Review Article

Strengthening detection, referral and care of childhood psychiatric conditions: Implementing an out-reach programme

***Amila Chandrasiri[1], Darshani Hettiarachchi[2], Konara Mudiyanselage Somarathna[3], Ajanthikumari Wannisinghe[4], Sajeewa De Silva[5]**

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Introduction

Childhood psychiatric conditions have emerged as a significant public health issue worldwide. It is estimated that 10% of children and young people have mental health problems so significant that they impact not only their day-to-day life but, if left untreated, they will continue into adulthood[1]. Sri Lanka is also facing the issue of the rising prevalence of childhood mental health issues. The prevalence of attention deficit hyperactivity disorder is reported as 6.5% among primary school children aged 6 to 10 years[2]. However, most of the affected children remain untreated. Poor detection of these conditions is recognized as the major barrier to providing appropriate care. Lack of capacity for detection and late referral is the key contributory factor[3]. These conditions can make a significant impact on educational performance as well[1]. Recent adverse social influences are further complicating the problem[4]. Detecting and referring childhood psychiatric conditions is one of the objectives of the school health programme in Sri Lanka. However, because of various issues, the intended outcome has not been achieved. Lack of awareness and skills in detecting these conditions and referring for appropriate services are major barriers to achieving the desired outcomes[1]. Perceived stigma in society is identified as another hindrance to reaching and seeking services[5]. Therefore, a programme was planned and implemented to strengthen the detection, referral and provision of optimal care for childhood psychiatric conditions. This article describes the design and implementation of the programme in achieving its objectives.

[1]*Consultant Community Physician, RDHS Office, Galle, Sri Lanka,* [2]*Consultant Child Psychiatrist, Teaching Hospital Karapitiya, Sri Lanka,* [3]*Regional Director of Health Services Office, Galle, Sri Lanka,* [4]*Medical Officer, Mental Health, RDHS Office, Galle, Sri Lanka,* [5]*Medical Officer, School Health, RDHS Galle, Sri Lanka*
**Correspondence:* amilachan@yahoo.com
https://orcid.org/0000-0002-3242-1489
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Designing and implementing the programme

The programme was implemented in one education division in the District of Galle in Southern Sri Lanka. According to the education system in Sri Lanka, the smallest administrative block is an 'education division'. The selected area was semi-urban with a complex socio-economical context. A higher prevalence of childhood mental health issues had been reported in the area and that has been raised as a concern in many divisional-level forums. The programme was designed and implemented in several stages.

Stage 1: Identifying and advocating for stakeholders

First, a stakeholder analysis was done to determine stakeholders. Education officials, health officials, teachers, students and parents were identified as key stakeholders. Advocacy was done for key stakeholders to gain support. Certain key stakeholders like the Divisional Education Director and Medical Officer of Health were personally advocated through one-to-one discussions. The importance of the programme and the expected roles were described. Good support was assured. The Counselling Teacher of the school was identified as the key focal point for implementing the programme at the school level. It was planned to advocate it through group awareness.

Stage 2: Conducting awareness and training for school teachers and public health staff

As the next step, awareness and training were given to two key implementing parties in the programme viz.

school teachers and public health staff. A one-day 'face to face' training was given to all the counselling teachers in the division. The programme was jointly conducted by the two key resource persons of the programme viz. Specialist Child Psychiatrist and Specialist Community Physician. Identifying common mental health issues among school children, initial response and making appropriate referrals were covered during the training. Gathering of teachers and providing conference facilities were done by education authorities. This was followed by a zoom training session delivered to all teachers in the zone. This was a shorter programme than counselling teacher training and it was directed at sensitizing teachers about the issue and providing basic knowledge in identifying childhood mental health issues. Good feedback was received from teachers about the appropriateness and acceptability of the programme. Significant knowledge improvement was noted in pre- and post-surveys.

Stage 3: Starting the outreach programme

Detection and referral of mental health issues were planned to be done in three main ways:

1. Counselling teachers were entrusted with the task of identifying children with mental health issues within the school. They were supposed to approach the student appropriately, do the initial assessment and determine whether a referral for psychiatric care was needed. They encountered children following self-referrals or when referred by other teachers. As general awareness was done for teachers, it was assumed that they will become more sensitized.

2. Children with mental health issues were identified during School Medical Inspections (SMIs). Medical Officer, Mental Health (MO-MH) participated in SMIs in schools with more than 500 student populations. Schools were clustered and referrals from nearby small schools were directed to these schools.

3. Students identified in both ways were first referred to the MO-MH. Two out-reach clinics were assigned to accept referrals. MO-MH conducted these two clinics once a month. Therefore, parents could easily access these clinics following 15-30 minutes of travel. After doing the initial assessment, MO-MH started treatment for manageable cases at the primary care level. Students who required specialist care were referred to the Specialist Child and Adolescent Psychiatrist. A special monthly specialist clinic was established in the Divisional Hospital, Ahangama. Necessary drugs to treat common conditions were supplied to respective hospitals.

