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REVIEW ARTICLE

Status of Child and Adolescents Psychiatry in State of Uttar Pradesh

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Abstract

India has one of the largest numbers of young people in the world, with 35.3% of the total population falling between the ages of 0 and 14 years. Childhood is a time of mental and physical development and anything affecting the development of a child will have negative consequences as an adult. As reported from various surveys prevalence of mental morbidity vary from 1.8 to 15.2% in children and adolescents. Developing countries such as India have certain risk factors that contribute to additional children's issues, such as socioeconomic inequality leading to reduced access to education, child labour and these problems are even more severe in low socioeconomic states like Uttar Pradesh. To attend to the needs of such large population the manpower and infrastructure is not adequate. The paper will review the status of child and adolescent mental health services in our state.

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Introduction

India has one of the largest numbers of children and adolescents (hereafter referred to as children unless specified) in the world, with 35.3% of the total population falling between the ages of 0 and 14 years. Childhood is a time of mental and physical development and anything affecting the development of a child will have negative consequences as an adult. Therefore, it is important to focus on the mental wellbeing of children.

Uttar Pradesh is the country's most populous state, with 16.4 per cent of the population of the nation. There are 85.3 million children under 18 years of age in state of Uttar Pradesh, out of which Child population (0–6 years) is 29,728,235 constituting India's largest child population and among 0 to 14 age group Uttar Pradesh is second only to Bihar with 33.7 percentage of adolescents population compared to total population.[1]

As per NMHS 2015-16, prevalence of mental disorders across country in age group 13 to 17 years is 7.3%, common mental morbidity in this age group includes depressive episode and recurrent depressive disorder (2.6%), agoraphobia (2.3%), intellectual disability (1.7%), autism spectrum disorder (ASD) (1.6%), phobic anxiety disorder (PAD) (1.3%) and psychotic disorder (PD) (1.3%).[2]

Over the last five decades, many epidemiological surveys have been done across state of Uttar Pradesh to find out the prevalence of mental morbidity

among child and adolescent population and findings suggests the prevalence of mental morbidity vary from 1.8 to 15.2%. Although these prevalence rates are much less than that reported from developed countries, due to the large population of children and adolescents in India, the magnitude of the problem is much more than the developed countries.[3]

Developing countries such as India have certain risk factors that contribute to additional issues among children and adolescents, such as socioeconomic inequality leading to reduced access to education, child labour and the problem is more severe in states like Uttar Pradesh that has the poorer socioeconomic condition. School dropouts also add up to this. Uttar Pradesh has one of the highest numbers of school dropouts.[4]

To attend to the needs of such large population the mental health related manpower and infrastructure is not adequate. The paper will review the availability of different types of child and adolescent mental health services in our state.

Prevention and Promotion

There have been various programs and strategies developed by Government of India which includes Integrated Child Development Services (ICDS), Rashtriya Kishor Swasthya Karyakram (RKSK) and Rastriya Bal Swasthya Karyakram (RBSK).

The ICDS scheme was launched in year 1975 with the objective to improve health and nutritional status of child in the 0-6 years of age group and to lay the foundation for proper psychological, physical and social development of the child but in spite of increasing funding over the past three decades, the ICDS is still short of its stated objectives and faces a number of challenges. Also, despite having widespread coverage of population, operational gaps mean that service delivery is not consistent in quantity and quality across the country.[5]

The RKSK was launched on 7th of January 2014 to have a coverage of 253 million adolescents - male and female, married and unmarried, rural and urban, in and out-of-school adolescents with a significant focus on undeserved and marginalized groups. This program expands the scope of adolescent health programming in our country- from being limited to reproductive and sexual health, it now includes in its ambit nutrition, violence and injuries (including gender based violence), mental health, substance misuse and non-communicable diseases.[6]

The RBSK is an important initiative with a aim of early identification and intervention for children from birth to 18 years, to cover learning difficulties and behavioural disorders such as autism are covered under it. Few early intervention centres are being established at the District Hospitals across the state as District Early Intervention Centers (DEIC). The main aim of DEIC is to give referral support to children suffering from health conditions during health screening, for children up to 6 years of age. The RBSK also put emphasis on screening of children at Anganwadi centre and availability of mobile health team to ensure proper coverage, but still a lot needs to be done to make these services easily and readily available across the whole population.[7]

Some activities are being done under each program but full implementation has not been done.

