

A Global Programme for Child and Adolescent Mental Health: A Challenge in the New Millennium

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BACKGROUND

In 2003, during the presidency of Dr Ahmed Okasha, the World Psychiatric Association (WPA) initiated the Global Programme for Child and Adolescent Mental Health. The Programme was conducted in collaboration with the World Health Organization (WHO) and the International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP). This unique initiative focused on three key areas: *Awareness, Prevention, and Treatment*. The respective task forces generated products that will have a continuing impact on advocacy, training, prevention, and services development. A special product of the collaboration was the WHO Child and Adolescent Mental Health Atlas which for the first time documents objectively the gaps in global services and training available, worldwide, for child and adolescent mental health (World Health Organization, 2005).

The WPA Presidential Global Programme on Child Mental Health was always mindful of the need to respect and support the rights of children, adolescents, and their families. Its overall objectives were as follows:

- To increase awareness by health decision makers, health professionals, and the general public of the magnitude and severity of problems related to mental disorders in childhood and adolescence, and the possibility of their resolution.
- To promote the primary prevention of mental disorders in childhood and adolescence and foster interventions that will contribute to healthy mental development.
- To offer support for the development of services for children and adolescents with mental disorders and promote the use of evidence-based methods of treatment.

The Global Programme was initiated by Prof. Ahmed Okasha, as President of the WPA, and coordinated by an International Steering Committee chaired by Prof. Okasha and Prof. Norman Sartorius. In the process of implementation, the Programme generated several worldwide initiatives, for example, field trials for the prevention of school dropout in Alexandria (Egypt), Nizhnij Novgorod (Russia), and Porto Alegre (Brazil). The results of the Global Programme were presented in 2005 at the World Congress of Psychiatry in Cairo.

As will be detailed in later chapters, the Global Programme began a process that stimulated the task forces to focus on particular areas. The process itself is of interest in that it demonstrated the need for priority setting in an area of health care that requires resource rationing. The Programme harnessed the collective wisdom of knowledgeable individuals worldwide.

The Awareness Task Force recognized the need to help constituencies to develop informed advocacy. Consequently, it produced as its primary offering a manual for implementing an awareness campaign. Rather than focusing on a nebulous prevention campaign, the Prevention Task Force identified a key area in which it would be possible to make a demonstrable impact. The preventive setting chosen was in schools, specifically in regard to school dropout, a problem that has broad implications for child mental health. Recognizing the need for training materials that could be used in the developing world, the Treatment Task Force produced two manuals and collateral documents concerning the treatment of externalizing and internalizing disorders. As a whole, through these activities, the Global Programme accomplished the goal of raising global awareness of child and adolescent mental health needs and how these might be addressed. This volume gives details of the overall Programme and its research activities, provides background documents, and directs readers to available resources. The volume itself is part of a continuing effort to enhance advocacy and disseminate information.

CHILD RIGHTS CONTEXT FOR THE GLOBAL PROGRAMME

Children and adolescents must be respected as human beings with clearly defined rights. *The United Nations (UN) Convention on the Rights of the Child* delineates the rights that should be accorded children and their families (United Nations Convention on the Rights of the Child). The Convention is applicable to children in all cultures and societies and

has particular relevance for those living in conditions of adversity. Two additional documents should be mentioned in connection with the convention: *The Optional Protocol on the Involvement of Children in Armed Conflicts* and *The Optional Protocol on the Sale of Children, Child Prostitution, and Child Pornography*. All three documents provide comprehensive guidance to the human-rights entitlements of children, adolescents, and their families.

Children with mental health problems are entitled to benefit from the guarantees of the Convention; however, this is not the case in many parts of the world. The magnitude and impact of mental health problems have not yet been properly recognized by many governments and decision makers. The world has failed to address not only well-defined mental disorders, but also the mental health problems of children exploited for labor and sex, orphaned by AIDS, or forced to migrate for economic and political reasons (Foster, 2002). These problems are increasing. It is estimated that, in 26 African countries, the number of children orphaned for any reason will be more than double by 2010, 68% of them as a result of AIDS. Fourteen million children in 23 developing countries will lose one or both parents by 2010 (World Health Organization, 2003).

