

SeeTheChild

Hidden Mental Health Problems Among Children Identified Through Research- A Case Of Middle Child Age Alcoholism

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Presentation outline

- Background
- Alcohol use in childhood
- Gaps in human resources for CAMH
- Uganda context
- SeeTheChild study (Objectives, Methods, preliminary results, Conclusions)
- Acknowledgement

Background

- Internationally 20% of children have mental health problems, with increased prevalence associated with poverty, family disruption and exposure to trauma
- Half of all mental disorders begin by age 14
- Failure to recognise and treat psychiatric problems in children has severe and irreversible consequences for their education, relationships, emotional and psychological development
- Development of CAMH services is now a WHO priority for sub-Saharan Africa

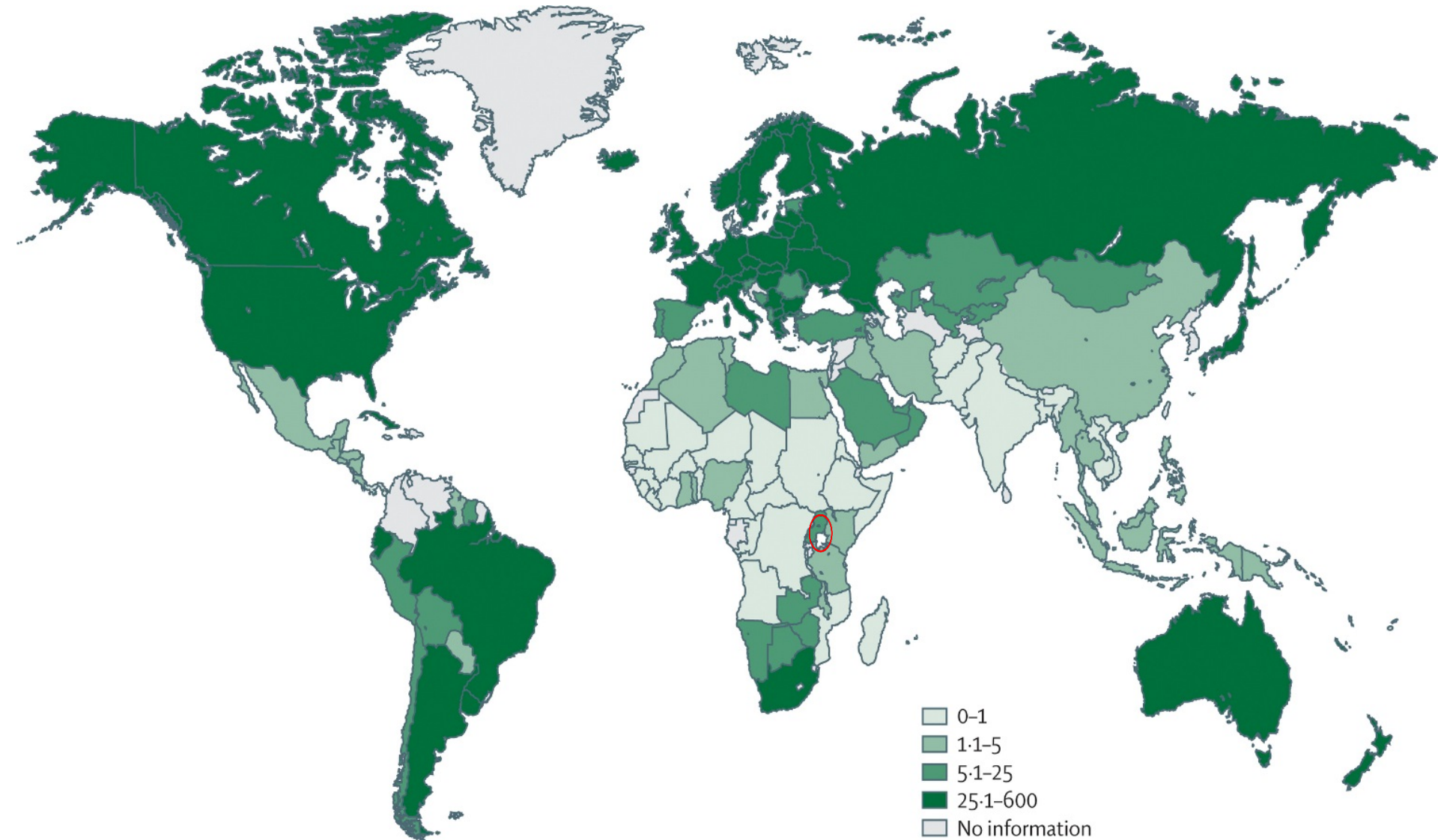
Belfer ML 2008

Alcohol in childhood

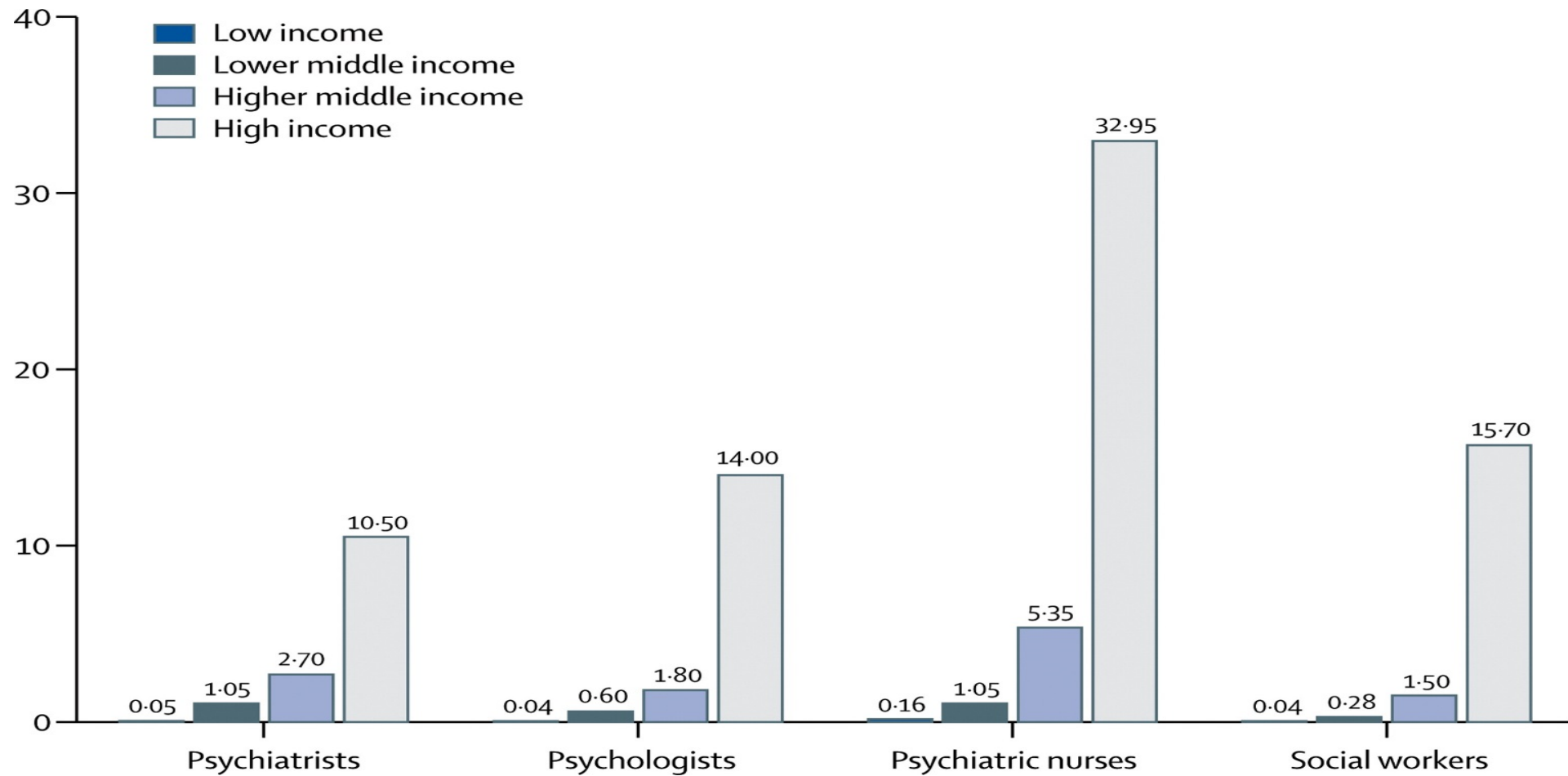
- Early alcohol consumption is a risk factor for dependency, cognitive, emotional and behaviour problems
- Children who drink alcohol before the age of 15, are five times more likely to have alcohol problems than those that start drinking after age 21
- Limited information exist on childhood alcohol use in the communities among children in sub-Saharan Africa

