CHILD AND ADOLESCENT PSYCHIATRY IN DEVELOPING COUNTRIES

Mohammad S I Mullick

MBBS, PhD,FCPSPsych, MRCPsych, DCAP

Professor

Child & Adolescent Psychiatry

Department of Psychiatry

BSM Medical University, Dhaka, Bangladesh

Email: mullick@bdonline.com

Child & Adolescent Psychiatry in Developing Countries

- **Children & adolescents in Developing 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**

Child & Adolescent Psychiatry in Developing 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 Developing 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%**
- **Mullick et al 2005 Bangladesh 15%**
- **Srinath et al 2005 India 12.5%**

Child & Adolescent Psychiatry in Developing Countries

Variation of prevalence is due to-

- **Case definition**
- **Area: rural, urban, slum**
- **Age group under study**
- **Sampling strategy and sample size**
- **Study design**
- **Instruments**
- **Cross cultural issues**
- **Others**

Prevalence for groups of Diagnosis

Groups of disorders	Weighted prevalence (95% CI)
Overall rate	15.2 (10.9-20.8)
Any anxiety	8.1 (5.1-12.7)
Any hyperkinesis	2.0 (1.0 – 4.1)
Any behavioural	8.9 (5.6-13.6)
Pervasive developmental	0.2 (0.00-0.9)

Child & Adolescent Psychiatry in Developing Countries

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

The possible cause :

- **Rapid urbanization**
- **Urban migration**
- **loss of social capital**
- **Economic drifting**
- **breaking of social institution & values**

Magnitude of the problems

- **Around 10-20% 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 Developing 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 Developing 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 Developing 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

CAMHS in Developing Countries: Basic consideration

- Different from Western model
- Based on available 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

Key Strengths of Developing Countries

- Relatively stable society
- Supportive family environment
- Warm Teacher-Student relationship inherent in the culture
- Excellent infrastructure of NHS
- Adequate ‘potential’ manpower
- Good number of non-government agencies for child care
- Increased awareness at all level

Proposed model of CAHMS for Developing 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

Strategic Points for Feasible CAMHS in Developing Countries

Adopting a policy to develop :

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

Strategic Points for Feasible CAMHS in Developing Countries

- 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

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

- **WPA Assistance program**

  for supporting feasible action plans

Child &Adolescent Psychiatry in Developing Countries

CONCLUSION

- Vast gap between service need and service provisions
- Urgent need to develop strong Child and Adolescent Psychiatry policy and resource-based feasible programs
- Significant improvement recent years & room for further improvement
- Potential collaboration and networking among regional & international community
- Critical role of regional,& international agencies
  - Training, assistance, and research collaboration

Let us nurture our young people today for better tomorrow

Thank you

CHILD AND ADOLESCENT PSYCHIATRY IN DEVELOPING COUNTRIES

Mohammad S I Mullick

MBBS, PhD,FCPSPsych, MRCPsych, DCAP

Professor

Child & Adolescent Psychiatry

Department of Psychiatry

BSM Medical University, Dhaka, Bangladesh

Email: mullick@bdonline.com