Other important child rights documents and conventions are the following: *The Declaration of Helsinki* (1984), revised in Tokyo (1995) and Edinburgh (2000), codifying the principles of ethical research in medicine; *The Bioethics Convention of the European Union*; *The Belmont Report* proposed by the US National Commission for the Protection of Human Subjects in Biomedical and Behavioral Research (1978); and *The Declaration of Madrid of the WPA* (2002), concerning the principles of ethical research with human beings.

THE BURDEN OF CHILD AND ADOLESCENT MENTAL DISORDER

A disproportionately large percentage of the “burden of disease” (World Health Organization, 2001) falls into the category of “neuropsychiatric conditions in children and adolescents” (see Figure 1.1). This estimate of disability-adjusted life years (DALYs) actually underrepresents the burden caused by disorders such as attention-deficit/hyperactivity disorder (ADHD), conduct disorder, learning disorder, mood disorder, pervasive developmental disorder, and mental retardation (Fayyad, Jahshan, and Karam, 2001). The WHO report *Caring for Children and Adolescents with Mental Disorders* (Foster, 2002) highlights the following facts: (a) up to 20% of children and adolescents worldwide suffer from disabling mental illness (World Health Organization, 2000); (b) suicide is the third leading cause of death among adolescents worldwide (World Health Organization, 2001); (c) major depressive disorder often begins in adolescence, across diverse countries, and is associated with substantial psychosocial impairment and risk of suicide (Weissman *et al.*, 1999); and (d) conduct disorder tends to persist into adolescence and adulthood and is associated with juvenile delinquency, adult crime, dissocial behavior, marital problems, poor parenting, unemployment, and poor physical health (Patterson, DeBaryshe, and Ramsey, 1989). Kessler *et al.* (2005) has found that approximately 50% of adult mental disorders begin before the age of 14 years.

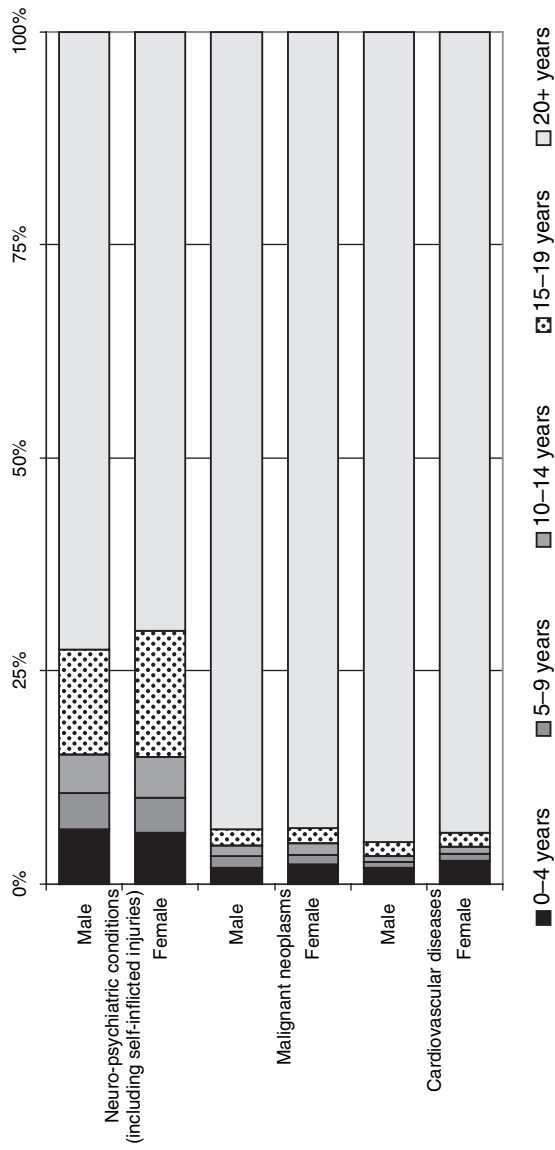


Figure 1.1 Disability-adjusted life years in the year 2000 attributable to specific causes by age and sex (World Health Organization, 2005)

The cost to society of the mental disorders of children can be calculated. Leibson *et al.* (2001) reported that, over a 9-year period, the median medical cost of a child with ADHD is 4306.00 USD compared to 1944.00 USD for a child without ADHD. These data suggest that mental health disorders in children represent a huge burden for children, families, and society; and that a human-rights framework is essential if children are to get effective, good quality care.

