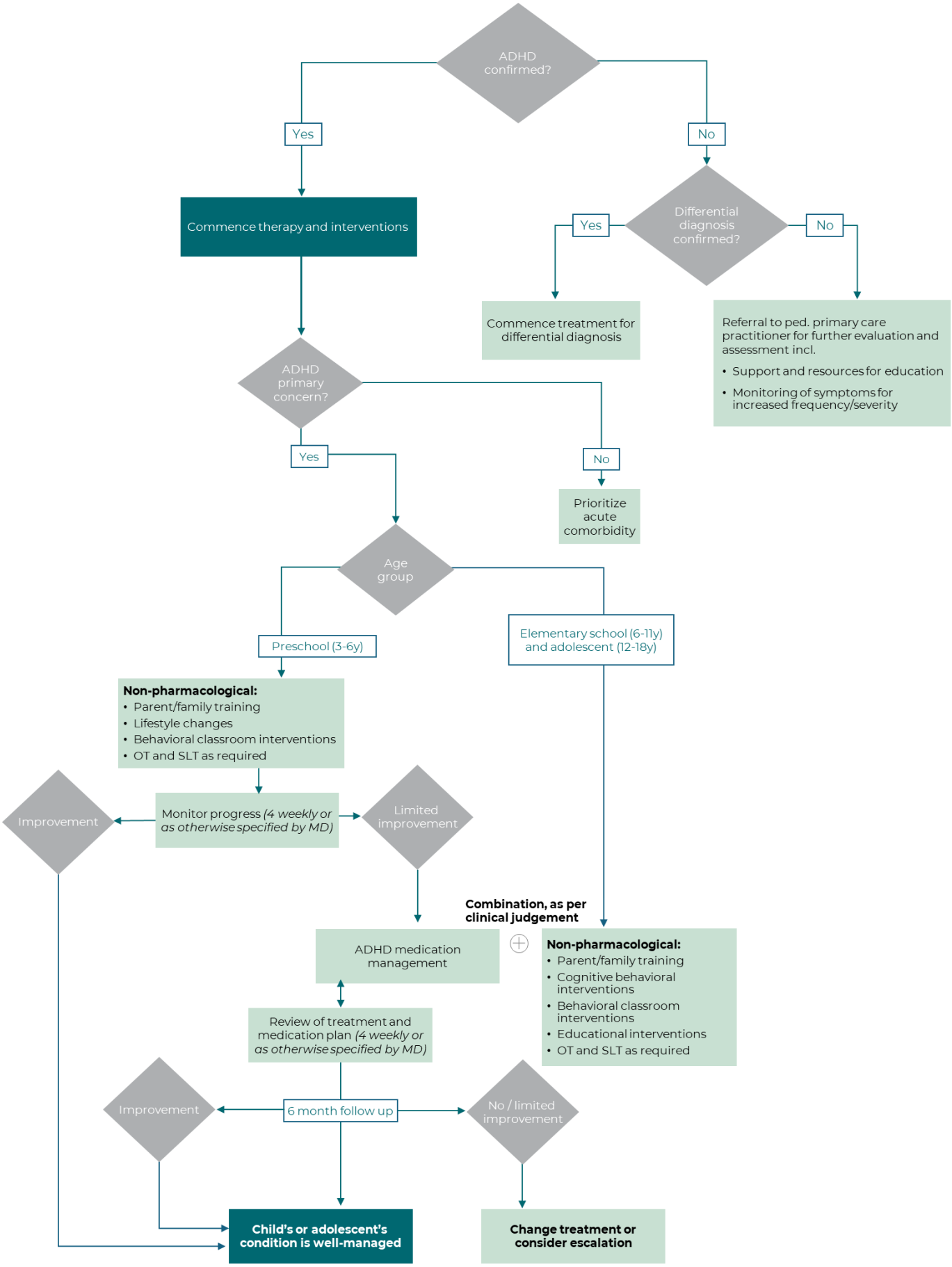
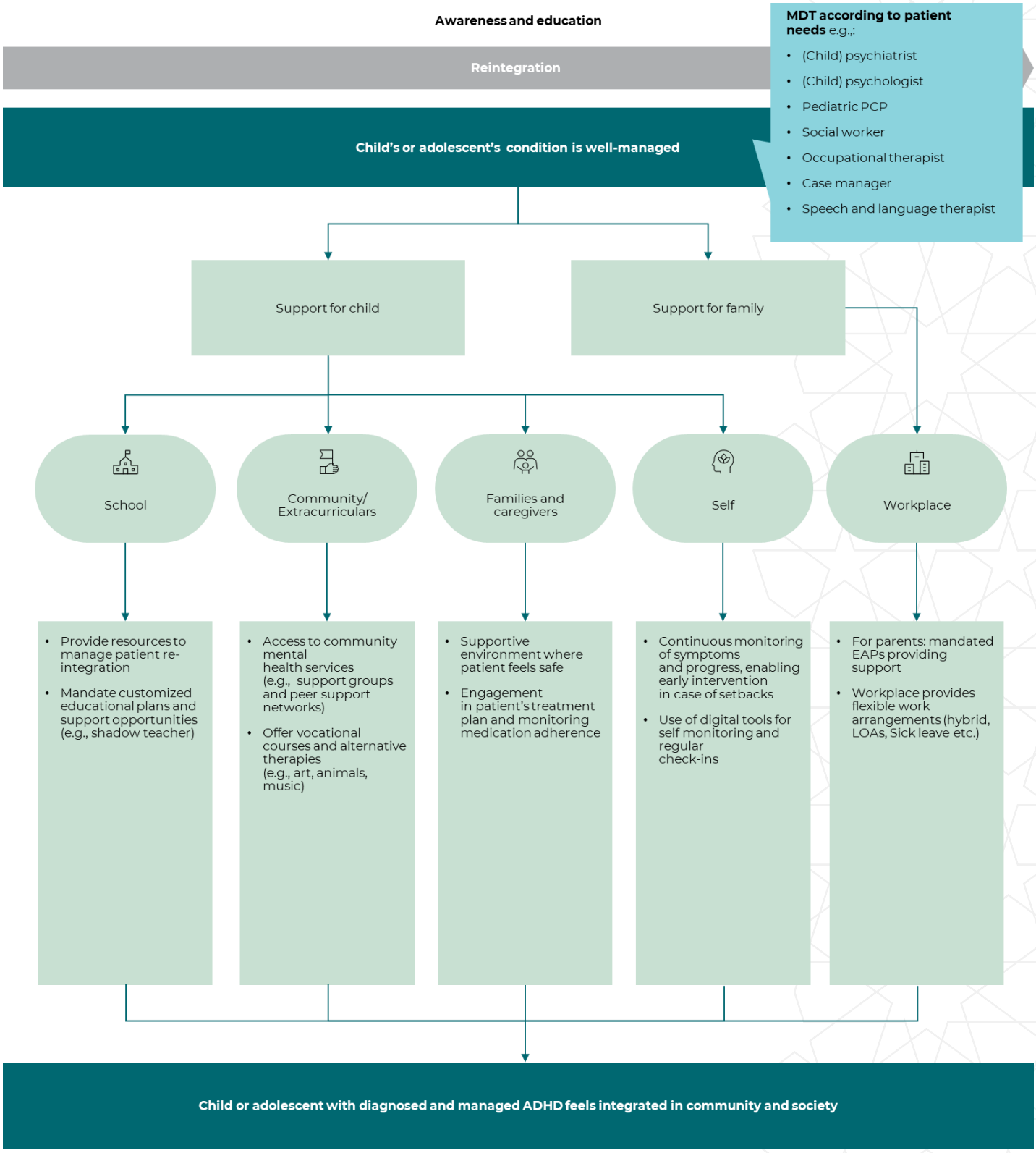
29	2016	Federal Law No. (3) of 2016 on Child Rights Law (Wadeema)	https://uaelegislation.gov.ae/en/legislations/1176

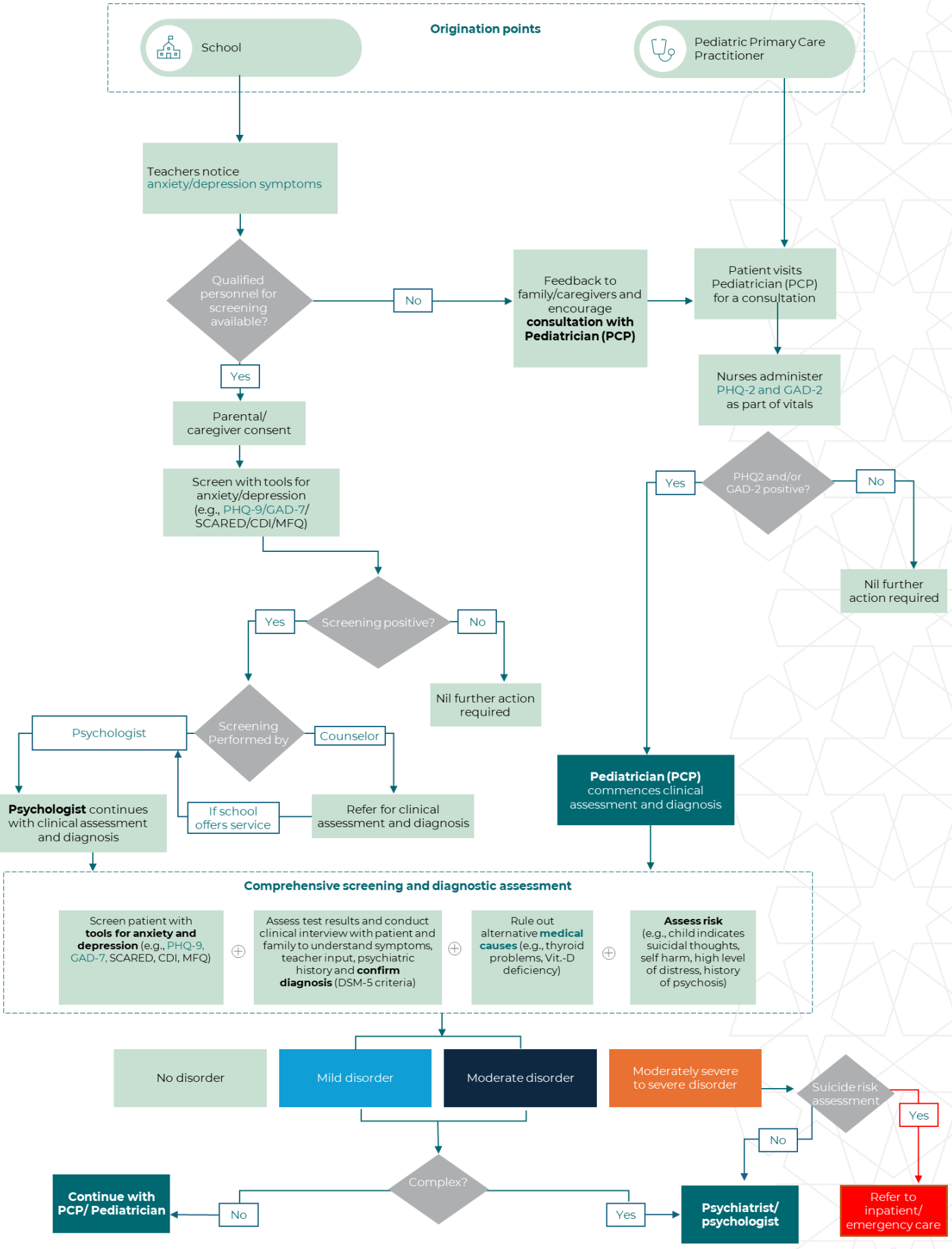
Appendix A: Referral Pathway for ADHD

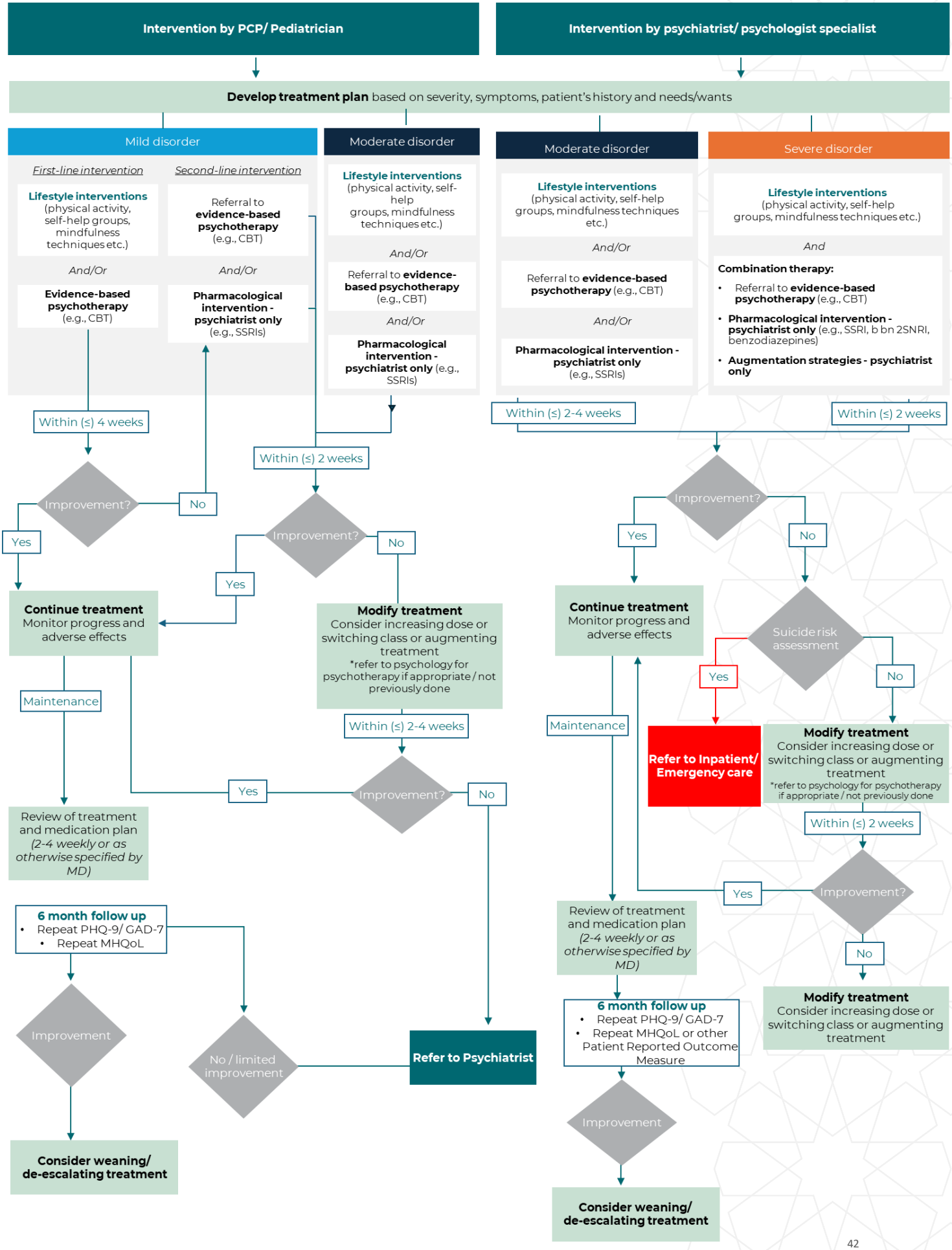


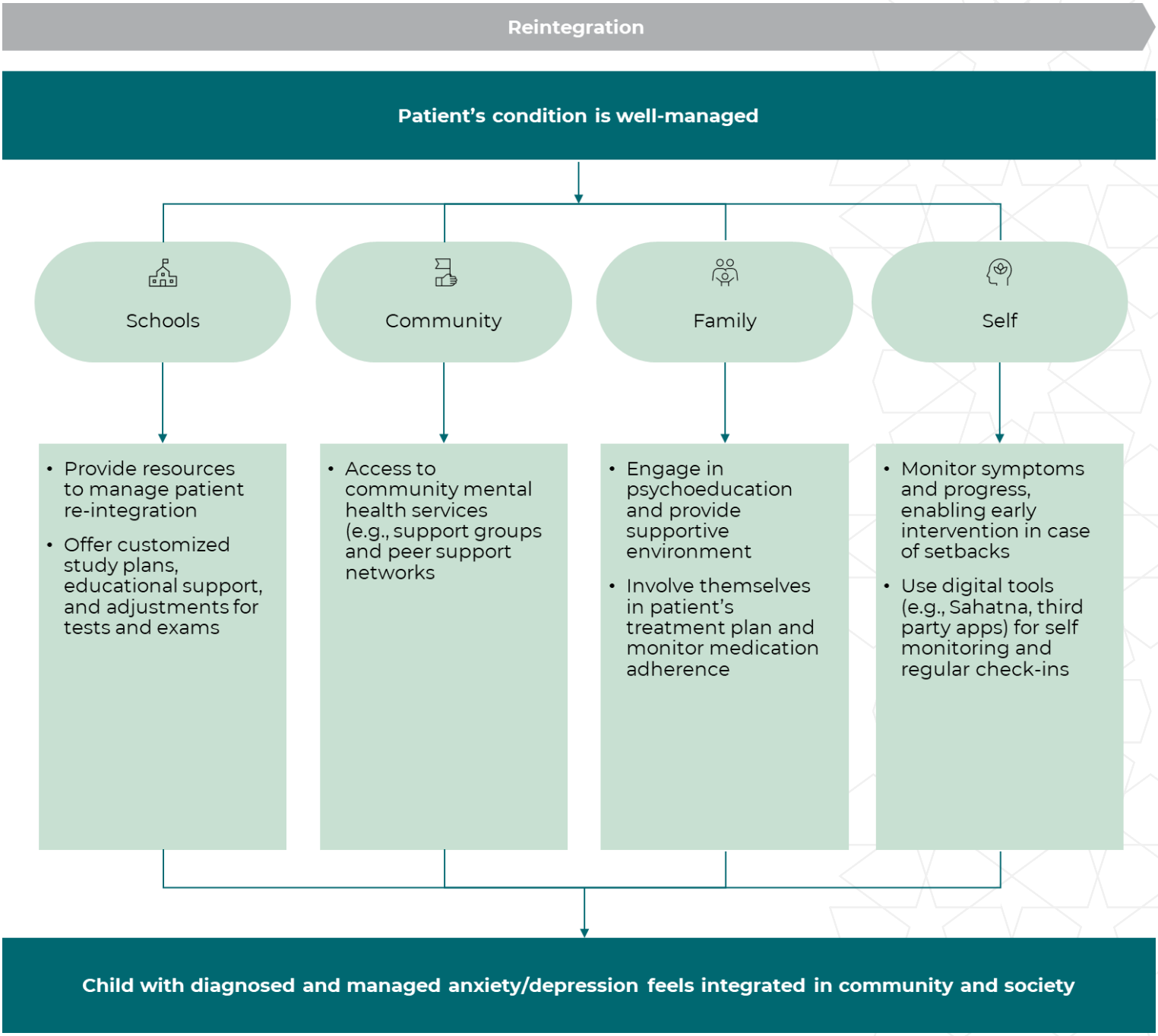

ADHD confirmed?
Yes
No
Commence therapy and interventions
Differential diagnosis confirmed?
Yes
No
Commence treatment for differential diagnosis
