Child psychiatry in Bombay: the school mental health clinic

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The school mental health clinic is an unusual amalgamation of the mental health and education sectors in Bombay. It aims to detect emotional problems in schoolchildren, increase mental health awareness in teachers and other professionals and determine any risk or causal factors in schoolchildren suffering from mental health problems. It also offers cross-cultural research opportunities.

Mental health has traditionally been accorded low priority in developing countries. This may be because of the predominance of infectious illnesses and low user uptake. The latter results from faith in traditional systems of medicine and social stigma attached to accessing formal mental health services. However, this scenario has been undergoing a change with greater urbanization, industrialization and improved levels of education. Integration of mental health services into general hospitals means that medical professionals and the wider population are aware of their presence and hence suitable patients are referred for assessment and treatment (Munjal and Ahuja, 1992).

Child psychiatry is also still in its infancy in India, as a result of a number of factors. The joint family system meant that there was a network of carers and sometimes up to three generations living under the same roof. Parental responsibility was thus shared, with older generations providing much of the guidance in bringing up children. With the disintegration of the joint family and the rise of the nuclear family, the task has been left to the parents, both of whom would usually be working full time to make ends meet. This led to a number of emotional problems in children for which services were required.

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MODELS OF HEALTH DELIVERY IN BOMBAY (MUMBAI)

In Bombay (Mumbai), as in the rest of the country, private and public sector health services exist as completely separate entities. The Bombay Municipal Corporation runs three teaching hospitals, of which the BYL Nair Hospital is one.

In 1979, the World Health Organization ‘International Year of the Child’, it was decided to set up a pilot project in Nair Hospital to assess the mental health problems of municipal schoolchildren. The pilot was successful, and a clear need was identified for more permanent structure to the service. This was then converted to the school mental health clinic (SMHC) in 1981 with a clear set of objectives. These were:

1. To increase mental health awareness in teachers and other professionals coming in contact with schoolchildren
2. To screen children for psychiatric problems
3. To achieve early intervention where indicated
4. To try and determine risk or causal factors if any.

SMHC staff

The SMHC consists of a trained psychiatrist, a registrar and a senior house officer. The non-medical staff include two clinical psychologists and two social workers. The clinic accepts referrals from schools and a timetable is set up to visit schools during term time. The registrar, a clinical psychologist and social worker visit the school. Children with learning difficulties, emotional and behavioural problems are referred by the teachers. The child is seen along with the parents and a standard psychiatric assessment is performed.

The clinical psychologist conducts IQ (Indian Version, Kulshreshta, 1960; Malin, 1972) and other psychological tests (Child Apperception Test, Verma et al, 1972; Phatak, 1984) as needed. The social worker assesses the social situation and provides advice on any matters arising. The team then discuss the case at the multidisciplinary review before recommending appropriate action. Frequently parental reassurance or educa-

tion is enough to allay fears. Cases requiring further input are then followed up at the Nair Hospital clinic. A combination of community-based assessment and hospital-based follow up can thus be offered.

Working with other professionals

The SMHC also has the task of training other professionals who come in contact with children. These include teachers and school medical officers who are frequently the first point of contact for the families. Teachers attending such training courses report being able to understand emotional problems in their pupils better. Training conferences are conducted and are enthusiastically attended by teachers. School medical officers receive training in recognizing emotional problems, e.g. depression and anxiety disorders. They are also educated about ongoing monitoring of the child once he/she is discharged from the clinic.

NATURE OF REFERRALS

Learning difficulties needing further assessment are the commonest reason for referral. This is followed by behavioural problems, speech problems, convulsions, delayed milestones, hyperactivity and school refusal. When further assessed, borderline intellectual functioning forms the commonest diagnosis. This is followed by specific development disorders, commonly in scholastic skills, with hyperkinetic and conduct disorders next.

It is important to put these findings in context. Children in many schools would have otherwise dropped out or been considered a failure if their intellectual functioning was not assessed. A comprehensive assessment then helps to plan remedial education and also helps the parents understand their child's school failures. Parents are frequently relieved to know of the diagnosis. A similar response is seen in patients with specific development disorders. Management of children with nocturnal enuresis involves use of star charts, psychoeducation of the parents and imipramine. Absence of commercially available pad and buzzer systems means they cannot be used in management. Children with hyperactivity are managed with behavioural modification.

DIFFICULTIES ENCOUNTERED

As with all public services, resources are a major stumbling block. With the school population in municipal schools being close to half a million, a single SMHC seems woefully inadequate. Around 1000 children each year are assessed by the SMHC. Problems remain relating to follow-up in schools themselves. Teachers trained in identifying emotional problems are a valuable resource. They are frequently relied upon to be the local resource. Staff shortages — one clinical psychologist and one social worker — are obvious.

Parents are frequently day labourers and have to endure loss of a day's earnings to get their child to hospital. There are additional costs of transport to and from hospital for follow up. Nevertheless, the parents' enthusiasm in trying to understand their child's problems is exemplary. This would, at times, mean that either parent goes without food for the day. In an ideal world, one would have wanted to have highly trained teachers and clinical psychologists in each school, referring cases which are difficult to manage onward to hospital. In the absence of such, resources have been spread thinly with good effect.

FUTURE PERSPECTIVES

The SMHC offers an interesting platform for conducting research into childhood disorders in a developing country. Plans for research include looking into the effects of parental separation on children, coping mechanisms employed by children with physical and mental handicaps and studies on school dropouts. There are plans to study the feasibility of setting up a separate clinic for adolescents. The SMHC welcomes joint projects to explore the similarities and differences in presentations and outcomes in childhood mental disorders between developing and developed countries. HM

Conflict of interest: none.

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KEY POINTS

- The school mental health clinic is a joint collaboration between the health and education sectors in Bombay.
- Common referrals include learning difficulties, behavioural problems and delayed milestones.
- The school mental health clinic offers exciting opportunities for cross-cultural research.