Progress and Opportunities in Building Capacity in Child and Adolescent Psychiatry in Asia

CAMH in Primary Care Fiji

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Declaration of Interests

The authors have no affiliations with or involvement in any organization or entity with any financial interest (such as honoraria; educational grants; participation in speakers’ bureaus; membership, employment, consultancies, stock ownership, or other equity interest; and expert testimony or patent-licensing arrangements), or non-financial interest (such as personal or professional relationships, affiliations, knowledge or beliefs) in the subject matter or materials discussed in this presentation.
Introduction

• Three (3) day workshop program with primary care workers

• Plan for a repeatable project with other Fiji districts that could be as self-sufficient as possible within Fiji

• Inclusion of psychiatrists in training from both Fiji and Australia

• Conducted in Lautoka, Western District of Fiji in 2017, then Savusavu, Northern District in 2018

• Organisation and arrangements done within Fiji especially by MoH; FCAP providing technical and education support

• Joint Project of:
  • Fiji Ministry of Health (MoH)
  • Fiji National University (FNU)
  • RANZCP Faculty of Child and Adolescent Psychiatry (FCAP)
Lautoka 2017
Fiji Population = 884,887 (2017)

- **Location**: URBAN 55.9%, RURAL 44.1%
- **Ethnicity**: I-TAUKEI 57% (2007), INDIANS 37%, 6%
- **Religion**: CHRISTIANS 52.9% (2007), HINDUS 38.1%, 7.8% Islam
Fiji

Gender
- Males – 50.7%
- Females – 49.3%

Languages
- English
- Fijian
- Hindi

Life Expectancy
- Males – 66 years
- Females – 71 years

GNI per capita: US $3,950 (World Bank, 2009)
Demographics

• Median age is 27.5 years, i.e. half of population is below 27.5 years

• 69.% of the population is below the age of 40
Hospitals in Fiji

- **Northern:** Labasa, Savusavu, Rabi, Ringold Isles
- **Western:** Sigatoka, Nadi, Tailevu
- **Central/Eastern:** Suva, Nadi, Lakeba Sub-Division

- Divisional Hospitals: 3
- Sub-Divisional Hospitals: 16
- Area Hospitals: 3
- Special Hospitals: 2
Program Objectives

• Provide a training opportunity in child and adolescent emotional well being and mental health for primary care clinicians and nurses in Fiji
• Target primary care workers to improve their understanding of child and adolescent emotional well being and mental health needs as first-line providers of health services
• Improve understanding and knowledge of the multi-factorial aspects of emotional well-being and mental health of children and adolescents.
• Integrate mental health care into basic public/primary health care services for earlier recognition, support, intervention and referral of children and adolescents with mental health needs.
• Use this earlier recognition, understanding and support to help reduce the risk of mental illness and support families in the long term.
• Build relationships within and between primary care workers in different areas of Fiji, as well as with facilitators from both Fiji and Australia
• Develop and test teaching materials such as lectures and training cases to assess uptake and interest in the target group of primary care workers, for use in future workshops.
Description of Program

• Personable approach getting a clear understanding of each others work and context

• Attending to culture and religious values

• Flexible program with a range of teaching tools selected on basis of group feedback and outcomes of case discussions
  • Brief presentations on topics requested by local presenters and participants
  • Small group discussions based on brief case histories
  • Practical exercises in brief intervention tools
  • “Tracking Better” Program - a trauma focused visual psychoeducational system developed by Dr Deeta Kimber in Melbourne for use in remote indigenous areas
Our Approach

Learning from the group and local presenters about the strengths and values of their own system
- Focus on prevention and public health in Fiji
- Infant and maternal mental health in a relatively young population
- Significant capacity already present in primary care clinicians

Reflecting on our identities to account for their effect on the group process
- Career stage
- Experience of our own systems
- Cultural identity (iTaukei, Indo-Fijian, Australian, countries of origin and migration)
- Relational vs individual self
Relational Exercise
Themes that Emerged

