

Child Psychiatry Without Psychiatrists: A New Model for Old Problems

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Introduction

Child psychiatry was developed around the turn of the century following an increasing recognition of childhood behavioural and emotional issues. Most child psychiatrists provide care within specialty clinics and tertiary hospitals. Treatment for mental health disorders for children and adolescents has improved considerably with more evidence-based and effective medications, and psychosocial interventions.¹ However, the practice of child psychiatry is not cost-effective in its present form. Other professionals can perform some of the functions of child psychiatrists at a fraction of the cost. In addition, there is an urgency to meet the treatment gap of childhood mental health disorders. It is not feasible to train more psychiatrists to address this increased demand due to resource constraints in terms of doctors and time.

A New Approach of Care

Existing evidence suggests that a population-based strategy is necessary, with the goal of providing balanced, step-based care, in varying intensity interventions, to young people and their families.² Utilising such an approach will take into consideration the increasing gap between mental health issues within the community and the limited

resources available in hospitals. This mental health gap would therefore require a change in the provision of care without compromising on quality or outcomes; a move away from the traditional mental healthcare model which is largely illness-centric, stigmatising, and resource-intensive.

Response to Intervention Model

Taking reference from education which is population-based and universal, and worldwide literacy levels reaching 90%,³ we would like to propose using an educational framework as the approach forward. Schools do not treat learning difficulties—they provide a standard of care that encourages learning, and give educational interventions as needed when the child is struggling. Ultimately, the one-to-one intervention that healthcare uses, is provided once the child is deemed needing such resource-intensive care. This model is called a Response to Intervention (RTI) model which was originally described for use in special education⁴ and empirically validated.⁵

Using the RTI framework on population-based child and adolescent mental health would leverage on systematic assessment and early detection in partnership with community stakeholders (e.g. schools, primary care physicians). It identifies strengths and builds on resilience of

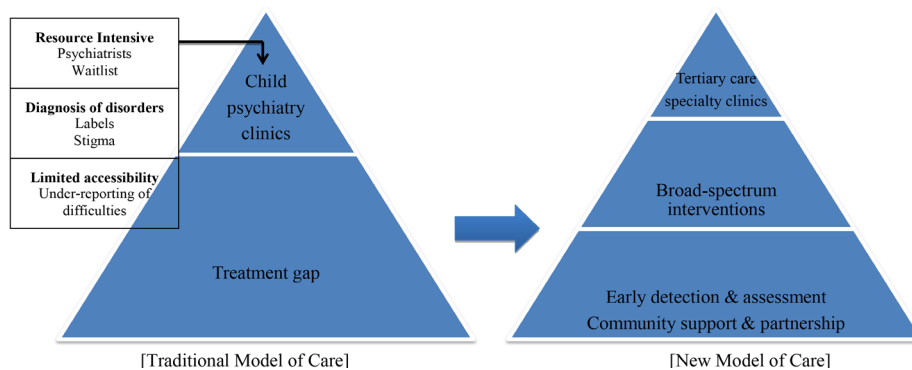


Fig. 1. A RTI framework of care for child and adolescent mental health.

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the child and his surrounding systems (e.g. family, school), as well as implement broad-spectrum, community-based interventions that are transdiagnostic and non-stigmatising (Fig. 1).

Examples in the Local Context

Low intensity treatment administered within the community by teachers and counsellors can address general difficulties (e.g. academic stress, peer relationship) and milder presentation of mental health issues, with a wider outreach and a reduction of the reliance on specialty clinics. The establishment of a Singapore National Mental Health Blueprint in 2007 focused on population-based initiatives and the community mental health masterplan in 2012 reinforced the strategy. The core of the blueprint for children is a regionally deployed community team called Response, Early Assessment and Intervention in Community Mental Health (REACH). The REACH team is an early identification process for emotional and behavioural difficulties. Working with school-based professionals, the plan was to train a cadre of frontline school personnel to manage mental health issues in the early stages in school and at home. Primary care physicians and social service agencies within the school's vicinity were similarly engaged to form a network of community support for students and families. Parent support groups from schools as well as disease support groups were included to improve understanding and knowledge transfer. The REACH programme and its outcomes have been described.⁶ The initial implementation has shown that unlike specialty clinics, community assessment has identified an almost equal number of behavioural and emotional disorders in schools suggesting that anxiety and depression were clearly under-diagnosed.

The traditional mental healthcare model relies on professional manpower resources within a tertiary specialist clinic setting. There is often a long wait time before children receive treatment. Evidence-based treatment is well applied only in tertiary facilities and will benefit only a portion of the population. It is now possible to adopt technology and incorporate it as part of treatment for a population-based approach to care. An array of online and application-based interventions is now widely available. Some require specialist clinical support while others are in self-help format employing either parents and/or teachers in the process. The majority of these interventions are informed by cognitive behaviour therapy principles, and have been implemented among children and adolescents with positive outcomes. Systematic reviews published to date suggest that computerised protocols for depression and anxiety are, in general, effective for young people under the age of 18.⁷ In Singapore, we have started to deploy some of these

strategies to assist the community teams in their work.⁸

For children and adolescents with more serious and complex needs, specialist clinics continue to provide interventions that are differentiated and empirically robust, through the expertise of a multidisciplinary team (MDT) comprising not only of psychiatrists, but clinical psychologists, social workers and other mental health professionals. This represents the final element in the stepped care approach of the population-based RTI model. The role of a specialist MDT is also to deliver suitable training and consultation for community partners to ensure seamless collaboration for accessible mental health programmes.

Conclusion

Mental healthcare of the future is an evolving concept that will continue to require an open mind with a compassionate heart. The population-based RTI approach is necessary because of the dual challenges of increasing demands and limited resources when working with young people and their families. It should be a model that is accessible, feasible, timely, effective, and yet affordable and safe. The paradigm shift from acute tertiary care in hospitals and specialty clinics to preventive and long-term self, family and community interventions is not easy to accept. By adopting a population-based RTI approach, we hope that this can be an evidence-based delivery system that is effective globally, regardless of resources.

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