Advancing child and adolescent mental health services in Bangladesh: what direction ?

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Plan

- **Brief scenario**
- **CAMHS and need for expansion**
- **Possible direction of CAMHS advancement**
- **Postgraduate program and predicted outcome**
- **Conclusions**

Children & Adolescents in Bangladesh

Facts and findings

Younger aged nation

<18Y: roughly 45% of population

Children & Adolescents in Bangladesh

Facts and findings

Adverse conditions:

- Poverty
- Illiteracy
- Stigma
- Underage marriage
- Urbanization

Children & Adolescents in Bangladesh

Facts and findings

Resilient conditions:

Traditional society

Strong family support and family cohesion

High social capital

Religiosity

Increased education

CAP disorders in Bangladesh

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

CAP disorder in Bangladesh

- **Behavioral disorder rates lower than in the West, but changing …..**
- **Emotional disorder rates higher than in the developed world…**

CAP disorder in Bangladesh

- **These rates similar to other countries with traditional societies**
- **Societal factors shape the distribution of disorders**

CAP disorder in Bangladesh

- **OCD high, with prominent religious content**
- **ADHD similar to other countries**
- **ASD is less prevalent but increasing**

CAP disorders: clinical presentations

- More somatization among children and adolescents

- Anxiety and depression present with somatic symptoms

CAP disorders: clinical presentation

- **Conversion disorder rate - high**
- **Its psychotic presentation is significant can be called as ‘Psychotic Hysteria’**
- **Possession state (‘Jinn possession’) significant and leads to maltreatment**

CAP disorders: clinical presentation

- **Mass hysteria among school children in 2007**

- **Future ‘epidemics’ possible due to cultural-cognitive construct as evident in sporadic outbreaks**

CAP disorders: clinical presentation

- **Self-harm far more common than suicide**
- **A common reason for emergency medical treatment**
- **Emergence of ‘group self harm’**

Existing CAMH Services in Bangladesh

- **Community Level:**

  Screening, special education, vocational training, rehabilitation, hospital referral

- **Secondary & Primary level :**

  early detection and intervention, referral

- **Tertiary level :**

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

Existing CAMHS in Bangladesh

Limitations

- **Specialized service restricted to tertiary hospitals**
- **Inadequate interdisciplinary teams**
- **No/less organized school health services**
- **Nonexistence/ poorly organized multidisciplinary teams**

Existing CAMHS in Bangladesh

- **CAMHS manpower & facilities extremely scarce and maldistributed**
- **Most of the children and young people are out of services and thereby undiagnosed & untreated**
- **Need to develop and implement CAMHS in right direction to combat the need effectively**

Key Strengths of Bangladesh for CAMHS

- 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 Bangladesh : Key components

The service model must be

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

CAMH in Bangladesh: Steps

- Adopting policy
- Developing strategic plan
- Implementing CAMHS
- Monitoring and evaluation
- Legislation

CAMHS in Bangladesh : policy contents

Need to develop :

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

CAMHS in Bangladesh : Strategic actions

- **Priority to most prevalent/serious psychiatric disorders**
- **Pediatric-psychiatric liaison services**
- **Establishing alternate multidisciplinary team involving family & community**

Strategic Points for Feasible CAMHS in Bangladesh

- **Developing culture-specific, resourced –based and cost-effective treatment protocol**

- **Coordinated services through health, education, social agencies**

Key Strategic Points for Feasible CAMHS in Bangladesh

- **Provision for postgraduate training course for specialized services, training, advocacy and research**

- **Brief training for the 'potential' manpower- parents, teachers, child health working staff, GPs, social workers, counselors ,volunteers and religious leaders**

MD Residency Program in CA Psychiatry

- The program in has been started in this year by the BSMMU, Dhaka, the only postgraduate medical University in Bangladesh
- One of the 56 programs of the University
- It is competency-based, learner-centered, residential, structured

MD Residency Program in CA Psychiatry

Program Objectives

- Clinical expertise
- Health advocacy
- Academic perspectives
- Collaborative capacities
- Administrative capacities
- Professionalism
- Research

MD Residency Program in CA Psychiatry

The program structure

- Phase A: 2 Years- basic part
- Phase B: 3 Years- specialty part

MD Residency Program in CA Psychiatry

The program: entry qualification

- Phase A: MBBS or equivalent with registration
- Phase B: successful completion of Phase A having FCPS, MD degree in general psychiatry

- Provision for enrollment of overseas candidate

MD Residency Program in CA Psychiatry

The program: domains of learning

Active and integrated learning process in

- **Knowledge**
- **Skills**
- **Attitude demonstrated through behavior**

to achieving the program objectives

MD Residency Program in CA Psychiatry

The program: training rotations

Phase A

- General Psychiatry - 12 months
- General Medicine - 3 months
- Paediatrics - 3 months
- Neurology - 3 months

MD Residency Program in CA Psychiatry

The program: training rotations

Phase B

- Neurodevelopmental Psychiatry - 6 months
- Core Child and Adolescent Psychiatry -18 months
- Specialties in Child & Adolescent Psychiatry- 9 months

MD Residency Program in CA Psychiatry

The program: assessment process

- Formative
- Summative

MD Residency Program in CA Psychiatry

The program: expected outcome

Getting competent CA Psychiatrists to

- meet and respond to the changing health care needs and expectation of the society
- practice as CA Psychiatry specialists
- be able to teach and train in this filed
- conduct, participate in relevant research
- contribute in the policy matters
- advocate, co-ordinate and collaborate

Key Strategic Points

- **Postgraduate program in child and adolescent psychiatry is the one of the core components of the strategy**
- **That only can ensure specialized services, training, advocacy and research**
- **In other words, viability and sustainability of the suitable CAMHS in term of quantity and quality depend with this program**

Conclusions

- **Vast gap between services need and service provisions**
- **Urgent need to adopt a policy and action plan for CAMHS to move from ideality to reality**
- **Need-based training and education must be the key strategy**
- **Strengthening newly started postgraduate program in CA Psychiatry for greater interest**

Conclusions

- **Needs to blend between established models and new experimental models**
- **Conducting innovative researches on possible ways of services for providing the data in favor of practicable CAMHS**
- **Potential collaboration and networking among regional & international community**

Thank you all