Muslim Hands
Advocacy 2020

BREAKING THE SILENCE: A DISCUSSION ON CHILD MENTAL HEALTH IN THE DEVELOPING WORLD

SUMMARY INTERIM REPORT ON THE CONCEPTUALISATION OF MENTAL HEALTH AND LEARNING DIFFICULTIES BY STUDENTS, PARENTS AND TEACHERS

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ABOUT MUSLIM HANDS

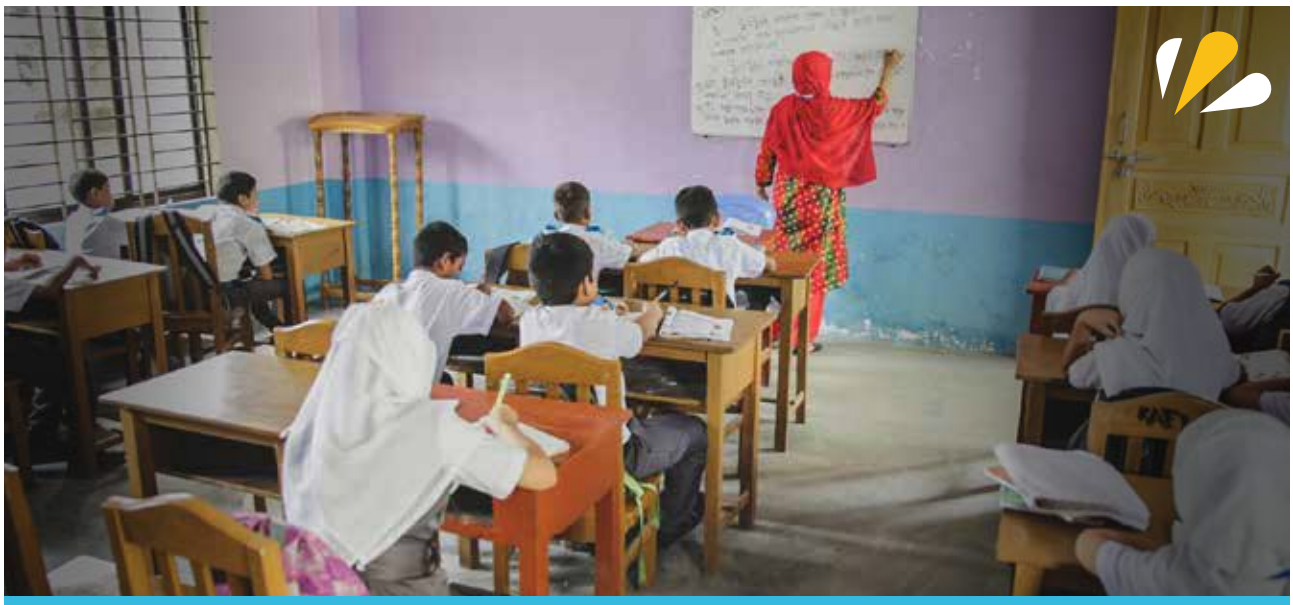
Muslim Hands is an international aid agency and NGO, that grew from a grass roots movement, responding to the Bosnian war in the early 90s and since then, has responded to countless more emergencies, as well as establishing long term projects such as schools, healthcare clinics and livelihood programmes worldwide. We operate in over 30 countries around the world, working with our partners and offices on the ground, distributing aid in an effective, efficient, and transparent manner to make a lasting difference to the communities we work with. We are dedicated to tackling the root causes of poverty, supporting people over long-term periods, and creating sustainable development opportunities for communities all around the world.

As a child focused charity, our aim is to ensure that we are at the forefront in responding to those vulnerable children. We want to promote the social inclusion of all children and dedicate our work to protect children's rights. Aside from the concrete aid we deliver, advocating is a much-needed approach that allows us to fight for the rights of children through increasing awareness and educating communities. Although developing countries have made great progress in getting children into the classroom and more children than ever are now in education, there is still a lot of work that needs to be done when it comes to fostering emotional wellbeing for pupils and offering quality learning environments.