Referral to ped. primary care practitioner for further evaluation and assessment incl.
• Support and resources for education
• Monitoring of symptoms for increased frequency/severity
ADHD primary concern?
Yes
No
Prioritize acute comorbidity
Age group
Preschool (3-6y)
Elementary school (6-11y) and adolescent (12-18y)
Non-pharmacological:
• Parent/family training
• Lifestyle changes
• Behavioral classroom interventions
• OT and SLT as required
Improvement
Monitor progress (4 weekly or as otherwise specified by MD)
Limited improvement
Combination, as per clinical judgement
ADHD medication management
Non-pharmacological:
• Parent/family training
• Cognitive behavioral interventions
• Behavioral classroom interventions
• Educational interventions
• OT and SLT as required
Review of treatment and medication plan (4 weekly or as otherwise specified by MD)
Improvement
6 month follow up
No / limited improvement
Child's or adolescent's condition is well-managed
Change treatment or consider escalation


Awareness and education
Reintegration
Child's or adolescent's condition is well-managed
MDT according to patient needs e.g.,:
(Child) psychiatrist
(Child) psychologist
Pediatric PCP
Social worker
Occupational therapist
Case manager
Speech and language therapist
Support for child
Support for family
School
Community/ Extracurriculars
Families and caregivers
Self
Workplace
Provide resources to manage patient re-integration
Mandate customized educational plans and support opportunities (e.g., shadow teacher)
Access to community mental health services (e.g., support groups and peer support networks)
Offer vocational courses and alternative therapies (e.g., art, animals, music)
Supportive environment where patient feels safe
Engagement in patient's treatment plan and monitoring medication adherence
Continuous monitoring of symptoms and progress, enabling early intervention in case of setbacks
Use of digital tools for self monitoring and regular check-ins
For parents: mandated EAPs providing support
Workplace provides flexible work arrangements (hybrid, LOAs, Sick leave etc.)
