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The socio-demographic characteristics and burden of mental health issues of children attending in Dhaka Shishu (Children) Hospital, Dhaka, Bangladesh

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Abstract

Introduction: Mental health disorder constitute is a major public health problem which is globally contributed to 13%of the global burden of disease measured as disability adjusted life years. Now a days it is a higher burden in low and middle income socioeconomic countries like Bangladesh. The reported prevalence of mental health disorders varies from adult 6.5% to 31% and children13.4% to 22.9%.There is a negative attitude towards the treatment of those affected children. The treatment is not a priority in health care delivery. But it is important to increase mental health care delivery system in tertiary care hospital in big cities as well as in primary health care.

Objective: To find out the socio-demographic characteristics, incidence and burden of mental health issues in Dhaka Shishu (Children) Hospital.

Methodology: This retrospective study was carried out from mental health clinic in Dhaka Shishu (Children) Hospital since January 2017 to December 2017.

Result: Result showed that 196 children with mental health issues were seen in mental health clinic at Dhaka Shishu (Children) Hospital, among them the incidence of mental health problem 5.2% of those ASD was (57%) Intellectual impairment with speech delay (10.58%) ADHD (7.21%) behavior problem (4.40%) ASD with ADHD (2.88%) learning difficulty (2.88%) others (10.9%). Male are predominant (3.16:5). The age group of the most children were >2 to 5 years (48.1%) and 5 to 9 years (37.5%). The children came mostly from higher wealth quintile (52%). Among male average total difficulty score was 16.55 ± 2.8, and among female average total difficulty score was 17.22 ± 3.5, No sex difference in total difficulty score or individual scale score was found following independent t test (P>.05).

Conclusion: The burden of mental health disorder is increasing in Bangladesh day by day, so far the children with mental health disorder unrecognized and under-researched area. To improve the mental health services in Bangladesh for early intervention, epidemiological survey and clinical research are needed. Also need to increase well trained multidisciplinary professionals to provide proper services to the tertiary and primary health care center.

Keywords: mental health service, Depressive mood, Socio-demographic factor

1. Introduction

Mental health disorder constitute is a major public health problem which is globally contributed to 13%of the global burden of disease measured as disability adjusted life years. Now a days it is a higher burden in low and middle income socioeconomic countries like Bangladesh. The magnitude of mental health problems in children has not yet been recognized sufficiently by many governments and decision makers. Epidemiological studies of child and adolescent psychiatric disorders in the developing world have generated prevalence estimates ranging from 1 to 49% (Hackett 1999) [1]. In the developing world, child psychiatric disorders are common but child mental health professionals are scarce. In the developed world, child psychiatric disorders cause serious distress or social impairment to around 10% -20% of children at any one time. (BIRD 1996) [2, 3]. Prevous studies have indicated that between 17% and 26% of the children and adolescents meet the diagnostic criteria for at least one psychiatric disorders (Muris P, Meesters C, Van den Berg F 2003) [4]. What few studies there have been of child psychiatric disorders in developing countries suggest that the prevalence there may be at least as high (Nikapota 1991) [5], which is perhaps unsurprising since so many children in the developing world are exposed to poverty, malnutrition, infectious disease, violence and social disintegration. However, most of these studies lack one or more of the methodological features required for generating believable prevalence estimates, namely: an adequate sample size, a representative sampling frame, standardized assessment measures that are suitable for generating exact diagnoses, explicit and internationally accepted diagnostic criteria, and assessment not just of