We believe that every human has the right to an education, access to clean water and food and the means to support themselves, their family and their community. Education has been at the heart of what we do for over 25 years. It is a way out of poverty, a driving force for social change and an important aspect of personal development and welfare. We run education projects around the world and have built up a global network of schools, each catering to the specific needs of the area they are serving. Our work in education is about providing opportunities that empower people to build a better future for themselves, and to help improve the access to quality education for children in vulnerable, marginalised, and displaced communities.

To have greater impact in achieving results, Muslim Hands hopes to advocate to address the systemic cause of the problems that children in the developing world face and inform those on the importance of education. Through promoting an awareness raising campaign and using our position to help influence change, we hope to help make a real difference to the lives and wellbeing of many children worldwide.

Syed Lakhte Hassanain, Chairman



INTRODUCTION

Despite huge strides in recent years, the mental health treatment gap remains enormous and represents a gross inequity that exists with people's ability to access mental health provisions in Low-Income and Middle-Income Countries (LMICs) [1].

The World Health Organisation (WHO) has published data that shows the global burden of mental disorders increasing and predict health systems throughout the world will be unable to cope [2]. Approximately 85% of the world population resides in 153 LMICs and more than 80% of people who have mental disorders are located in LMICs [3]. However, it is estimated that 90-95% of mental health resources, including human resources for psychological therapies, are being delivered in countries that only account for 5% of the population. [4-8]. This is a global inequity and it is unjust.

Adult mental health and mental health throughout childhood are associated [1, 9, 10]. Estimates show mental health problems will affect at least 10–20% of youth in LMICs [11, 14]. These estimates are thought to be conservative and do not address issues such as stigma [9, 12], demand side barriers or supply side barriers [13]. However, despite decades showing the need for clear evidence-based research that leads to practical sustainable interventions, published research from LMICs contributed just 5% of the mental health research-related articles to the internationally indexed literature on mental health between 1997-2001 [12]. Furthermore, research has identified that despite the high demand for mental health and community-based support services in LMICs, availability and access to mental health services are grossly limited or often inadequate [3, 9, 11, 12]. The reality is Child and Adolescent Mental Health (CAMH) treatment is limited or simply does not exist for many children in LMICs [1-13].

Mental health problems among people with a learning disability are often overlooked, underdiagnosed, and left untreated as a result of poor understanding, awareness, evidence in this area and symptoms being mistakenly attributed to the person's learning disability [14]. Data has shown that people with lower intellectual ability had higher rates of symptoms of common mental health problems (25%) compared to those with average (17.2%) or above average (13.4%) intellectual functioning [15]. One study found that 54% of people with a learning disability have a mental health problem [16]. Furthermore, children with learning disabilities are four and a half times more likely to have a mental health problem than children without a learning disability [17]. To date, the authors are unaware of any study that has investigated the understanding of both the learning needs and mental health needs of students in any LMIC.

Stigma associate with mental health and learning difficulties is a global phenomenon as are a range of discriminatory behaviours shown to those that have mental health issues or learning disabilities [6, 18]. A huge factor associated with lack of mental health early intervention is stigma [4-8, 18-19].

For example, one study showed that 80% of people with depression had experienced discrimination from family members, work relationships, within their marriage or with other interpersonal relationships in Nigeria [19]. However, there is a scarcity of literature regarding stigma or stigma reduction strategies concerning children and adolescents, with evidence especially rare for LMICs. Mental health stigma remains a significant barrier to help-seeking and can worsen youth mental health [8]. The efforts to combat stigmatisation of youth with mental health disorders, professionals must involve educating family members, peers, and school staff in an effort to overcome their inclinations to make negative assumptions and discriminate against these youth [8].

In the absence of costly professional therapeutic support available to children in LMICs [20], community-based interventions have been suggested. Existing studies on adolescent mental health interventions in LMICs have largely focused on either generic mental-health promotion for younger children in schools or psychological treatments for highly selected trauma-affected populations [21-22]. Despite 1 in 6 children in a number of LMICs being absent from education due to child labour, disability or exploitation [23], School-Based Interventions have been proposed to provide the basis for promoting the mental health of young people in LMIC [24] as they are one of the most important community settings, central to the lives of most young people in most LMICs [21-24]. The school setting provides a forum for promoting emotional and social competence as well as academic learning and offers a means of reaching the significant number of young people who experience mental health problems [23-24].