Service Delivery

There is huge treatment gap for psychiatric services in India and state of Uttar Pradesh. Mental health gap in India ranges from 70 to 92% for different disorders according to NMHS 2015-2016.[8]

In Uttar Pradesh, there is a dearth of Child and Adolescent Psychiatric Services. Only a few centres in the state provide holistic services for the same, which mainly include the tertiary hospitals. The state currently has 23 tertiary centres, out of which only 3 have a specialist child and adolescent units.

In recent years, the state government has also put a lot of effort through the District Mental Health Program by appointing a psychiatrist at every district hospital and provision of a social worker and nursing staff as well.[9]

The state government also provides for various special schools for children with an intellectual disability running under the names of Mamta (State School for Mentally Challenged boys and girls) in Lucknow and Allahabad. The total capacity in this special school is of 50 children each. Similarly, shelter houses with a capacity of 50 have been set up in 3 districts; Meerut, Gorakhpur and Bareilly. 126 NGOs are registered under Govt of Uttar

Pradesh out of which 44 are training centres for people with intellectual disability, and another 9 are training institutes for teachers for such children. No government or NGOs sponsored or special private schools for occupational training in children with autism spectrum disorder (ASD) and specific learning disorders (SLD) have been set up. Only a few private institutes are there to cater to the special needs of these children. Considering the huge population of children and adolescents in the State of Uttar Pradesh services available are very sparse and not readily available to all and there is urgent need of enhancing the training program to include dedicated training programs for Child and Adolescent population.

The major care provider for CAMH issues in the state of Uttar Pradesh are medical colleges, Private Psychiatrists, District hospitals and NGOs School-based care and community care services are limited to big cities only. There are few NGOs working for the health needs of children and adolescents in state of Uttar Pradesh such as Aam Welfare foundation, Aasra Foundation, Adarsh educational trust etc. but their main focus is on provision of food and cloth to vulnerable children, education and literacy, civic issues and providing shelter to orphans. There is serious lack of NGOs in State of Uttar Pradesh who are actively involved for the mental health needs of the youth.

Policy

Recently government of India has increased its focus on mental health issues, national policy on mental health was put forward in 2014, and it has put emphasis on care and management of vulnerable group of children such as children of persons with mental illness and promotion of training of Auxiliary nursing midwives for skill upgradation in mental health. This work force caters to children and mother's mental health issues of underprivileged areas of state, but still a lot of ground work is needed to be done for sufficient implantation of these policies.[10] Mental Health Care Act 2017 (MHCA) has also taken few good steps like provision of half way homes, sheltered accommodation, provision of child mental health services and prohibition of separation of children under 3 years of age from their mothers who are suffering from mental illness unless there is threat to safety of the child.[11] Research suggests that up to 70% of youth in conflict with law have some diagnosable mental health problems. Commoner ones includes externalising disorder such as conduct disorder (40.9–64.7%), attention deficit hyperkinetic disorder (ADHD, 4.1–19.2%) or substance use disorders (40.2–50.4%). Externalising disorders are associated with increased chances juvenile delinquency, violence, and recidivism. To take care of these children and adolescents Juvenile Justice Act (JJA) 2015 has mandated early identification of children in need of care and protection (CINCP), ensuring their psychological wellbeing, and to promote their social reintegration & rehabilitation.[12]

One of the most welcoming steps from government is implementation of new education policy which is supposed to bring pedagogical framework for early childhood care and education for children up to the age of 8 years which is supposed to reduce early school difficulties, increase interest in studies and might reduce school dropout rates. Substance use is also one the major concern especially in adolescents age group as this not only imposes serious health issues but also leads for poor academic performance, family conflicts, monetary challenges, and act as a gateway for exposure to other substances and possibility of legal issues as well. So, to take care of substance use among children and adolescents, adequate rehabilitation services, training of teachers and parents for early identification of substance use and appropriate laws should be made for substances which are frequently used at this age such as Volatile substances and Inhalants.