symptoms but also of resultant distress and social impairment (Fleitlich-Bilyk 2004) [6].Bangladesh is a low-income nation with a large population with a population pyramid with wide base, suggesting younger people in the population (BBS 2004) There have been few epidemiological studies of the prevalence of child and adolescent psychiatric disorders in Bangladesh, and indeed there scarcity of validated psychiatric measures in Bengali that could be used for this purpose.The prevalence of childhood disability in Bangladesh is increasing with the improvements in child survival (Zaman 1999) [7]. Now a day‟s behavior problems form an increasing proportion of the presenting complaints. Studies of mental health disorders in Bangladesh urban settings suggested rates as 20% boys and 10% girls in primary schools as reported by teachers (Rabbani 1999) [8] The reported prevalence of mental health disorders varies from adult 6.5% to 31% and children13.4% to 22.9%.There is a negative attitude towards the treatment of those affected children. The treatment is not a priority in health care delivery. But it is important to increase mental health care delivery system in tertiary care hospital in big cities as well as in primary health care. Depression is one of the most common diseases world-wide, and has a heavy socioeconomic burden [1, 2]. Depression has been ranked third on the World Health Organization's list of medical conditions with the greatest disease burden worldwide, and is expected to top that list by 2030. The 1-year prevalence of a major depressive disorder was reportedly 6.6% in the USA [3], 2.9% in Japan [4], and 2.5% in Bangladesh [5]. An epidemiological study in Bangladesh found that major depression had a high disease burden, with a disability-adjusted life years (DALYs) value of 1,287 years (per 100,000 persons), representing 49% of the burden of all mental diseases [6]. Moreover, depression significantly influences health outcomes, such as disability, premature mortality, comorbidity with chronic disease, and decreased quality of life, in both Western countries [7] and Bangladesh [8]. Despite the high prevalence and social burden of depression, only a small percentage of people with depression use psychiatric services [4, 9]. Further-more, the majority of Children with mental disorders, including depression, do not seek help from mental health services (MHSs) [10,11].In order to provide effective treatment for people suffering from mental health problems, it is critical to identify the barriers that they face when accessing MHSs Previous studies have revealed that such barriers include structural factors (for example, the cost of services) and attitude factors (for example, negative perception and prejudice against mental disorders) [13,14]. These attitudes toward mental disorders differ according to socio-demographic characteristics such as age, gender, and education level [14, 15]. Therefore, the individuals' socio-demographic characteristics may directly or indirectly influence their use of MHSs [16]. Several previous studies have found that men [16, 17], adolescents, and seniors [10, 12, 16, 18] with a low socioeconomic status [12, 18, 19] or living in rural areas [20] were less likely to access MHSs. Factors influencing the use of MHSs are various according to studies as mentioned above because each country has a unique healthcare delivery system. The aims of this study were to determine the use conditions of MHSs and to identify the socio-demographic factors associated with MHS use after considering the effect of mental health related factors among Children with a depressive mood, using a nationwide representative Bangladeshi sample.

2. Objectives

1. To find out the socio-demographic characteristics, incidence and burden of mental health issues in Dhaka Shishu (Children) Hospital.
2. To determine the prevalence of mental health problems among Urban and Rural children.

- **Specific objective**

To determine the associate factors of mental health problems in children.

3. Material and Methods

This retrospective study was carried out 196 patients from mental health clinic in Dhaka Shishu (Children) Hospital since January 2017 to December 2017. The data used in this study were obtained from the conducted was Dhaka Shishu (Children) Hospital, Dhaka, Bangladesh. This study was carried out during the period of January 2017 to December 2017 in the Department of Pediatrics, Dhaka Shishu (Children) Hospital, and Dhaka Bangladesh. Our study subjects were attending children aged between 1 -15 years of Dhaka Shishu (Children) Hospital. The representative and reliable study that assessed health status, health behaviors, and nutritional status. The study used a stratified, multistage, probability-sampling design to represent the entire Bangladeshi population. The Health Interview was performed using self-administered structured questionnaires to obtain information regarding socio-demographic characteristics, health status, health service use, and health behaviors. Trained interviewers visited each household and assisted the participants with specific items in the self-administered tool. The reported prevalence of mental health disorders varies from adult 6.5% to 31% and children13.4% to 22.9%.There is a negative attitude towards the treatment of those affected children. The treatment is not a priority in health care delivery. The edited data were entered on to the template of SPSS 16 for windows. Informed written consent was taken from the participant after explaining all the facts potential dangers to the subjects in case of primary data collection.