EPIDEMIOLOGY AS A BASIS FOR THE PLANNING OF SERVICES

Epidemiological data are important for the development of public policy and programmes to improve children's mental health. Epidemiological research answers the following questions (Leibson *et al.*, 2001): How many children in the community have mental health problems? How many children make use of mental health services? What is the distribution of mental health problems and services across age, sex, and ethnic group? Are there historical trends in the frequency of child mental health problems? What is the developmental course of mental health problems from childhood to adulthood? What etiological factors can be identified to inform the design of prevention and treatment programmes? How cost-effective are child mental health services? What are the outcomes for children who receive services? The answers to these questions provide a rational basis for service design and implementation.

The prevalence of child mental disorders worldwide appears quite similar. The 6-month prevalence rates for all mental disorders in the general population (boys and girls included) are 16.3% in 8-year-olds, 17.8% in 13-year-olds, 16% in 18-year-olds, and 18.4% in 25-year-olds. The most severe disorders vary in prevalence between 4.2% in 8-year-olds and 6.3% in 25-year-olds (Verhulst, 2004). Table 1.1 gives an overview of the prevalence of mental disorders in the general population, split into five groups, and classified according to developmental features and course of illness (Schmidt, 2006; Remschmidt and Schmidt, 2001).

These epidemiological data, based on studies in Europe and the United States, can be used for the planning of services in all regions of the world; however, it is crucial to supplement the data with local studies that reflect cultural dimensions of the presentation of disorders and the degree of impairment they convey.

THE CHILD AND ADOLESCENT MENTAL HEALTH ATLAS

The WHO Child and Adolescent Mental Health Atlas (World Health Organization, 2005) is one of the first systematic attempts to gather countrywide data on treatment resources available for children and adolescents with mental disorders. From key informants, the Atlas collected data on health policy and legislation, mental health financing, mental health services, human resources for care, data collection capacity, the care of special populations, and the use of medication.

The WHO Child and Adolescent Mental Health Atlas follows other Atlas projects such as those for general mental health services, neurological disorder, and epilepsy (World Health Organization, 2005). The findings related to children and adolescents are striking in comparison to the data obtained for adult mental health services (Table 1.2):

Table 1.1 Prevalence of mental disorders in children and adolescents based on population studies in Europe and the United States (Leibson *et al.*, 2001; Verhulst, 2004)

Early-onset disorders with lasting impairment		Developmentally dependent interaction disorders	
• Mental retardation	2%	• Feeding disorder (at age 2)	3%
• Autism	~0.5‰	• Physical abuse and neglect	~1.5%
• Atypical autism	1.1‰	• Sibling rivalry (in 8-year olds)	14%
• Receptive language disorder	2–3%		
• Expressive language disorder	3–4%		
• Dyslexia	4.5%		
<i>Developmental disorders</i>		<i>Early-onset adult-type disorders</i>	
• Disorders of motor development	1.5%	• Depressive episodes	2–4%
• Nocturnal enuresis in 9-year-olds	4.5%	• Agoraphobia	0.7–2.6%
• Encopresis in 7-year-olds	1.5%	• Panic disorders in adolescents	0.4–0.8%
• Oppositional defiant disorder	~6.0%	• Somatoform disorders	0.8–1.1%
		• Schizophrenia in adolescents	0.1–0.4%
		• Bipolar disorders in adolescents	<0.4%
		• Alcohol abuse in adolescents	~10%
		• Alcohol dependence in adolescents	4–6%
		• Personality disorders in 18-year olds	~1%
<i>Disorders of age-specific onset</i>			
• Mutism in 7-year-olds	0.8%		
• Stuttering	1.0%		
• Specific phobias	3.5%		
• Obsessive–compulsive disorder	1–3.5%		
• Anorexia nervosa	0.5–0.8%		

Table 1.2 Mental health services available for children and adolescents in most European countries*Outpatient Services*

Child and adolescent psychiatrists in private practice

Psychoanalytical child and adolescent psychotherapists in private practice

Hospitals outpatient departments

Child psychiatric services in public health agencies

Child guidance clinics and family counseling services

Early intervention centers, social pediatric services

Day Patient Services

Day patient clinics

(two types: integrated into inpatient settings or independent)