• Assessment and formulation of child and adolescent mental health problems in primary care,
• Understanding and intervening in child and adolescent mental health problems in the context of family, community, culture and religion,
• Neurodevelopment disorders and education failure including ASD, ADHD and ID,
• Childhood trauma disorders and trauma informed care for both child, adolescents and their parents including acute traumas i.e. natural disasters and chronic trauma i.e. child abuse,
• Stigma
• Management of child abuse including managing disclosures of sexual abuse,
• Brief psychotherapeutic or psychosocial interventions that are suitable for primary care including when and who to refer to and how to deliver in primary care (relaxation, DBT, CBT, Motivational Interviewing, Trauma Focused approaches) and
• Use of psychotropic medication in primary care.
Educational Approaches

1. Problem-based small group discussion triggered by selected case vignettes which were then summaries and discussed in the larger group.

2. PowerPoint presentations were kept to 10 – 12 minutes and very focused supporting topics triggered and emerging from the small case-based vignettes discussions.

3. Practical experiential exercises around tuning into and managing stress.

4. Exercises demonstrating intervention strategies such as relaxation methods and motivational interviewing.

5. Active participation of all participants in contributing to small group discussions and feeding back to the larger group.
Motivational Interviewing

- Develop discrepancies
- Amplify ambivalence
- Express empathy
- Roll with Resistance
- Support self-sufficiency
Case 1
Peter is a ten year old boy who lives with his extended family in a small island village that was hit by a recent cyclone. The house was destroyed. Peter saw one of his sisters badly cut by a piece of flying metal from the roof. Peter’s father was visiting relatives in another island at the time of the cyclone and was not able to be contacted for three days. One year before the cyclone, Peter had suffered burns after accidentally tipping a pot of boiling rice water over his body. He had spent two months recovering in the general hospital at the main city. After being discharged, Peter’s mother went back home while he spent another month staying with relatives while he recovered. He still complains of pain over the site of the burns and has occasional nightmares about being burnt, though these had been improving.
A month after the cyclone, Peter’s parents took him to the local health clinic because of diarrhoea, stomach aches, poor appetite and weight loss. His sleep was poor, though he denied any nightmares. He was diagnosed with gastroenteritis and given medical treatment. Peter continued to lose weight over the next three months. He also begun to wet his pants and was refusing to separate from his mother. He had stopped attending school, although he enjoyed it in the past. He still was happy to play soccer with his friends. He represents to the health clinic and the nurse contacts you, asking for advice.

- *Where there is no Child Psychiatrist* p166
- *IACAPAP Textbook of Child and Adolescent Mental Health, Section F4 (available free online)*

**Questions for discussion:**

1. What are the differential diagnoses?
2. What are some of the predisposing, precipitating, perpetuating and protective factors?
3. What treatment plan would you recommend?
4. What may be the consequences if nothing is done?
GROUP II

1. How would a situation like this be addressed in ur community?
   - Ignore
   - Police
   - Talk to the tuara ni koroi/priest (Counsel)
   - Women's group (safi ni maruma)

2. How would you as a mental health clinician think about a case like this?
   - Counselling the family (counsel on parenting)
   - Child welfare decree
   - Domestic violence decree

3. What questions would you ask about the boy Michael?
   - Why do you think Michael is dangerous?
     (to you/wife/animals)
   - What makes him aggressive?
   - What are some of the good things about Michael?

What questions would you ask about Mary?
How did you meet Michael's father?
How long have you been dating b4 the pregnancy?
Was it a planned pregnancy?
Why does ur husband hit you?

How do MHC deal with violence?
Violence traumatises children and makes them prone to psychological problems later in life. (Depression/Anxiety)
Counselling on anger management/proper parenting

* VIOLENCE BEGETS VIOLENCE.
GROUP B - TRAUMA PRESENTATION IN YOUNG CHILD

1. What are the major emotional development needs that are important for Timani at his age and at this time?
   - Problems: 5-year-old
     - Caught in the wave and thrown into a tree
     - Mother severely injured, hospital/haven't seen her since the tsunami
     - Father dead
     - Staying with his sister and cousinst

   - Solutions:
     - Staying in the longest attachment (sister, aunt, mother)