Educational opportunities throughout life are associated with improved mental health outcomes. The promotion of emotional health and wellbeing is a core feature of the WHO's Health Promoting Schools initiative [25]. There is good

evidence that mental health promotion programmes in schools, especially those adopting a whole school approach, lead to positive mental health, social and educational outcomes [23-25].

Programmes incorporating life skills, social and emotional learning, and early interventions to address emotional and behavioural problems, can improve academic performance [25-26]. However, to date there has been no known research on direct school-based mental-health interventions, and only for the mental health promotion of young people in LMIC settings.

Furthermore, as far as the authors are aware, no research has investigated the teacher, parent and student narrative on mental health attitudes or learning disabilities in LMICs.

Utilising schools as a sustainable solution to providing mental health intervention is not new: the UK has recently pledged to develop measures to enable teachers to have confidence and skills required to identify mental health issues in young people before they become critical [27], thus, reducing the costs of mental health in the UK. All new teachers in the UK will be trained to spot signs of mental health issues, backed up by statutory guidance to make clear the schools' responsibilities to protect a child's mental well-being. Accessing the expertise of teachers in this way is seen as sustainable and affordable [27]. Therefore, given the mental health demand is significantly higher in LMICs, it makes sense that LMICs should adopt a position whereby they can not only identify signs of mental health in young people, but they can provide affordable and sustainable early mental health intervention to prevent a mental health crisis.

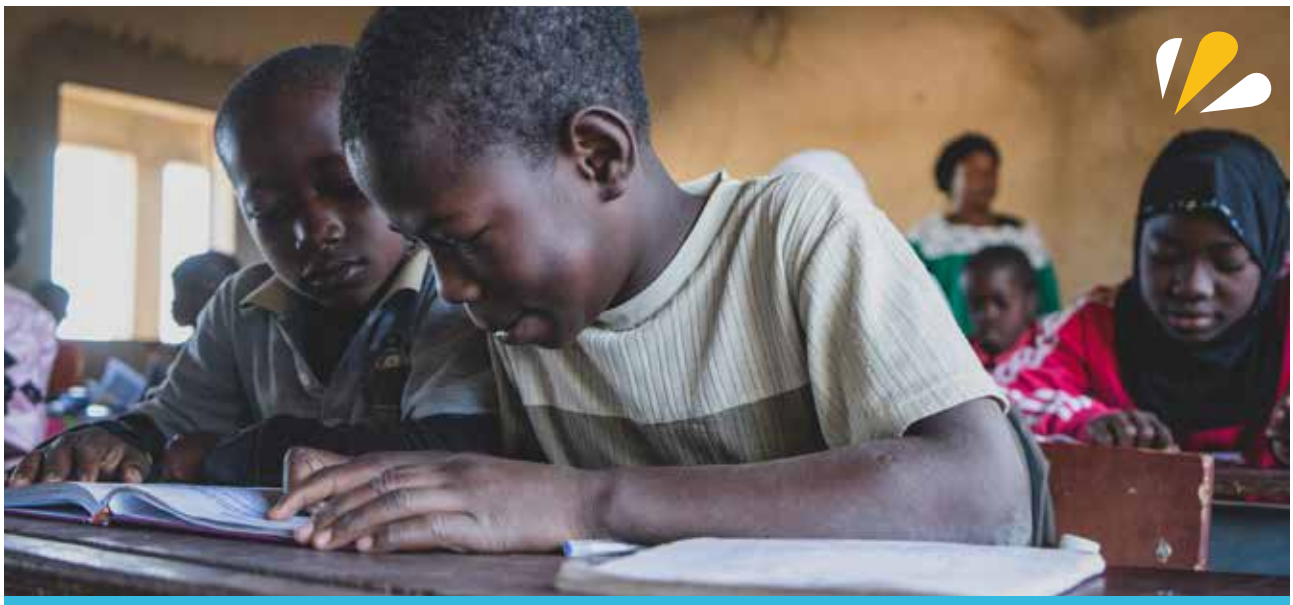
THE GLOBAL CAMH RESEARCH PROJECT: OUR OVERALL AIMS