Human Resource and Training

Training of medical officers are being done at various centres to increase their knowledge and understanding of common mental illness including common mental disorders in children and adolescents such as Learning disabilities.

District Mental Health Program (DMHP) is also helping in not only providing treatment of mental illness but also reducing the stigma and increasing awareness towards mental illness. DMHP is also providing training of medical officers for early identification and management of common mental illness at primary health facilities. Report

on evaluation of District Mental Health Program by Indian Council for Market Research (ICMR) has also suggested that DMHP has been a positive step towards management of mental illness and there is a significant difference in awareness about mental illness in districts where DMHP is functional as compared to Non DMHP districts, But still utilization of budget is not up-to the mark at all the districts in state of Uttar Pradesh which further needs more focused attention from the government.[13]

Number of post graduate seats for both MD in Psychiatry and M Phil Psychology were very minimal but due to constant efforts from government in last few years currently number of seats of MD in Psychiatry are increased to 65 and 54 for M. Phil clinical psychology, but still there is vast dearth of manpower considering huge population of the state. During tenure of MD in Psychiatry only 3 months of training is advised as per National Medical Commission (NMC) which seems to be insufficient considering the vast nature of Child and Adolescent Psychiatry and time and expertise needed to practice the same. Another major issue is that most of the medical colleges don't have expert child and adolescent psychiatrist available to train post graduate trainees which further defeats the purpose of training in child and adolescents psychiatry during MD in Psychiatry.

Recently two seats of one year fellowship program in child and adolescents psychiatry is been started by department of Psychiatry, King George's Medical University. Indian Association of Child and Adolescent Mental Health (IACAM) has also started one year certificate course in Child and Adolescent Psychiatry for General Psychiatrist.

Discussion

Schools

The mental health of children and adolescents should be the foremost priority as they are said to be the future of the nation. Making healthcare accessible and affordable is another way to improve the mental health situation in the state. Schools can be a good starting points as large number of children spend good part of time at school. Awareness can be increased in school teachers and other staff about mental health problems of children and simple ways to help children at school. Similarly, many programs which help in better mental development of children like good behaviour games, incredible years may be implemented. Other programs like "Youth Aware of Mental Health Program" for anxiety and depression or "sources of strength" for suicide prevention may be implemented in adolescents.[14]

Life Skill Training (LST) program is being practiced in various forms in different parts of country. LSE focuses on various skills domains such as decision making, coping and communication, interpersonal skills, critical thinking skills and self-management skills. Purpose of these skills is to improve coping, dealing with failures/breakups and to make them less vulnerable for substance abuse and prevention of adolescent suicide. One of the similar approach has been adopted by Delhi government in form of happiness program in schools, it aims to improve mindfulness, self-awareness, critical thinking, development of effective communication skills, empathy and coping skills. In recognition of importance of "Life Skills" and with a view to making it accessible to all children and adolescents, similar approach can be used in state of Uttar Pradesh through training of school teachers.[15] Gate keeper training of School Health Professionals, School Counsellors, Teachers and Students is a very nice approach for early identification of high risk adolescents for suicide, this has been done at many states with very good outcome, there is need of incorporation of this training program to every school in state of Uttar Pradesh.[16] Further we can develop a manual for common mental illness of child and adolescents and can use of this at district level with help of the DMHP to increase the coverage of population.[17]

Community

Considering huge population of Uttar Pradesh it is almost impossible to have enough psychiatrist and trained physicians to deal with emerging mental health issues of child and adolescents. So, to overcome these shortcoming various community-based approaches can be used after raising community awareness. Many of these were used

in study groups conducted in various parts of world and found to be effective.