1. **Inclusion criteria**
   - Child age between 1-15 years attending children.
2. **Exclusion criteria**
   - Child whose parents are unwilling to consent.

4. Results

This retrospective study conducted during the period from January 2017 to December 2017. A total of 196 children aged between 1-15 years along with their parents were selected, finally 196 were interviewed (response rate 83%). Among the respondents 35.7% were aged between 1 – 5 years, 43.4% were aged between 5 – 10 years and 20.9% were aged between 10 – 15 years. Among the respondent 45.4% were male. Table shows the distribution of the respondent by parent's characteristics. Among the fathers 67.3% were service holders, 23.5% were business man and 9.2% were engaged in other occupation. Among the mothers 65.8% were house wives and rest were working mothers. Regarding level of education of father 15.3% studied up to Primary or below 12.8% studied up to SSC, 16.3% studied up to HSC, 33.7% were Graduate and 21.9% were post

graduate. Regarding level of education of mother 23.5% studied up to Primary or below 16.3% studied up to SSC, 21.4% studied up to HSC, 24.5% were Graduate and 13.8% were post graduate. The distribution of the respondents by monthly family income. Among the respondent 26.0% had monthly family income <10000 taka, 36.2% had between 10000 and 30000 taka, 29.6% had between 30000 – 50000 taka and 8.2% had income above 50000 taka. Table shows the distribution of the respondents by number of child in family. Among the respondents 27.6% had single child, 23.0% had two children and 49.5% had more than two children. [Table 2] shows the distribution of summery statistics of the total difficulty score and five sub scale by sex. Among male average total Difficulty score was 16.55 ± 2.8, Emotional symptom score was 4.98±1.7, Conduct Problem score was 3.18 ±1.38, Hyperactivity score 3.82 ±1.4, Peer Problem score 4.58±1.4 and Pro - social behavior was 4.0±1.58Among female average total Difficulty score was 17.22 ± 3.5, Emotional symptom score was 5.32±1.9, Conduct Problem score was 3.55 ±1.6, Hyperactivity score 3.47 ±1.9, Peer Problem score 4.89±1.5 and Pro-social behavior was 4.30±1.7.[Table 3] shows the distribution of summery statistics of the total difficulty score and five sub scale by age. Among subjects aged between 1 – 5 years average total Difficulty score was 16.67 ± 3.2, Emotional symptom score was 4.64±1.7, Conduct Problem score was 3.73 ±1.7, Hyperactivity score 3.53 ±1.3, Peer Problem score 4.77±1.5 and Pro-social behavior was 3.8±1.6. Among subjects aged between 5 – 10 years average total Difficulty score was 17.01 ± 3.2, Emotional symptom score was 5.47±1.8, Conduct Problem score was 3.04 ±1.4, Hyperactivity score 3.66 ±1.3, Peer Problem score 4.85±1.7 and Pro-social behavior was 4.28±1.6. Among subjects aged between 10 – 15 years average total Difficulty score was 17.17 ± 3.3, Emotional symptom score was 5.41±1.9, Conduct Problem score was 3.5 ±1.4, Hyperactivity score 3.73 ±1.4, Peer Problem score 4.51±.87 and Pro-social behavior was 4.49±1.6. No sex difference in total difficulty score or individual scale score was found following independent t test (P>.05). [Table 4] shows the distribution of the respondents by classification of total SDQ score and sub scales. According to total difficulty score 37.3% are normal, 41.8% were borderline and 20.9% were abnormal. In terms of Emotional symptom score 61.2% are normal, 15.8% were borderline and 23.0% were abnormal. In terms of Conduct problem score 64.3% are normal, 14.8% were borderline and 20.9% were abnormal. In terms of Hyperactivity score 94.9% are normal, 3.6% were borderline and 1.5% were abnormal. In terms of Peer problem score 20.4% are normal, 57.1% were borderline and 22.4% were abnormal. In terms of Pro-social behavior score 20.9% are normal, 25% were borderline and 54.1% were abnormal. Table shows the distribution of the study subjects by SDQ score and socio demographic score. No statistically significant association was found between age (P>.05), sex (P>.05)