2. How might we explain his behavior?
   - Post Traumatic Stress Disorder
     - Skull blow injury, disorientation, wandering around

   - What might we advise the teachers and caregivers about how to provide support and care for him?
     - Inform/educate about traumatic stress disorder
     - Teacher to stand in as a parent, not teach but engage the child (Timani) in activities that will allow them to express their feelings about the tsunami
     - Teachers to take child to hospital to work with
     - Parental roles
     - Counselling for parents and other stakeholders (like support Pacific)

- Housing
- Social
- Safety
- Preparatory
- Protective
- Psychological

Symptoms

6. Teachers
   - Talk about what has been told through
   - Drawings
## Evaluation Summary: Lautoka 2017

<table>
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<tr>
<th>Feedback CAMH in PC Fiji Sept. 2017</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neither agree or disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
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<td>The overall program was informative</td>
<td></td>
<td></td>
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<td>93%</td>
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<tr>
<td>The information presented was relevant</td>
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<td>I feel confident about adapting the material presented, where appropriate, for local settings</td>
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<td>73%</td>
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<tr>
<td>The program materials were appropriate</td>
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<tr>
<td>The facilities were suitable</td>
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<tr>
<td>The program was well organised</td>
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<tr>
<td>The overall quality of the program was good</td>
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<td>You felt intellectually stimulated</td>
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<td>7%</td>
<td>93%</td>
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<tr>
<td>The travel arrangements were well handled</td>
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<td></td>
<td></td>
<td>8%</td>
<td>92%</td>
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<tr>
<td>The accommodation was suitable</td>
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<td>The social functions were well organised</td>
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<td>10%</td>
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<tr>
<td>The meals were suitable</td>
<td></td>
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<td>7%</td>
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<tr>
<td>You felt socially supported during your time at the study group</td>
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<td></td>
<td></td>
<td>8%</td>
<td>92%</td>
</tr>
</tbody>
</table>
Comments from Evaluation

- Majority of participants found the clinical case discussions to be the most relevant and useful sessions within the workshop and appreciated the realistic and practical approach to problem solving applied by the facilitators.

- “The case presentations are really useful as it relates more to what we face in our settings.”

- “I found that the case studies were very useful and helped me to understand mental disorders much better at a clinical level.”

- “All sessions were useful – learnt new things especially on mental health in children & adolescent, how to deal with traumatised children.”

- Several participants commented on the inclusive and comfortable environment of the workshop which encouraged open discussion and comparison of local issues.

- “Very satisfied because it was not only just facilitators talking but everyone, had a chance to talk about experiences and share a piece of their mind. “

- When asked to report on anything that wasn’t covered in the program two participants requested further information on assessment tools and therapeutic interventions. Topics also requested included intellectual disability and developmental disorders.

- One participant highlighted the need for involvement from the Ministry of Health (Western District) and Paediatricians in the workshops “...so that a proper channel of protocol can be put in place for such referrals.”

- “A very lively and informative workshop. Would love to get others from our team to attend and be empowered.”

- Majority of participants were satisfied with the level of interaction and were thankful for the opportunity to network and develop helpful relationships with their colleagues and local counterparts.

- A number of participants reported the workshop exceeded their expectations and encouraged facilitators to maintain future CAMH in Primary Care training sessions.

- “For me it was very informative and (the workshop) built my confidence.”
Outcomes

• Flexible style of training delivery in CAMH

• Focus on neurodevelopmental disorders, trauma-based difficulties, infant mental health, stigma and childhood sexual abuse

• Strong networking and linkage of professionals locally and international

• Successful training of Fijian and Australian psychiatric trainees in teaching

• A transferrable repeatable training package which is now available
Recommendations of Project

• That the group of participants and local trainers remain in communication to share resources and ask questions
• Follow up training in different districts, incorporating local trainers, senior trainees and early career psychiatrists
• Ongoing development and use of CAMH in Primary Care Fiji model
• Integration of paediatricians and child health professionals to integrate physical and mental health
• Consider visits to local primary care facilities prior to the training to familiarise trainers with clinical settings of participants
-Thanks Fiji!