Stage 4: Follow-up and evaluation of the programme

Follow-up was assigned to the school counselling teacher and the teacher had to ensure that the child was following the appropriate care. An ongoing evaluation system was initiated. Each counselling teacher was entrusted with the responsibility of sending a monthly return of the number of referred children to the Divisional Education Director.

Discussion

Factors contributing towards the success of the programme

This programme has shown the importance of developing collaboration between the health and education sectors in achieving successful outcomes. Inter-sectoral collaboration is vital in achieving a common goal in addressing a particular issue[6]. As the needs of school children with psychological and behavioural health problems often exceed the expertise and possibilities of a single professional service or organisation, cross-service collaboration is indispensable to adequately meeting these needs[7]. Integration of care was another feature of this programme. Service fragmentation and service duplication remain persistent problems in mental health service delivery systems[8]. Therefore, organisations within the education and healthcare service systems must collaborate sufficiently, for instance by sharing resources such as staff, logistics and information[7].

Initial advocacy was a key factor in obtaining a satisfactory contribution from the education sector. Advocacy is essential to obtain support from other non-health sectors for a health promotion programme[9]. Active involvement of the education sector is a vital factor for successful implementation of any school-based health programme. This programme was a live example of the importance of involving the education sector in carrying out a health promotion programme in the school setting. As the programme continued, the ownership of the programme was strategically transferred to the education sector. This is important in sustaining the programme within the education system.

A careful stakeholder analysis was done at the beginning and that was a decisive factor for success.

This helped in determining which partners were involved in the programme and bringing them together towards a common goal. Stakeholder analysis made sure that all partners began the project with a clear understanding of what success will look like and how they can contribute to that successful outcome[10]. This process also helped the programme implementers to realise conflicts of interest among partners. It is important to identify these conflicts beforehand and take appropriate precautionary measures.

Identifying counselling teachers as the focal point in implementing the programme was another critical factor. The Ministry of Education took a policy decision to appoint counselling teachers for every school to serve school children with various mental health issues. However, due to a lack of capacity and training, the desired effect could not be obtained[4]. However, this programme identified this as a potential group in taking the lead role of the programme. Teachers are close to students and become the earliest observers of behavioural changes in school children[11]. Setting up an in-built monitoring system was another key factor in its success. Monitoring of the programme was vested in the education sector. Each school was requested to send a monthly return including the number of students referred to mental health (MH) clinics. These numbers were tallied with attendance to identify gaps. A system was set up to alert schools if the referred children did not attend the clinic. This enabled the counselling teacher to follow up on why the student did not reach the MH clinic.

Making services available at the primary care level was a distinct feature of this programme. Lack of accessibility is known as a major barrier to obtaining optimum mental health services in Sri Lanka[12]. This programme successfully eliminated that barrier by extending child mental health services to the primary care level. The 'two-step referral system' was able to minimise the burden on the specialist clinic. Starting a specialist child psychiatry clinic at the primary care level appeared to be a practical and feasible strategy to enhance accessibility.

Health system re-orientation

Rather than establishing a new system, this programme was based on the principle of re-orienting the existing health system. This programme was driven within the existing public health programmes like school medical programmes and primary care mental health services. Both these programmes are well-established health services in Sri Lanka and this programme intended to utilise the existing framework[13]. Participation of MO-MH in SMI was a successful strategy to extend services to grass root level with minimum extra effort. This added significant strength to the programme as it was initiated on a well-recognised and deeply rooted health programme. Re-orienting health services are primarily about the health sector changing from focusing primarily on clinical and curative services to increasingly focusing on health promotion and prevention[14]. Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. Thus, this programme was a good example to show the responsiveness of the health system. However, this programme utilised this existing framework to deliver an expanded service. This system did not require extra human resources or financial costs except for the time and effort spent on training.

Challenges and barriers

However, certain challenges and barriers have emerged. A lack of cooperation from certain schools was noted. Excess workload vested on teachers and pressure for completing the syllabus within the allocated time could be responsible for this lack of cooperation. The lack of commitment of parents was another barrier. After doing the referral, some students were not taken to the MH clinic as their parents were reluctant to go. Perceived stigma and lack of priority can be identified as the key underlying factors for defaulting care. Distribution of essential psychiatric drugs to primary care hospitals was another challenge. According to the norms of drug distribution certain drugs which were specifically used in managing childhood psychiatric conditions were routinely not distributed to primary care hospitals. However, a policy decision has been taken at the district level to provide the necessary drugs.

Conclusion

This outreach programme appeared to be a successful model in strengthening the detection, referral and care of childhood psychiatric conditions at the school level. Identifying key stakeholders and appropriate advocacy were the key factors for the successful initiation of the programme. This programme was based on re-orienting existing health services and human resources. Inter-sectoral collaboration with the education sector significantly contributed to its success. This model can be replicated in other education divisions as well.

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