Table 1: Distribution of Socio-demographic and health-related parent's characteristics (n=196)

Particulars		**n**	**%**
	Father's	occupation	
Service		132	67.3
Business		46	23.5
Others		18	9.2
	Mother's Occupation		
Housewife		129	65.8
Working Mother		64	32.7
	Father's qualification		
Primary or below		30	15.3
SSC		25	12.8
HSC		32	16.3
Graduate		66	33.7
Post graduate		43	21.9
	Mother's qualification		
Primary or below		46	23.5
SSC		33	16.3
HSC		42	21.4
Graduate		48	24.5
Post graduate		27	13.8
	Family Income		
> 50000 BDT		16	8.16
30000-50000 BDT		57	29.08
10000-30000 BDT		75	38.26
<10000 BDT		45	22.96
Number of Children in Family			
One		54	27.55
Two		46	23.46
More than Two		96	48.97

Table 2: Distribution of Socio-demographic and health-related of the scales by sex (n=196).

SDQ	**Sex**				**Independent t-test**	
	Male		**Female**			
	Mean	SD	Mean	SD	t	P value
Total difficulty Score	16.56	2.792	17.22	3.457	-1.456	.147

Emotional symptom	4.98	1.764	5.32	1.945	-1.271	.205
Conduct Problem	3.18	1.378	3.55	1.644	-1.694	.092
Hyperactivity	3.82	1.450	3.47	1.192	1.870	.063
Peer Problem	4.58	1.460	4.89	1.532	-1.411	.160
Pro-social Behavior	4.00	1.581	4.30	1.717	-1.258	.210

Table 3: Distribution of Socio-demographic and health-related of the scales by age (n=196)

SDQ score	Age					
	1 – 5 year		5– 10 year		10 – 15 year	
	Mean	SD	Mean	SD	Mean	SD
Total difficulty Score	16.67	3.234	17.01	3.122	17.17	3.263
Emotional symptom	4.64	1.786	5.47	1.862	5.41	1.871
Conduct Problem	3.73	1.693	3.04	1.410	3.51	1.381
Hyperactivity	3.53	1.259	3.66	1.350	3.73	1.397
Peer Problem	4.77	1.534	4.85	1.708	4.51	.870
Pro-social Behavior	3.83	1.659	4.28	1.645	4.49	1.630

Table 4: Classification of Socio-demographic and health-related children according to total subscales (n=196)

SDQ	Classification of difficulty*		
	Normal	Borderline	Abnormal
Total difficulties	73 (37.3)	82 (41.8)	41 (20.9)
Emotional symptom	120 (61.2)	31 (15.8)	45 (23.0)
Conduct problem	126 (64.3)	29 (14.8)	41 (20.9)
Hyperactivity	186 (94.9)	07 (03.6)	03 (01.5)
Peer problem	40 (20.4)	112 (57.1)	44 (22.4)
Pro social behavior	41 (20.9)	49 (25.0)	106 (54.1)

Figure in parenthesis denotes percentage*some children had difficulty in more than one domain

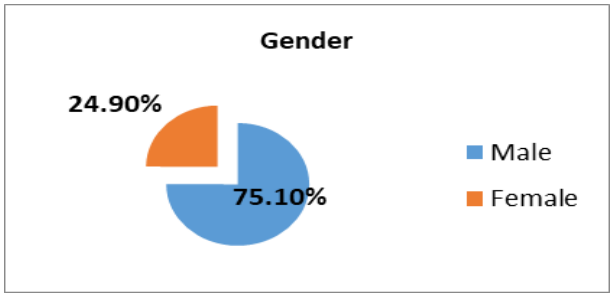

Fig 1: Gender variation of male and female.