- **Assess the mental health needs of students in school in several LMICs. The research project has already recruited over 200 schools in Pakistan as well as multiple schools in Malawi and Bangladesh.**

- **Explore the narratives used to describe the meaning of the terms 'mental health' and 'learning difficulties' by teachers and parents.**

- **If teachers show an absent of understanding or a limited understanding of the terms, provide CAMH Teacher Training in schools. If parents show an absent of understanding or a limited understanding of the terms, provide schools with a mental health awareness raising programme toolkit.**

- **Support teachers by providing them with mental health intervention training for sustainable school-based mental health interventions and a learning disabilities tool kit to support learning and well-being in the classroom.**



A MULTI-STAGED METHOD

We have identified three LMICs of interest to carry out CAMH action research, these are Bangladesh, Pakistan, and Malawi. In brief, in each LMIC a simple three phased approach is taken:

1. Understanding a) the current perspectives on mental health in each country from the view of the teacher, the parent and student and b) carry out an assessment of need for students within the study. This will be done using psychometric assessment methods and semi-structured interview methods.

2. Design and deliver any required teacher training for that intervention or advocacy programme. (Dependent on phased 1).

3. Evaluation of the 'success' of that intervention (in terms of cost, sustainability, and effectiveness, as gathered by feedback data).

INTERIM FINDINGS: BANGLADESH (PHASE 1)

Due to the COVID-19 breakout, we were unable to collate data from Pakistan and Malawi and the data collection on the current feasibility within those two countries has been put on hold.

This current research in Bangladesh was designed to explore the narratives used to describe the meaning of the terms 'mental health' and 'learning difficulties' that were provided by teachers, students and parents from two schools, one in Dhaka city and one in a rural location.

Our mixed methods approach also investigated the mental health needs and learning needs of the students within the study using quantitative and qualitative feedback data from a semi-structured interview and the following psychometric assessments: the Strengths and Difficulties Questionnaire (SDQ), the Risk-Taking Behaviour Assessment Scale (RTB), The Rosenberg Self-Esteem Scale (RSES) and an Adapted Version of the Revised Children and Adolescent Depression Scale (AV-RCADS and AV-RCADS-P). A pre-selected sample of participants were identified as being high needs from rural and non-rural schools in Bangladesh and further subdivided into student respondents, parent respondents, and teacher respondents in both a rural and a non-rural location. All child respondents were between 7 and 14 years of age. The majority of the student respondents were male, but with a relatively even split (52% male and 48% female). Quantifiable ordinal data was subjected to the nonparametric Mann Whitney U or the Kruskal Wallis One-Way Analysis of Variance using SPSS.

Mental health needs were identified in students in both rural and city locations, although students in the rural location had significantly higher mental health needs.

Several other findings were made. Semi-structured interviews were taken from students and parents in a rural and a non-rural location. Written narratives were also received from teachers. All narratives were explored using the thematic method of analysis to ascertain the meaning of the terms 'mental health' and 'learning difficulties' held by teachers and parents in a rural and a city location (Dhaka) in Bangladesh.

> **Thematic analysis revealed that parents in the rural location do not understand the terms 'mental health' or 'learning disabilities' and therefore, it is not seen as a problem despite high reported mental health needs. Teachers in both the rural and city location have a limited understanding of both terms, as do parents in the city location. This lack of understanding is shown to prevent students access to support and increases stigmatization.**

These findings of this investigation support Mental Health Educational Awareness advocacy.