Night clinic treatment facilities

Inpatient Services

Inpatient services at university hospitals

Inpatient services at state psychiatric hospitals

Inpatient services at general community hospitals or pediatric hospitals

Complementary Services

Rehabilitation services for special groups (e.g. children with severe head injury or epilepsy)

Different types of residential care setting

Residential groups for adolescents

- In less than one third of all countries, is it possible to identify an individual or a governmental entity with the sole responsibility for child mental health.
- In all but the wealthiest countries, public education regarding child mental health lags well behind that for other health problems.
- Worldwide the gap in meeting child and adolescent mental health needs is staggering. In most countries between one half and two thirds of all needs go unmet.
- School-based consultation services for child mental health do not operate regularly to the extent required in either developing or the developed countries. This gap leads to a failure to prevent school dropout and other significant consequences.
- Funding for child and adolescent mental health services is rarely identifiable in national health budgets. In low-income countries, services are often “paid out of pocket.”
- While *The UN Convention on the Rights of the Child* is identified by most countries as a significant document, rarely are the child mental health provisions of the Convention exercised.
- The work of nongovernmental organizations in the provision of care is rarely connected to ongoing country-level programmes and too often lacks sustainability.
- In developing countries, the development and use of “self-help” or “practical help” programmes, not dependent on trained professionals, are more a myth than a reality.
- In 62% of the countries surveyed, there is no essential drug list for child psychotropic medication. In 53% of the countries, there are no specific controls in place for the prescription of medication to children.
- Although, worldwide, there is great interest in ADHD, in 47% of countries psychostimulants are either prohibited or not available for use.

CARING FOR CHILDREN WITH MENTAL DISORDERS: DIMENSIONS OF THE CHALLENGE

A system of care provides a range of services from least restrictive (community and family-based) to most restrictive (hospital-based). The concept of “system” does not dictate a particular theoretical orientation or the use of particular therapies. Implementation may lack uniformity depending on the particular setting. The geographic area covered by a “system” can be as small as a local community or as large as a country. In a system, it is assumed that there is some form of facilitated transfer of the patient between the components of the continuum of care. Facilitated transfer is difficult to ensure.

In Europe, systems of care have been very much connected to the development of child and adolescent psychiatry as a medical specialty (Blanz *et al.*, 2006). In recent decades, those working in the field have learned that interdisciplinary cooperation is an absolute necessity for scientific and clinical progress. In nearly all European countries, the number of child psychiatrists and other child mental health workers has increased dramatically over the past decades; however, in other areas of the world, mental health professionals are usually absent or in short supply. The situation in different countries is very heterogeneous with regard not only to the number of child psychiatrists, but also to the organization of departments and services, and the research, training, and continuing medical education that take place within them. In the planning and implementation of treatment, it is crucial to select appropriate components and integrate them as a coherent

Table 1.3 Salient results from the WHO Child Mental Health Atlas^a (Belfer and Saxena, 2006)

	High income ^b	Low income ^b
National policy for CAMH	16/18	4/16
CAMH ^c	14/18	0/16
Epidemiological data	8/20	1/16
Annual health survey data about CAMH	12/20	3/16
Stigma as barrier to care	16/20	5/16
Financing of services:		
Consumer/family only	0/20	6/16
Tax-based/government	2/20	1/16
International grants	10/20	2/16
Nongovernmental organizations	4/20 [†]	0/16
Social services	4/19	0/16
Medication available without cost to family	8/20	3/16

[†]Does not reflect emergency or disaster services.
^a64 countries responded to the survey over a three-year period.
^bWorld Bank country categories.
^cCAMH = child and adolescent mental health.

treatment plan (Remschmidt, 2001). Table 1.4 summarizes the intervention possibilities for the major mental disorders encountered in children and adolescents.

Modern care for child and adolescent mental disorders reflects the following issues (Stroul and Friedman, 1986; Grimes, 2004). The main arena for service delivery is no longer inpatient, but rather in outpatient, day treatment, and complementary community services (Table 1.4).