Gender variation of male 75.10% and female 24.90%.

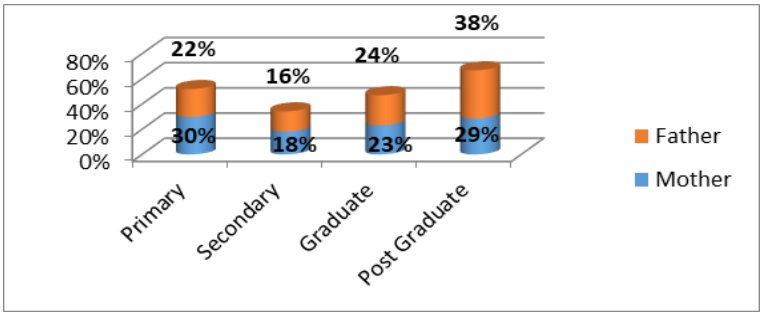

Fig 2: Parents Education level

Among 210 sample case including 196 patients Parents Education level primary father and mother 22% and 30%, Secondary level 16% and 18%, Graduate level 24% and 23%, Post Graduate level 38% and 29%.

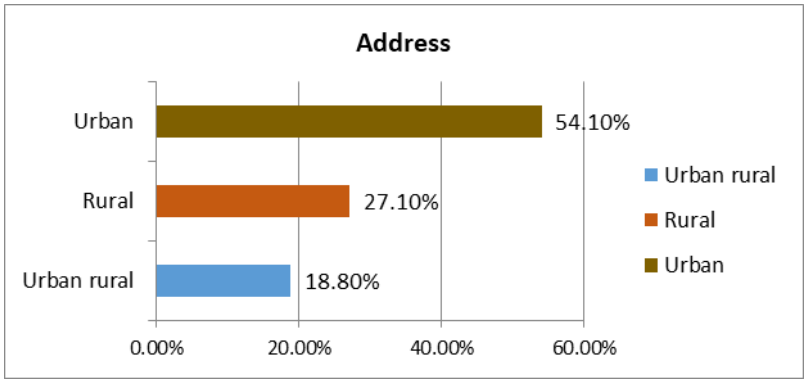

Fig 3: Address position Urban and Rural.

Address position Urban 54.10%, Rural 27.10% and Urban Rural 18.80%.

Table 5: Distribution of Socio-demographic and health-related the children in different domains in combination.

Combined difficulty	N	%
None	98	50.0
Emotional only	23	11.7
Conduct only	19	9.7
Hyperactivity only	01	0.5
Peer problem only	26	13.3
Emotional + Conduct	09	4.6
Emotional + Peer	07	3.6
Conduct + Peer	07	3.6
Emotion + Hyperactivity + Peer	04	2.0
Emotion + conduct + Hyperactivity	02	1.0
Total	196	100.0

Table 6: Distribution of Socio-demographic and health-related the children by across age and sex (n=196).

	Normal	SDQ score Borderline	Abnormal	Test Statistics
Age group				
1-5 yrs.	31(42.5)	24(29.3)	15(36.6)	$\chi^2 = 3.07$
5-10 yrs.	28(38.40	40(48.8)	17(41.5)	df 4
10-15 yrs.	14(19.2)	18(22.00)	9(22.00)	P= 0.55
Sex				
Male	35(47.9)	42(51.2)	12(29.3)	$\chi^2 = 5.62$
Female	38(52.1)	40(48.8)	29(70.7)	df 2 p= 0.60

