STRATEGIC PROPOSITION FOR CHILD AND ADOLESCENT MENTAL HEALTH SERVICES IN LOW INCOME COUNTRIES

Mohammad S I Mullick

MBBS, PhD,FCPSPsych, MRCPsych, FRCPsych,DCAP,FAACAP

Professor of Child & Adolescent Psychiatry

Chairman

Department of Psychiatry

BSM Medical University, Dhaka, Bangladesh

Email: msimullick@gmail.com

Child & Adolescent Psychiatry in Low Income Countries

Children & adolescents in low income countries

- <18Y: roughly 45% of population
- Subject to conditions with negative impacts that affect physical and psychological well being…poverty, malnutrition, illiteracy

- Conversely, subject to conditions with positive impact… traditional society, strong family support and a high degree of cohesiveness within the family, resiliency

Child & Adolescent Psychiatry in Low Income Countries

Children & adolescents in low income countries

Possible resiliency:

- Routine natural calamity
- Migration
- Oppression
- Preparedness of accepting situation

Child & Adolescent Psychiatry in Low Income Countries

PREVALENCE

- **Lal et al 1977 India 35.6%**
- **Geil et al 1981 Colombia 29%**
  India 22%
  Sudan 10%
  Philippines 15%
- **Almeid-Filho 1984 Brazil 23%**
- **Bird et al 1988 Puerto Rico 18-49%**

Child & Adolescent Psychiatry in low incone Countries

PREVELANCE

- **Javed et al 1992 Pakistan 9.3%**
- **Kasmini et al 1993 Malaysia 6%**
- **Gureje et al 1994 Nigeria 20%**
- **Hackett et al 1999 India 9%**
- **Fleitlich et al 2004 Brazil 13%**

Child & Adolescent Psychiatry in Developing Countries

PREVELANCE

- **Mullick et al 2005 Bangladesh 15.2%**
- **Srinath et al 2005 India 12.5%**
- **Margot et al 2005 India 23.0%**
- **Syed et al 2007 Pakistan 34.0%**
- **Rabbani et al 2009 Bangladesh 18.3%**
- **Ali et al 2009 Bangladesh 14.9%**

Child & Adolescent Psychiatry in Low Income Countries

Trend of Disorder is changing from more emotional disorder to the more behavioural disorder

The possible causes :

- **Rapid urbanization**
- **Urban migration**
- **Loss of social capital**
- **Economic drifting**
- **Breaking of social institution & values**

Magnitude of the problems

- **Around 15% of Children in Developing countries have emotional and behavioral problems**
- **Severe enough to result in substantial distress or social impairment**
- **Warranting a psychiatric diagnosis, and warranting treatment too**

Exhibiting CAMHS in Low Income Countries

- **Tertiary level :**

  Assessment, diagnoses, Treatment, community referral, periodic follow-up

- **Secondary & Primary level :**

  Inadequate efficiency in early detection & and intervention

- **Community Services :**

  Screening, Special education, vocational trainings, rehabilitation, hospital referral

Existing CAHMS in Low Income Countries

- Specialized service restricted to tertiary hospitals
- Inadequate provision for LD Psychiatry Services
- No/less organized school health services
- Nonexistence - poorly organized MDT
- Little or no access for the vast effected children

Existing CAHMS in Low Income Countries

- Massive gap exists between need and service provision
- Severe shortage of resources, professionals
- Little prospects of meeting this need in near or fur future by developing systematic and planned professional services despite of willingness & ability to accept modernity and scientifically based service model

Key Strengths of Low Income Countries

- Relatively stable traditional society
- Strong family and neighborhood support
- Warm Teacher-Student relationship inherent in the culture
- Excellent infrastructure of NHS
- Adequate ‘potential’ manpower
- Good number of non-government agencies for child care
- Increasing awareness at all level

CAMHS in Low Income Countries: Basic consideration

- Different from Western model
- Based on potential resources
- Part and parcel of NHS & NCHS
- Integrated part of NMHS
- Provided through School Health Service
- MDT will be different in composition and competency
- Collaborative between health, social & educational agencies
- Active involvement with private level

CAMHS in Low Income Countries: Key components

Alternative ways of service model must be

- **Feasible**
- **Local resource based**
- **Practicable**
- **Possible to initiate and expand**

CAMHS in Low Income Countries: policy contents

Adopting a policy to develop :

- **specialist-based services**
- **resource-based non-specialist services**
- **integrated services**
- **school-based services**
- **nongovernmental approach with community participation**
- **governmental initiatives and support**

Feasible CAMHS in Low Income Countries: Strategic actions

- Developing paediatric-psychiatric liaison services
- Establishing alternate multidisciplinary team
- Short training of the potential manpower
- Involvement of the community
- Developing culture-specific, resourced – based and cost-effective treatment protocol

Strategic Points for Feasible CAMHS in Low Income Countries

Provision for postgraduate training course for specialized service by child & adolescent psychiatrists

Provision of training of the trainers for offering training and supervision

Involving "potential" manpower- parents, teachers, child health working staff, GPs, social workers, counselors ,volunteers

Offering short training on child mental health problems to them

Offering coordinated services through health, education, social agencies

Proposed model of CAHMS for Low Income Countries

- **Primary level – Non-specialist level**
  - Primary care service-GPs, PHWs
  - Social Welfare Service-Counselors
  - School Health Service- Teachers
  - Trained Child Mental Health Worker
  - Trained parents
- **Secondary level – Non/Specialist level**
  - Specially trained GP, pediatricians, neurologists
  - General Psychiatrists, Psychologists/ Behavioral Scientists
  - Social Welfare Worker
- **Tertiary level – Sub-specialist level**
  - Child & Adolescent Psychiatrists
  - Child & Adolescent Clinical Psychologists
  - Child & Adolescent Psychiatric Social Worker
  - Child & Adolescent Psychiatric nurses

Role of International & Regional Organization : Few Suggestions

- **Establishing dialogues**

  regional/national psychiatric organizations

- **Coordinated initiatives**

  for improving child mental health training

- **Assistances and partnership**

  in exchange programs, e.g., experts in training & research projects

- **IACAPAP Assistance program**

  for supporting feasible action plans

Child &Adolescent Psychiatry in Low Income Countries

CONCLUSION

- Vast gap between service need and service provisions
- Urgent need to adopt a policy and action plan for CAMHS in low income countries to move from ideality to reality
- Significant improvement recent years & room for further improvement
- Conducting innovative researches on possible ways of feasible services considering socio-cultural- economic and resilience factors in low income countries for providing the data in favor of practicable CAMHS
- Potential collaboration and networking among regional & international community

Thank you

STRATEGIC PROPOSITION FOR CHILD AND ADOLESCENT MENTAL HEALTH SERVICES IN LOW INCOME COUNTRIES

Mohammad S I Mullick

MBBS, PhD,FCPSPsych, MRCPsych, DCAP

Professor

Child & Adolescent Psychiatry

Department of Psychiatry

BSM Medical University, Dhaka, Bangladesh

Email: msimullick@gmail.com

STRATEGIC PROPOSITION FOR CHILD AND ADOLESCENT MENTAL HEALTH SERVICES IN LOW INCOME COUNTRIES

Mohammad S I Mullick

MBBS, PhD,FCPSPsych, MRCPsych, FRCPsych,DCAP,FAACAP

Professor of Child & Adolescent Psychiatry

Chairman

Department of Psychiatry

BSM Medical University, Dhaka, Bangladesh

Email: msimullick@gmail.com