Another approach that can be used is Population and Community-Wide Mental Health Awareness Programs (PCWMHA) which was used in China, Burundi, Indonesia, Nepal, Sri Lanka, and South Sudan. In this program children with war conflict settings were included. Various community level interventions to raise awareness and decrease stigma were done. Strategies including emotional and social support, education and awareness-raising targeting women's groups and caregivers, other strategies including microfinance, parent training, recreational activities, as well as games, meditation and yoga were also promoted to enhance the resilience of children and adolescents. In addition, adolescent-focused activities including peer dialogues, community drama, adolescent mobilization for social action, traditional-cultural ceremonies, support for reintegration and family reunification of ex-child soldiers, self-help groups, utilization of community and cultural resources, formal and non-formal education and child protection services were used to enhance the mental health of the children and adolescent's population.[18] There is need to develop similar prevention programs in our state that can target child mental health outcomes with special focus on primary prevention.

In another study conducted in Malaysia, psychoeducation about child mental health was delivered to teachers and parents in open sessions with key stakeholders assisting in increasing engagement with interventions. For settings with children affected by armed conflict, community sensitization and public awareness programs were conducted and it was found to be quiet effective in raising awareness regarding mental health issues of children and adolescents.[19] Similar models can be used in our state as well to raise awareness among teachers and parents regarding mental health issues of the vulnerable group as they are the one who can help in early and effective screening among children and adolescents as well as can help in reducing stigma towards common mental disorders.

Community-based rehabilitation, such as building children's skills in daily living activities and assisting parents find income-generating activities, life skills programmes, apprenticeships, vocational skills training, and livelihood programmes, should also be included for childhood development disorders.[20] Many studies around the world have found that these interventions are effective in reducing social exclusion and helping rehabilitation services. There is a need to strengthen rehabilitation services in our state.

There is also need of increasing awareness about mental illness of children and adolescents by the ways of electronic and paper media, involvement of imminent personalities of the state so that stigma and myths related to mental illness of young can be reduced and participation of members of community can be increased.

The gap between the burden of mental disorders and available evidence-based services is widening in low-and middle-income countries, so there is a need to strengthen community-based mental health care for children and adolescents, including school-based primary screening and non-school-based screening of children on various community platforms such as homes, non-governmental organisations, prisons, and community centres.

Clinical Services

Considering huge population of children and adolescents in state of Uttar Pradesh there is need to increase number of child psychiatrist, which can be achieved by increasing focus of training of psychiatrist in child psychiatry and starting of speciality courses such as DM courses in child psychiatry which is currently not available in our state. To improve delivery of the community components of interventions, government is currently focusing on training in psychiatry of medical officers posted in far-flung areas with limited access to mental health services. To enhance population coverage, our primary care physicians working at PHCs/CHCs and District hospitals should get sensitization regarding common mental illness of child and adolescents population, currently training of primary care physician is being done at KGMU but involvement of other pioneer institutes of the state would be required so that most of our physician gets basic knowledge about common mental

issues of this vulnerable population. There is need of better networking and much greater coordination between paediatricians and child psychiatrists and between child psychiatrists and general adult psychiatrists to ensure a smooth referral system for child and adolescents suffering from mental illness. Other health workers such as nurses, ANMs and ASHA must also be aware about mental health problems of children, so that referral can be done at an appropriate time and early intervention can be done to achieve better outcomes.

Other than these we need to improve the utilization of grass route workers such as community health worker who have more robust reach in community, they are responsible for outreach, education, promoting adherence, and documentation and monitoring outside of the health facility. Formal providers, who have not received professional training in mental health, including teachers, law enforcement officers, and social workers should also be brought to the picture to ensure coverage of population which are left out by medical health workers. Similarly, non-formal providers who are lay persons who do not have a formal role in the health or other service provision programs should also be involved. Non-governmental organizations often recruit and train lay persons in the community to take on psychosocial programs. For children and adolescents with common mental disorders who are in remote areas of the state where no formal health services are available these service providers can be of great help.

There is an urgent need for a mental health policy for young to provide a developmental framework for the enhancement of mental health resources and guide adequate development of services and with a mere 1.15% of the gross domestic product of India being spent on healthcare, the budget for mental health is less than 1%. Out of this, the budget utilized specially for the mental health of children is minuscule.[21] We can take help of WHO child and adolescent mental health policies and service guidance package to build policy for comprehensive mental health needs of children and adolescents. Recognizing the needs of this population and putting in place appropriate actions is the need of the hour.