Figure in parenthesis denotes percentage

5. Discussion

This retrospective study was conducted among school going children aged between 1-15 years of Dhaka Shishu (Children) Hospital an aimed to estimate the prevalence of mental health problems and its associated factors in s children at the age of 1-15 years in the Dhaka Shishu (Children) Hospital with Strength and difficulties questionnaire. The present study observed emotional and behavioral disorders among 20.9% school going children. Another 41.8% were diagnosed as having borderline disorder and 37.3% were normal. A cross sectional survey of 1–15-year children attending main stream private and community schools in Dhaka on 675 parents found 47% normal, 19% borderline and 34% abnormal babies. Assessment of children's mental health in their study was conducted using SDQ Socio-demographic and Mental health-related and based on cut-off provided by Goodman (Syed 2007). Majority of the studies conducted on prevalence of psychiatric morbidity among children from community shows wide range of Figures. The higher prevalence of emotional and behavioral problems in the present study may be due to the fact that they are determined based on screening questionnaire alone. The prevalence of emotional and behavioral problems varies between urban and rural children in different studies. As seen in a similar study by Srinath *et al*. (2005) reported 4.2% emotional and 12.8% behavioral disorders in rural area. In the same study they observed 11.4% emotional and 17% behavioral disorder in urban area. These dissimilarities either may be due to variations in diagnostic tools or better child mental health facilities. In another study carried out by Mullick *et al*. (2005) in Bangladesh found 9.6% emotional disorders and 10.6% behavioral disorders in the urban area. The prevalence in the present study was a bit higher than these estimates from previous literature evidences. One of the reasons may be that, present study was restricted to urban school going children only. One study was done among urban primary school children in Dhaka, Bangladesh by Rabbani (1999) and found 13.4% behavioral disorders which are much lower than that in our study. For example Rabbani (1999) used Rutter B2 Scale for detection of prevalence among primary school children. Mullick (2005) in their pioneering study used Bangla translation of a standardized child psychiatric interview, the Development

and Well-Being Assessment (DAWBA) which was validated against routine clinical diagnoses on a consecutive series of 100 referrals to a child mental health service. They used stratified sampling for representation of rural, urban and slum strata. In a comprehensive review of studies about the prevalence rates of behavioral and emotional disorders among school going children authors reported 3.6% to 24% with a mean 10.2%.Among the five domains, present study observed emotional problem in 23% children, Conduct problem in 20.9% children, Hyperactivity in 1.5% children, Peer problem 22.4% children and Pro-social behavior 54.1% children. Study by Margot (2005) on urban school children using similar method showed significantly higher rates of behavioral problems. In another study carried out by Elhamid (2008) in Egypt Using both parent and teacher rated version of SDQ Socio-demographic and Mental health-related where prevalence of emotional and behavioral problem was high reported by parents 20.6%. Abnormal prosaically score 11.8%, Emotional problem 2.0%, Conduct disorder 6.6%, Hyperactivity 0.7%. Based on the review of published literature elsewhere, it was evident that socio demographic factors may affect psychiatric morbidity among children such as gender, school type and parental education as well as socioeconomic status. In the present study the average age of the children was 7.9± 2.6 years ranging from 5 – 9 years and the disability is 20.9%. Khan *et al* (2009) had conducted the study among children of 2-9 years and found the prevalence of 14.6%. Mullick and Goodman (2005) studied the prevalence of mental health disorders among 5 to 10 year old children in Bangladesh. They reported some kind of disorder i15.4% of rural children, 10% of urban children and 19.5% of slum children. Current study is done in urban children and the percentage is higher than then the urban prevalence reported other studies. Although result of the current study suggests no sex variation, published article provides rather opposite evidence, particularly higher prevalence among boys was found in most studies, one study found female preponderance (Eapen 2003). Rabbani *et al*. (1999) showed that male children were more likely to have behavioral disorders than were females with a male to female ratio: 2:1. Abdel-Fattah *et al*. (2004) showed education as a predictor that opposes our study finding. In the present study mother's occupational status appeared as a significant predictor of child's emotional and behavioral disorder adjusting for all factors in the model (P=.002). Similar result reported by (Abdel-Fattah 2004) that students with working mothers were more liable to develop emotional and /or behavioral disturbance than those with non-working mothers. Before „thought" and „language", „emotion affect" within the context of relationships that forms the basis for all future development of the children. Early onset of emotional and behavioral problems in school going children and adolescents are related to a variety of health, social and academic problems including juvenile crimes and school dropout (Anderson 1987). Early interventions can prevent behavioral and emotional problems and poor school performance which requires early detection, evaluation and identification of risk factors of behavioral and emotional problems in school going children and adolescents. SDQ Socio-demographic and Mental health-related can be used as a screening tool and after screening high risk children should be referred to child mental health clinic or child developmental Centre for thorough psychiatric assessment. Studies like present one will guide psychiatrists to develop programs of supports and services for children with emotional and behavioral problem.