David J. DeWit, et al 2000; E Mick, J Biederman et al 2002

Human resources for mental health by income group (psychiatrists, psychologists, nurses, and social workers) per 100 000 population *Shekhar Saxena, et al (2007).*



Human resources for mental health by income group per 100 000 population



UGANDA

- In Uganda almost half of the population (51%) is under 15 years of age
- One third of the population live below the poverty line
- The effects of HIV/AIDS, poverty, war, displacement, trauma, bereavement, child abuse, domestic violence increase burden of mental disorders in children
- High alcohol consumption ≥ 15
- In this context few children with mental health problems are identified and treated



Objective

- To identify mental health problems (focusing on alcohol use) in middle childhood (5-8 years) in a ***subsample*** of the EBF cohort in Mbale district, Eastern Uganda

Study site: Mbale, Eastern Uganda



Mbale

- Lumasaaba - Complex language with four different dialects.
- Imbalu – Male circumcision among the Bagisu, a cultural rite for initiation into manhood



Subjects and methods

- The research project ‘*SeeTheChild - Mental child health in Uganda*’ (STC) followed a subgroup from June to November 2014 with child psychiatric assessment recruited from a larger cohort: “*the PROMISE Saving Brains (SB) study.*”
- The PROMISE SB cohort included 5-7 year old children having participated in a exclusive breastfeeding promotion trial “PROMSIE EBF” in infancy
- Of 765 enrolled mother – newborn-child pairs in the PROMISE EBF study (2006-2008), Promise Saving Brains in Uganda saw 538 (70%) child-caretaker pairs again when the children had reached 5-7 years.



Exclusive breastfeeding promotion by peer counsellors in sub-Saharan Africa (PROMISE-EBF): a cluster-randomised trial

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Summary

Background Exclusive breastfeeding (EBF) is reported to be a life-saving intervention in low-income settings. The effect of breastfeeding counselling by peer counsellors was assessed in Africa.

Methods 24 communities in Burkina Faso, 24 in Uganda, and 34 in South Africa were assigned in a 1:1 ratio, by use of a computer-generated randomisation sequence, to the control or intervention clusters. In the intervention group, we scheduled one antenatal breastfeeding peer counselling visit and four post-delivery visits by trained peers. The data gathering team were masked to the intervention allocation. The primary outcomes were prevalence of EBF and diarrhoea reported by mothers for infants aged 12 weeks and 24 weeks. Country-specific prevalence ratios were adjusted for cluster effects and sites. Analysis was by intention to treat. This study is registered with ClinicalTrials.gov, number NCT00397150.

Findings 2579 mother–infant pairs were assigned to the intervention or control clusters in Burkina Faso (n=392 and n=402, respectively), Uganda (n=396 and n=369, respectively), and South Africa (n=535 and 485, respectively). The EBF prevalences based on 24-h recall at 12 weeks in the intervention and control clusters were 310 (79%) of 392 and 139 (35%) of 402, respectively, in Burkina Faso (prevalence ratio 2.29, 95% CI 1.33–3.92); 323 (82%) of 396 and 161 (44%) of 369, respectively, in Uganda (1.89, 1.70–2.11); and 56 (10%) of 535 and 30 (6%) of 485, respectively, in South Africa (1.72, 1.12–2.63). The EBF prevalences based on 7-day recall in the intervention and control clusters were 300 (77%) and 94 (23%), respectively, in Burkina Faso (3.27, 2.13–5.03); 305 (77%) and 125 (34%), respectively, in Uganda (2.30, 2.00–2.65); and 41 (8%) and 19 (4%), respectively, in South Africa (1.98, 1.30–3.02). At 24 weeks, the prevalences based on 24-h recall were 286 (73%) in the intervention cluster and 88 (22%) in the control cluster in Burkina Faso (3.33, 1.74–6.38); 232 (59%) and 57 (15%), respectively, in Uganda (3.83, 2.97–4.95); and 12 (2%) and two (<1%), respectively, in South Africa (5.70, 1.33–24.26). The prevalences based on 7-day recall were 279 (71%) in the intervention cluster and 38 (9%) in the control cluster in Burkina Faso (7.53, 4.42–12.82); 203 (51%) and 41 (11%), respectively, in Uganda (4.66, 3.35–6.49); and ten (2%) and one (<1%), respectively, in South Africa (9.83, 1.40–69.14). Diarrhoea prevalence at age 12 weeks in the intervention and control clusters was 20 (5%) and 36 (9%), respectively, in Burkina Faso (0.57, 0.27–1.22); 39 (10%) and 32 (9%), respectively, in Uganda (1.13, 0.81–1.59); and 45 (8%) and 33 (7%), respectively, in South Africa (1.16, 0.78–1.75). The prevalence at age 24 weeks in the intervention and control clusters was 26 (7%) and 32 (8%), respectively, in Burkina Faso (0.83, 0.45–1.54); 52 (13%) and 59 (16%), respectively, in Uganda (0.82, 0.58–1.15); and 54 (10%) and 33 (7%), respectively, in South Africa (1.31, 0.89–1.93).

