EDITORIAL

Child Psychiatry in Pakistan: A Growing Torment

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For every 1000 children born alive, 90 would fail to see their first birthday. The neonatal mortality of 71/100,000 presents a dismal picture of Child Health care in Pakistan.[1] Children encompass 43% of Pakistani population which is estimated to be more than 78,786,000 individuals according to a recent estimate (below the age of 18 years).[2] It is generally believed that children should be seen in the nexus of the family. In the context of Pakistan, 30% underweight children are in the milieu of extreme poverty, malnutrition, maternal depression and high fertility (average of 4 children per family) rate which leads to disregard towards child physical and mental health.

The enigma of child mental health is as obscure as mental health in general. It is common place to be asked if children develop mental illness. Child and adolescent psychiatrists makes for 0.01% of the general adult psychiatrist. If an estimate is to be made for the population to child psychiatrist ratio then it would come abysmally low. Similar figures are true for child psychologists, remedial teachers, speech therapists and appropriately trained special education teachers.

There is dearth of robust data on child psychiatric disorders from Pakistan. In order to examine the scholarly work on child mental health in Pakistan, search out on Pub Med, Psych Info, Google scholar and PakMedinet, could retrieve 89 articles; of this 47 were prevalence studies. There were 9 articles on attention deficit hyperactivity disorder (ADHD), 8 were hospital-based whereas one was school-based. Emotional and behavioural disorders were the focus of 4 cross-sectional surveys. Other studies looked into depressive illness, deliberate self-harm and autism.

It is needless to say that there is dearth of data on the estimates to child psychiatric disorders. The study exploring the prevalence of emotional and behavioural problem in school children was carried out in Lahore.[3] Using Rutter's children behavioural questionnaire, authors estimate the point prevalence to be 9%. Another study, using Parents-rated strength and difficulty questionnaire (SDQ), reported the prevalence of emotional and behavioural problem in the school going children of 5 – 12 years as 34%; proportion of abnormal scores were recorded in 40% males and 27% females.[4] Robust estimates on the prevalence of mental retardation were reported to be 19.0/1,000 children (95%, CI = 13.5 – 24.4) for serious retardation and 65.3/1,000 children (95%, CI = 48.9 – 81.8) for mild retardation.[5] Both these estimates were considerably higher than industrialized countries and some of the less developed countries. Lack of maternal education was strongly associated with the prevalence of both serious and mild retardation.

Maternal mental health is strongly associated with psychopathology in offspring. A case control study showed an association between mothers' mental distress and malnutrition in children. In this sample, 56% of mothers with underweight cases had poor mental health as measured by the self-reporting questionnaire (SRQ), compared to only 25% of controls.[6] Another study conducted at a university outpatient clinic showed that mothers of children with psychopathology were more likely to be depressed than the mothers of children who have had medical illnesses. The authors concluded that mothers bringing their children to child psychiatric clinic were at much greater risk of mental distress compared to the other group.[7] This study explores the distress in mothers of children suffering from mental health problems, thus highlighting importance of including parents in management of child mental issues. An important interventional study by Rehman *et al*. studied the impact of mental health programme over awareness regarding mental illnesses in children, parents, teachers and their friends among school attendees.[8] It reported a significant improvement in awareness of mental health through school mental health programme. They advocated the strategy of raising awareness on the maternal and child mental healthcare issues in low literacy rate countries like Pakistan.

The practice of child psychiatry is limited to few tertiary care centres in the country. Attention deficit hyperactivity disorder (ADHD) forms the bulk of cases seen in the office of a child psychiatrist. This is followed by depressive and anxiety disorders. A hospital-based practice would also cater to referrals on mental retardation, specific learning disabilities, and pervasive developmental/co-ordination disorders. Although the diagnosis of ADHD is as common as one in 20 children in the United States of America, the prevalence estimates from Pakistan cannot be overlooked; a tertiary

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care centre based study reported a frequency estimates of 34%.[9,10] This further pronounces the need of developing child and adolescent psychiatric services in Pakistan.

The constraints of resources plague child mental health care services as much as the adult mental health services. The child mental health care services are governed by multiple factors; the nature of the practice, referral conventions, relationship with paediatricians, general physicians and specialists are some of the important governing factors. While it is conventional to have referrals from the schools in established health care systems, one fails to see such a pattern of referral even from knowledgeable school systems in Pakistan. Major reasons are absence of mental health awareness among school teachers, lack of school healthcare systems, stigma attached to mental and emotional disorders and lack of effective interaction with the resource persons. In essence, child psychiatry services are a multidisciplinary one; liaison between speech therapist, clinical psychologist, paediatric neurologist and psychiatrist can be the difference. Similarly, communication with a class teacher is of paramount importance. On needs to bring the parents and teachers to similar level of understanding when it comes to principles of behavioural management.

The diagnosis in a child is also amorphous as opposed to adult psychiatric disorders. A detailed psycho-social history is well warranted in every case. This requires multiple sessions, collecting details of developmental history, family environment and significant like events, to the point of reconstructing a detailed anamnesis. While there are problems and difficulties in establishing a child psychiatry services, there is always a satisfying experience of seeing the child out-grow the problem with the aid of good clinical care and supportive environment. The extended family network remains as much a source of support as well as intrusion in parenting in some circumstances; it is the essence of a balance which needs to be discussed within the family meeting. Sometimes counselling alone suffices while at other time medications need to be prescribed. None of the medication licensed to use in children for ADHD or depression is addictive and can safely be withdrawn after recommended period or child achieving the healthy state. Early commencement of treatment helps child in managing stressors and following healthy life. Encouraging physical activity both at school and home would help child struggling with depression and the ADHD.

We are in need of a critical mass of trained child psychiatrists in order to sustain the teaching, assessment and practice of child psychiatrist in the country. A fellowship program would help to develop such a capacity. We also need demographically representative research, involving all stake holders, in order to make informed decision. A strong political will is required from all quarters - institutional leadership in private and public sector - in order to address the care and teaching issues of child psychiatry.

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