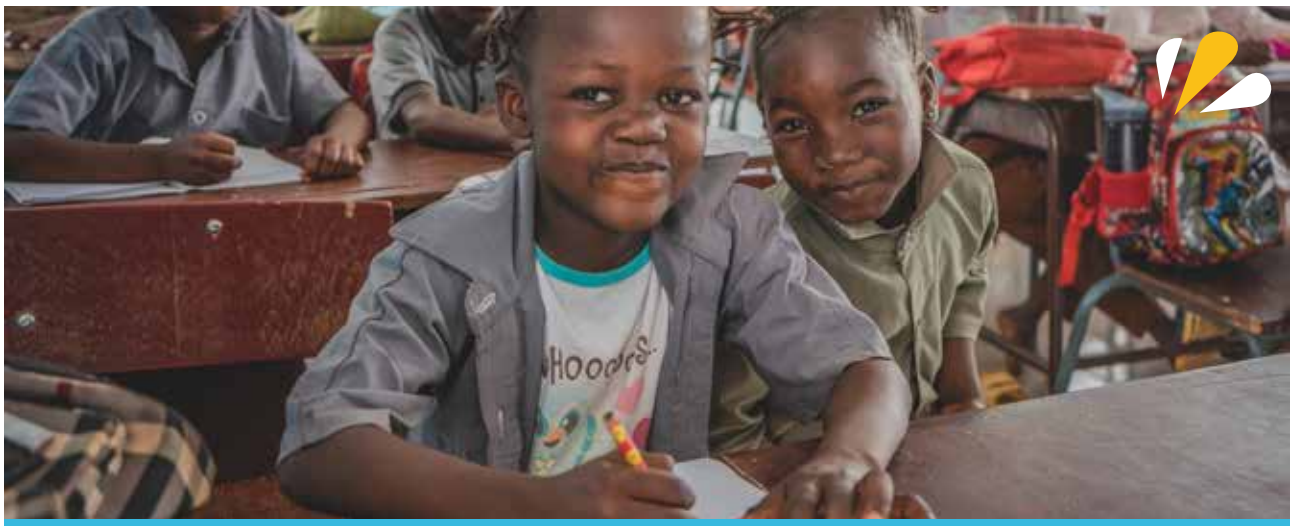
Please note, similar projects are in progress in Pakistan and Malawi.

INTERIM KEY FINDINGS IN BANGLADESH

- **Access to mental health interventions in schools are severely limited for young people in rural and city locations of Bangladesh despite a clear and present need.**
- **There is a clear lack of understanding about learning disabilities and mental health in rural locations in Bangladesh.**
- **A lack of, or limited parent and teacher understanding of 'mental health' and 'learning disabilities' prevents students accessing support and reinforces stigmatisation.**
- **Specialist teacher training on i) mental health interventions and ii) learning needs inclusion strategies would benefit students.**
- **There are more perceived barriers in rural locations than city locations that restrict access to education as well as mental health support due to poverty.**

PROPOSALS FOR BANGLADESH: PHASE 2 IN PROGRESS

1. A mental health advocacy programme to be ran by schools to support mental health awareness within communities.
2. Mental Health Teacher Training and toolkit to be piloted within Muslim Hands' schools to support early-stage intervention.



SUMMARY STATEMENT

Given the growing burden of mental health across the globe and an increasing population size, both high-income countries as well as LMICs could benefit from the identification of successful, low-cost, evidence-based interventions, particularly those that include the family and community-based provisions.

Mental disorders in LMIC do not attract enough global health policy attention and civil society movements for mental health in these countries are not well developed either, particularly because many LMIC lack data on adult mental health which results in critical gaps in the understanding of child and adolescent mental health. To provide the children and adolescent population around the world with mental health provision, school-based solutions appear to be a realistic and sensible step in the right direction to achieving this. Future intervention should include an effective dissemination of mental health and learning disability awareness to teachers, as requested, but also to families within the context of their environments, who then have the ability to spread their developed awareness from the home and further into their communities.

> **As a global society, we understand the relevance that schools can play in a child's development, and also their duty to promote the welfare of their pupils, which includes preventing the deterioration of children's health or development and acting promptly to enable all children have the best outcomes.**

Furthermore, teachers within schools are naturally in situations where they can observe children and identify behaviour that suggests a child may be suffering from a mental health problem or be at risk of developing one [28].

As global citizens, we can ensure that mental health provisions are available to all, including those in LMICs, by increasing global mental health awareness and developing sustainable interventions.

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