Child or adolescent with diagnosed and managed ADHD feels integrated in community and society

Appendix B: Referral Pathway for Anxiety and Depression




Intervention by PCP/ Pediatrician
Intervention by psychiatrist/ psychologist specialist
Develop treatment plan based on severity, symptoms, patient's history and needs/wants
Mild disorder
Moderate disorder
Moderate disorder
Severe disorder
First-line intervention
Second-line intervention
Lifestyle interventions (physical activity, self-help groups, mindfulness techniques etc.)
And/Or
Evidence-based psychotherapy (e.g., CBT)
Referral to evidence-based psychotherapy (e.g., CBT)
And/Or
Pharmacological intervention - psychiatrist only (e.g., SSRIs)
Lifestyle interventions (physical activity, self-help groups, mindfulness techniques etc.)
And/Or
Referral to evidence-based psychotherapy (e.g., CBT)
And/Or
Pharmacological intervention - psychiatrist only (e.g., SSRIs)
Lifestyle interventions (physical activity, self-help groups, mindfulness techniques etc.)
And/Or
Referral to evidence-based psychotherapy (e.g., CBT)
And/Or
Pharmacological intervention - psychiatrist only (e.g., SSRIs)
Lifestyle interventions (physical activity, self-help groups, mindfulness techniques etc.)
And
Combination therapy:
Referral to evidence-based psychotherapy (e.g., CBT)
Pharmacological intervention - psychiatrist only (e.g., SSRI, b bn 2SNRI, benzodiazepines)
Augmentation strategies - psychiatrist only
Within (≤) 4 weeks
Within (≤) 2 weeks
Within (≤) 2-4 weeks
Within (≤) 2 weeks
Improvement?
No
Yes
Improvement?
No
Yes
Improvement?
Yes
No
Continue treatment Monitor progress and adverse effects
Modify treatment Consider increasing dose or switching class or augmenting treatment *refer to psychology for psychotherapy if appropriate / not previously done
Continue treatment Monitor progress and adverse effects
Suicide risk assessment
Yes
No
Maintenance
Within (≤) 2-4 weeks
Maintenance
Refer to Inpatient/ Emergency care
Modify treatment Consider increasing dose or switching class or augmenting treatment *refer to psychology for psychotherapy if appropriate / not previously done
Within (≤) 2 weeks
Review of treatment and medication plan (2-4 weekly or as otherwise specified by MD)
Yes
Improvement?
No
Yes
Improvement?
No
6 month follow up
Repeat PHQ-9/ GAD-7
Repeat MHQoL
Review of treatment and medication plan (2-4 weekly or as otherwise specified by MD)
Modify treatment Consider increasing dose or switching class or augmenting treatment
Improvement
No / limited improvement
Refer to Psychiatrist
6 month follow up
Repeat PHQ-9/ GAD-7
Repeat MHQoL or other Patient Reported Outcome Measure
Improvement
Consider weaning/ de-escalating treatment
Consider weaning/ de-escalating treatment


Reintegration
Patient's condition is well-managed
Schools
Community
Family
Self
• Provide resources to manage patient re-integration
• Offer customized study plans, educational support, and adjustments for tests and exams
• Access to community mental health services (e.g., support groups and peer support networks
• Engage in psychoeducation and provide supportive environment
• Involve themselves in patient's treatment plan and monitor medication adherence
• Monitor symptoms and progress, enabling early intervention in case of setbacks
• Use digital tools (e.g., Sahatna, third party apps) for self monitoring and regular check-ins
Child with diagnosed and managed anxiety/depression feels integrated in community and society