Specialized services for particular disorders are provided by highly qualified personnel who implement pragmatic, effective, and efficient treatment programmes. Programmes should be evaluated. The private practice of child and adolescent psychiatry varies with country and local circumstances. However, the coordination of different services is too often inadequate, causing obstacles for patients and impeding the delivery of effective intervention. Increased

Table 1.4 Therapeutic interventions for priority mental disorders of children and adolescents (World Health Organization, 2005)

Disorder	Dynamic psychotherapy	Cognitive-behavioral therapy	Psychopharmacotherapy	Family therapy	School intervention	Counseling	Specialized interventions	Other
Learning disorders			X		X	X		X
ADHD ^a		X	X ^b		X			
Tics		X	X	X				
Depression (and suicidal behaviors)	X	X	X*	X				
Psychoses			X	X	X		X	

^aADHD = Attention-deficit/hyperactivity disorder.
^bSpecific treatment depends on the age of the child or adolescent.

efforts are required to develop sustainable programmes. The worldwide absence of child and adolescent mental health policy requires correction (Shatkin and Belfer, 2004).

To address the lack of child and adolescent mental health policy, the WHO has developed *The Child and Adolescent Mental Health Policy Module* (World Health Organization, 2005b). This document is aimed at ministers of health and other policy developers. It provides precise guidance on policy development for child and adolescent mental health services. The module recognizes that, without a national policy, there is little likelihood of priority setting, financing, and accountability. The section of Child and Adolescent Psychiatry of the Union of European Medical Specialists (UEMS) has published guidelines for the design of training programmes in child and adolescent psychiatry. These guidelines have been implemented in several countries of the European Union and could serve as a universal model. They identify specific requirements and provide guidance on monitoring and quality assurance.

In developing countries, basic needs such as nutrition, water, and sanitation often overshadow mental health concerns. In many developing countries, up to half of the population are children (Rohde, Celia, and Berganza, 2004; Hong *et al.*, 2004; Robertson *et al.*, 2004). The difficult circumstances found in many countries violate the basic rights of children (Robertson, 2004) (e.g., armed conflict, the forced recruitment of children as soldiers, child abuse, prostitution, child-trafficking, homelessness, child labor, HIV/AIDS infection, a lack of provision for children's basic needs, and discrimination against minority children).

When present, systems of care in developing countries are either formal or informal (United Nations Children's Fund, 1990). Informal systems include those provided by families and their support network, natural healers, and faith-based organizations. Formal systems are provided either by the state or by an emerging private sector. In many countries, it is impossible to gather reliable data on services. A key problem for all developing countries is the provision of education and training programmes in child and adolescent mental health for doctors, psychologists, and other health and mental health workers.

THE ROLE OF INTERNATIONAL ORGANIZATIONS AND GLOBAL INITIATIVES

International organizations such as the WPA, the World Federation of Mental Health, WHO, the IACAPAP, the United Nations Educational, Scientific and Cultural Organization (UNESCO), and the United Nations Children's Fund (UNICEF) play an important role with regard to all aspects of child and adolescent mental health. The paramount goals and activities of these organizations are to raise public awareness of child mental health, facilitate the establishment of appropriate services in different parts of the world, establish training programmes for mental health workers in all parts of the world, fight for the rights of children, and ensure that *The UN Convention on the Rights of the Child* is observed in every country.

ADVOCACY

It is a constant challenge to develop and sustain programmes that support the care of children and adolescents with mental disorders. Advocacy seeks to keep the needs of these children on the agenda of nations and communities. The WPA Presidential Global Programme on Child Mental Health aims to promote the development of child and adolescent mental

health services and policy and to facilitate prevention. At international, national, and local levels, parent advocacy is a force for the development and maintenance of programmes. It should be the aim of all international organizations devoted to mental health to facilitate broader advocacy for children and adolescents everywhere in the world. Beyond their guild interests, professional mental health organizations of all types have an important role to play in advocacy. The health, social service, juvenile justice, and education sectors also have key roles to play as advocates for child and adolescent mental health.

CONCLUSION

Child and adolescent psychiatry and child and adolescent mental health services have evolved in remarkable ways in the past few decades. Old myths, old treatments, and old policies are no longer to be tolerated. The new era provides an opportunity to develop and implement evidence-based interventions, modern training programmes, and imaginative policies. Advocacy for these initiatives is the responsibility of many. The WPA Global Programme is an example of the type of collaborative, focused effort needed to promote child and adolescent mental health worldwide. The reward will be healthier and happier children and adolescents in more productive and stable societies.

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