Differences in MHS use between the age brackets

Regarding the distinction in MHS use between the age teams, some previous studies have made variable results among the adolescent, old, and older [34, 35, 16, 18, 20, 31, 32], whereas others have found that age wasn't related to MHS use [27]. However, those aged over sixty five years within the gift study were less seemingly to use services than their younger counterparts. According to previous reports, the older square measure less sensitive to psychiatrically symptoms and confuse such symptoms with those of the natural aging method, so preferring treatment at general medical centers instead of at specialized MHS establishments [20]. In distinction, younger individuals square measure a lot of attentive to the requirement of MHSs, leading to old individuals to use services a lot of oft [10]. AN exception to the current pattern was found during a study con-ducted in Iceland, during which the older were found to possess visited a lot of psychological state establishments and sought-after facilitate from psychiatrists a lot of oft. However, these results were explained by favorable conditions in Iceland, particularly a rise in free time and a cheap insurance system offered to those aged over sixty seven years [16]. On the opposite hand, whereas stigma against depression varies very little with age, the result of the stigma related to psychological state features a stronger impact on sure age teams [19], and significantly among the older with depression, stigma could be an important obstacle to their use of MHSs [38]. To effectively contend with these issues, bigger public health ways like education, counseling, and campaign for older individual's square measure needed to push their accessibility to MHSs.

Differences in MHS use between the education levels

Education level is a vital indicator of associate degree individual's socioeconomic standing [18], and is taken into account one amongst the predisposing factors toward the utilization of tending services [24].Many studies have found that those with the next education level use MHSs additional overtimes [12, 16, 18, 19, 32]. The findings of the current study concur thereupon finding, in this the themes with education that extended on the far side the high school level were additional seemingly to use such services than people who left the education system before high school. Moreover, those with higher-level education most well-liked specialized MHS establishments to medical aid centers [19, 34]. Additionally, one study found that patients with faculty degrees or higher UN agency suffered from depression were additional seemingly to receive care from a medical specialist [16]. Thus, the kind of MHS establishment and repair provider (doctor, nurse, or counselor) might vary in keeping with education level. However, this issue couldn't be considered within the gift study since the kind of MHS used was unknown. It ought to be noted that instruction was found to be related to low prejudice against mental diseases, and significantly depression [14]. Those with the next level of education usually have a positive angle toward the effectiveness of medicine treatment [15, 34], which reinforces their use of MHSs; conversely, the economic burden related to service use is mostly higher [15, 19] and also the level of awareness for medicine issues and treatment lower for those

with less education, therefore clogging MHS use in this cluster [12]. There-fore, so as to reinforce the utilization of MHSs among comparatively uneducated individuals littered with depression, associate degree education program that features info on the detection of depression symptoms and MHS use ought to be provided to enhance their mental state attainment.

