Implementing Child and Adolescent Mental Health Services in South Asia: What Direction?

Mohammad S I Mullick MBBS, PhD

Professor of Child & Adolescent Psychiatry

Chairman,Department of Psychiatry

BSM Medical University, Dhaka

Bangladesh

Email: msimullick@gmail.com

Conflict of Interest: None

Plan

- **Magnitude of the child & adolescent psychiatric (CAP) disorder in South Asia**
- **Cultural influence on presentation of CAP disorder**
- **Existing CAMH services in South Asia**
- **Future development of CAMH services in this region**

South Asia: at a glance

- **Place of ancient civilization and outlet of diverse invaders from Proto-australoids to Britons**

- **South Asian countries are:**

-Afghanistan
-Bangladesh
-Bhutan
-India
-Maldives
-Nepal
-Pakistan
-Sri Lanka


Asia
0 1,000 Miles
0 1,000 Kilometers
60° N
40° N
Bering Sea
EUROPE
Ural Mts.
Russia
Georgia
Armenia
Turkey
Azerbaijan
Kazakhstan
North Korea
Japan
Mongolia
Syria
Uzbek.
Turkmen.
Iraq
Kyrgyzstan
Tajikistan
Iran
Afghan.
China
South Korea
PACIFIC OCEAN
Kuwait
Bahrain
Qatar
Saudi Arabia
Pakistan
Bhutan
Nepal
U.A.E.
Yemen
Oman
India
Laos
Philippines
Bangladesh
Thai.
Vietnam
Cambodia
Myanmar
Arabian Sea
Philippine Sea
Bay of Bengal
Brunei
Malaysia
Maldives
Sri Lanka
Indonesia
Singapore
INDIAN OCEAN
AUSTRALIA
60° E
80° E
100° E
120° E

South Asia: at a glance

- **1600 M population: (22% of the world)**
- **Only 2% of the global income**
- **Highest rate of maternal deaths worldwide (27%)**
- **Neonatal deaths - 6-42/100 live births**

South Asia: at a glance

- **38% of < 5yos stunted due to malnutrition**
- **Immunization ranges 60-80%**
- **90% attend primary school but 1/3 drop out before graduating**
- **More than 25 million adolescents of lower secondary age are out of school**

South Asia: at a glance

- **Over 12% of children aged 5-14 do child labor**
- **14 out of every 1100 people use internet**
- **72% of population have access to electricity**
- **Marriage < 18 yr: 46% (highest in the world)**

Children & Adolescents in South Asia

Facts and findings

- **<18Y: roughly 45% of population**
- **Adverse conditions: poverty, illiteracy, stigma, underage marriage**
- **Protective conditions: traditional society, strong family support and family cohesion**

CAP disorder in South Asia

Prevalence

• Lal et al	1977	India	35.6%
• Geil et al	1981	India	22%
• Javed et al	1992	Pakistan	9.3%
• Hackett et al	1999	India	9%
• Mullick et al	2005	Bangladesh	15.2%

CAP disorder in South Asia

Prevalence

• 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%
• Joyasinghe	2010	Sri Lanka	21%

CAP disorder in South Asia

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

CAP disorder in South Asia

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

CAP disorder in South Asia

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

CAP disorders in South Asia

Summary

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

CAP disorders: clinical presentations

- More somatization among children and adolescents
- Commonest symptom: pain
- Anxiety and depression present with somatic symptoms

CAP disorders: clinical presentations

Misidentification of psychogenic complaints:

- misdiagnosis
- under diagnosis
- hassles for overanxious caregivers
- burden for other health professionals
- distress/ impact for affected children and adolescents

CAP disorders: clinical presentation

- **Conversion disorder rate - high**
- **Its psychotic presentation is significant can be called as ‘Psychotic Hysteria’**
- **Possession state both comes from and leads to maltreatment**

CAP disorders: clinical presentation

- **Mass hysteria among school children in 2007 in Bangladesh**
- **Characterized by dissociation, motor changes & histrionic/psychotic behavior**
- **Future ‘epidemics’ possible due to cultural-cognitive construct 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’**

Correlates of disorder

Major Risk factors

- Poverty
- Stigma and myth
- Large family
- Rapid, disproportionate and unplanned urbanization

Correlates of disorder

Major Risk factors

- **Specific pattern of stressors : Underage marriage, academic pressure, father lives abroad for job**
- **Unrestricted internet and TV channels cause cultural infiltration, leading to sexual harassment**
- **Harsh parental attitudes & behavior**

Correlates of disorder

Major Risk factors

- Child marriage, particularly for girls
- A series of stressors before and after marriage cause serious impact
- Married girls develop psychiatric morbidity mainly conversion and depression

Correlates of disorder

Notable Protective/Resilient factors:

- **Uniform & relatively stable society with traditional norms and values**
- **Supportive family environment**
  Family is the main source of caregiving
- **Higher Social capital**
- **Religiosity**
- **Increase in girls' education**

Existing CAMH Services in South Asia

- **Community Services :**

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

- **Secondary & Primary level :**

  Inadequate early detection and intervention

- **Tertiary level :**

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

Existing CAMHS in South Asia

Limitations

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

Existing CAMHS in South Asia

- **CAMH manpower & facilities extremely scarce and maldistributed**
- **Vast gap between need and provision, most of the children and young people are out of mental health coverage**

Existing CAMHS in South Asia

- **Can't meet the huge need through established models**
- **Systematic CAMH services are practically impossible with Western models of care**
- **Need affordable and culturally suitable CAMH services**

Key Strengths of South Asia 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 South Asia: Basic consideration

- Different from Western model
- Based on potential resources
- Part and parcel of NHS, NCHS & 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 South Asia: Key components

Alternative ways of service model must be

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

CAMHS in South Asia: 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 South Asia: 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 South Asia

- **Developing culture-specific, resourced –based and cost-effective treatment protocol**
- **Brief training for the 'potential' manpower-parents, teachers, child health working staff, GPs, social workers, counselors ,volunteers and religious leaders**
- **Coordinated services through health, education, social agencies**

Strategic Points for Feasible CAMHS in South Asia

- **Provision for postgraduate training course for specialized service**
- **Provision of training of the trainers for offering training and supervision**

Role of International & Regional Organizations : Few Suggestions

- **Establishing dialogues with**

  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

  for supporting feasible action plans

Conclusions

- **Vast gap between service need and service provisions**
- **Urgent need to adopt a policy and action plan for CAMHS in South Asia to move from ideality to reality**
- **Cultural variations of disorders affect treatment and service planning**

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

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