Interpretation Low-intensity individual breastfeeding peer counselling is achievable and, although it does not affect the diarrhoea prevalence, can be used to effectively increase EBF prevalence in many sub-Saharan African settings.

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SeeTheChild (STC)

- The STC study saw vulnerable children scoring high on the Strength and Difficulty questionnaire (SDQ)
 - SDQ total score ≥ 14 (n=122) called “SDQ-high”
and also control cases:
 - SDQ total score < 14 (n=27) called “SDQ normal”
- We present preliminary descriptive data regarding alcohol consumption using DSM4 criteria according to the MINI-KID psychiatric interview

Alcohol use disorders

DSM- IV	DSM V
Described two distinct disorders, alcohol abuse and alcohol dependence, with specific criteria for each.	Integrates the two DSM–IV disorders, alcohol abuse and alcohol dependence, into a single disorder called alcohol use disorder (AUD) with mild, moderate, and severe sub-classifications.
The diagnostic criteria for abuse and dependence were distinct: anyone meeting one or more of the “abuse” criteria within a 12-month period would receive the “abuse” diagnosis. Anyone with three or more of the “dependence” criteria during the same 12-month period would receive a “dependence” diagnosis.	Anyone meeting any two of the 11 criteria during the same 12-month period would receive a diagnosis of AUD The severity of an AUD—mild, moderate, or severe—is based on the number of criteria met.
	Eliminates legal problems as a criterion
	Adds craving as a criterion for an AUD diagnosis.
	Modifies some of the criteria descriptions with updated language.

Background characteristics

	SDQ-high	SDQ-low	DIFFERENCE
Maternal age	33.4	33.7	-0.3(-0.3;2.7)
Maternal education in years	5.6	6.0	-0.4 (-1.7;0.9)
Child age	7.7	7.9	-0.2(-0.5;0.3)
Child schooling, months	10.3	9.6	-0.6(-4.4;5.7)
Socio-economic quintile	2.6	2.6	0

Results

- 10/122 (8.2%) of children in the 'SDQ-high' group had alcohol problems
 - Of these 5/122 (5.6%) had alcohol abuse and 5/122 (4.0%) children had alcohol dependence
- 1/27 (3.7%) SDQ-normal children was alcohol dependent.

Associated factors

1. Cultural beliefs – male children have to drink alcohol
e.g –
 - Grandfather gives child alcohol without parents knowledge (where parents do not take alcohol),
 - Very early drinking by age 6/12
 - Either father or mother gives child alcohol.
2. Parental separation
3. Domestic violence
4. Associated mental health problem
 - Conduct problems
 - One child had attempted suicide
5. Poverty – one child had not started school due to financial constraints

Photo: showing millet for brewing

- Cultural beliefs-
“Alcohol makes them men”-a Father
- *“ For me am old enough to drink but my brother is still young”*
- *Types of alcohol include: Bushera, crude Waragi, Malwa (all locally made)*



Conclusions

- Alcohol use should be suspected and explored in middle childhood among children eligible for referral to CAMH services in Eastern Uganda
- Not only be restricted to children living without adult care
- More research is needed to address the generalizability of these findings across Uganda
- Interventions needed to prevent alcohol use disorders in children

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THANK YOU
MWEBALE NYO!