Differences in MHS use between financial gain levels

Income, that like education level is associate degree indicator of socio-economic standing [12], is additionally an element that promotes the utilization of tending services [24]. However, the current study found that the utilization of MHSs failed to take issue considerably with the monthly family financial gain. Similar results are according elsewhere [11, 12, 35]. Like several European countries, Bangladesh additionally contains a comprehensive insurance program that covers virtually the complete population for mental tending. Thus, individuals with medicine dis- eases associate degreed an occasional financial gain will use MHSs while not suffering an excessive monetary burden [11]. In contrast, the se- verity of medicine diseases was according to be higher among those with an occasional socioeconomic standing [11, 28], resulting in additional frequent use of the MHSs [26, 27]. As a result, MHS use is higher among the low-income population.

6. Limitation

This study was subject to many limitations. First, the severity and also the length of a depressive mood and also the presence of co-morbid mental state problems like anxiety, which can act as robust confounders relating to the association between socio-demographic characteristics and MHS use, couldn't be thought-about. Also, the kind of MHS establishments and repair suppliers used weren't determined. Second, the utilization of knowledge from a national health survey could suffer from respondent bias. The utilization of self-report measures for each depressive mood and MHS use could result in biases either because of recall or perceived stigma. There would be the discordance in time periods for patient use and also the live of a depressive mood. Third, these survey knowledge prevented North American nation from exploring necessary data on the utilization of pharmacotherapy like antidepressants. Therefore, discovered variations within the MHS use might not directly mirror variations within would like of MHS use. Fourth, subjects with a depressive mood weren't screened employing a standardized assessment tool since the information were collected from a general health survey and not a specialized mental state survey. Depressive moods were assessed by one question during this study; previous studies have investigated the accuracy of such a single-question technique, like a Yale study measurement the accuracy of the subsequent question: “Do you regularly feel unhappy or depressed?” The study showed that this question had a sensitivity of eighty six, a specificity of seventy eight, a positive sure thing of eighty two, and a negative sure thing of eighty two in screening for depression in patients with re-cent stroke [36]. Thus, one question has the potential to be a fast and affordable various to a lot of extended questionnaires in surveys involving giant samples [37]. Despite these limitations, this nationwide representative study provides elaborate data on this standing of MHS use among subjects with a depressive.

7. Conclusion

The findings of this study suggest that the use of MHSs differs among Bangladeshi subjects with a depressive mood according to socio-demographic factors. The aim of this study was to estimate the prevalence of mental health problems and its associated factors in children at the age of 1-15 years in the Dhaka Shishu (Children) Hospital Bangladesh. The problems are equally prevalent in both sexes. More than one in five (20.9%) children was found to have emotional and behavioral disorders, another 41.8% were with borderline difficulty score and 37.1% were with of normal range. Domain wise difficulty prevalence suggests emotional problem in 23% children, Conduct problem in 20.9% children, Hyperactivity in 1.5% children, Peer problem in 22.4% children and Pro-social behavior in 54.1% children the elderly, Children with a lower education level, and the employed were less likely to use MHSs. This study shows the relationship be- tween socio-demographic factors and the MHS use in tween socio-demographic factors and the MHS use in tween socio-demographic factors and the MHS use in some strong limitations including recall bias and lack of measuring important confounders. This study the results in may be a useful data for policy makers and mental health professionals in improving the public strategy of the mental health delivery system. In order to enhance the use of MHSs, mental health promotion strategies, including community outreach service, campaigns and education programs, should be targeted according to the characteristics of the population

8. Recommendation

Policy makers should be made aware about the important issue of behavioral and emotional problem which is prevalent in one fifth of the school children, so that they can address the issue in strategic planning. Emotional and behavioral problems in children should be regarded as a public health problem and action should be made to counteract the burden of morbidity on health system. Parents should be made aware about the possible factors that precipitate the condition among the children. Psychiatric assessment of the children should be included in the school health program, and should cover all children at least once in a year. Parents should be advised to spend substantial amount of quality time with their children further study is hereby recommended in the issue with greater sample size.

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