References

1. Census of India 2011. Provisional Population Totals. Office of the Registrar General and Census Commissioner India, New Delhi; 2011.
2. Gururaj G, Varghese M, Benegal V, Rao GN, Pathak K, Singh LK, *et al*. National Mental Health Survey of India, 2015-16: Summary. Bengaluru, National Institute of Mental Health and Neuro Sciences, NIMHANS Publication No. 128, 2016.
3. World Health Organization. Atlas: child and adolescent mental health resources : global concerns: implications for the future. World Health Organization, 2005.
4. Lata S, Khatri HL. Factors Leading to School Dropout in India. Shikshan Anveshika. 2017;7(2):106–110.
5. Kapil U. Integrated child development services (ICDS) scheme: A program for holistic development of children in India. Indian Journal of Pediatrics. 2002;69(7):597–601.
6. Desai S. Adolescent health: Priorities and opportunities for Rashtriya Kishor Swasthya Karyakram (RKSK) in Uttar Pradesh," Policy brief. New Delhi: Population Council, 2017. DOI 10.31899/pgy8.1004
7. Sangeetha J. Rashtriya Bal Swasthya Karyakaram (RBSK). TNNMC Journal of Community Health Nursing. 2019;7(2):34-37.
8. Gautham MS, Gururaj G, Varghese M, Benegal V, Rao GN, Kokane A, Chavan BS, Dalal PK, Ram D, Pathak K, Lenin Singh RK. The National Mental Health Survey of India (2016): Prevalence, socio-demographic correlates and treatment gap of mental morbidity. International Journal of Social Psychiatry. 2020;66(4):361-372.
9. Gupta S, Sagar R. National mental health programme-optimism and caution: a narrative review. Indian Journal of Psychological Medicine. 2018;40(6):509-516.
10. Rashtriya Bal Swasthya Karyakaram. Child Health Screening and Early Intervention Services National Rural Health Mission. National Health Mission. Ministry of Health and Family Welfare, Government of India, 2014.
11. Mental health Care Act 2017. Available from: https://egazette.nic.in/WriteReadData/2017/175248.pdf.
12. Snehil G, Sagar R. Juvenile Justice System, Juvenile Mental Health, and the Role of MHPs: Challenges and Opportunities. Indian journal of psychological medicine, 2020, 42(3): 304–310.
13. National Mental Health Policy of India 2014. Available from: https://nhm.gov.in/images/pdf/National_Health_Mental_Policy.pdf
14. Fazel M, Patel V, Thomas S, Tol W. Mental health interventions in schools in low-income and middle-income countries. The Lancet Psychiatry. 2014;1(5):388-98.
15. Happiness Curriculum 2019. State Council of Educational Research and Training, New Delhi. Available from: https://www.edudel.nic.in//welcome_folder/happiness/HappinessCurriculumFramework_2019.pdf
16. Patel R, Mehta R, Dave K, Chaudhary P. Effectiveness of gatekeepers' training for suicide prevention

program among medical professionals and medical undergraduate students of a medical college from Western India. Industrial Psychiatry Journal. 2021;30(2):217-223.
17. Hossain MM, Purohit N. Improving child and adolescent mental health in India: Status, services, policies, and way forward. Indian J Psychiatry. 2019;61(4):415–419.
18. Jordans MJ, Tol WA, Komproe IH, De Jong JV. Systematic review of evidence and treatment approaches: Psychosocial and mental health care for children in war. Child and Adolescent Mental Health. 2009;14(1):2–14.
19. Tol WA, Komproe IH, Jordans MJ, Ndayisaba A, Ntamutumba P, Sipsma H, et al. School-based mental health intervention for children in war-affected Burundi: a cluster randomized trial. BMC medicine. 2014;12(1):56. DOI: 10.1186/1741-7015-12-56
20. World Health Organization. Community-based rehabilitation: CBR guidelines. Geneva: World Health Organization; 2010. Available from: https://www.who.int/publications/i/item/9789241548052
21. Murthy RS. National mental health survey of India 2015–2016. Indian Journal of Psychiatry. 2017;59(1):21-26.