

Editorial

Mental Health Policy for Children and Adolescents in Developing Countries

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About half of all lifetime mental disorders begin before the age of 14 years^{1,2}. Worldwide prevalence rates for child and adolescent mental disorders are around 10%-20%, with similar types of disorders seen across cultures³⁻⁵. Young people have a high rate of self-harm, and suicide is a leading cause of death in young people². An Indian study reported that suicide accounted for a quarter of deaths in boys and between half and three-quarters of deaths in girls aged 10-19 years⁶. Poor mental health is strongly related to other health and development concerns in young people notably lower educational achievements, substance abuse, violence, and poor reproductive and sexual health². The suffering, functional impairment, exposure to stigma and discrimination, and enhanced risk of premature death that is associated with mental disorders in young people has obvious public-health significance. It is obvious that 'no health is possible without mental health' and that mental health issues form an integral part of child development.

The effectiveness of some interventions (including promotive and preventive interventions) for mental disorders in this age-group have been established, although more research is urgently needed to improve the range of affordable and feasible interventions^{2,5,7,8}. Despite these findings, the gap in mental-health services for children and adolescents with mental disorders is evident in virtually all countries^{5,9,10}.

Policy and service system gaps

In 1977, the WHO recommended that every country throughout the world should have a National Plan for Child Mental Health. The International Association for Child and Adolescent Psychiatry and Allied Professions endorsed the WHO's recommendation in 1992¹¹. However, the Child Mental Health Atlas showed wide variations in the development of documents related to policies and programmes, e.g. among the 66 reporting countries, only 6.3% of African as against 66.7% of European countries reported the presence of a child and adolescent mental health programme; and 0% of low-income (including India) and 78% of high-income countries reported having a document related to policy on child and adolescent mental-health⁹. Most of the surveyed countries do not have a national system to regulate use of psychotropics in children and adolescents and in more than 70% of the countries do not have an essential drug list for child psychotropic medication.

The Child Mental Health Atlas also showed that most of the surveyed countries could not identify a budget line for child and adolescent mental health services in country budgets and in low-income countries services are most often "paid out of pocket." Even in countries that have an identifiable budget for child and adolescent mental health services there is no parity with the resources provided for adult mental health services. In Latin America there are reports that recently initiated "structural re-alignment" and the accompanying privatization process may be having the paradoxical affect of reducing access to primary care services by those most in need⁹.

In the vast majority of countries outside of Europe and the Americas a system of services for child and adolescent mental health does not exist. In the developing countries whatever few services are available are mostly based in hospitals or other custodial settings. Contrary to popular belief, virtually no child and adolescent mental health beds are present in general hospitals facilities. School-based consultation services for child mental health are not employed in either the developing or the developed world to the degree possible⁹.

In most countries outside of Europe and the Americas the presence of a child psychiatrist is in the range of 1 to 4 per million, because only a few countries have developed national or regional standards for training for child psychiatrists. Specialization in nursing to work with children was identified in only 25 of 66 countries. Only 10 of 66 countries identify that more than 25% of their paediatricians receive mental health training and yet in 37 of 66 countries paediatricians are identified as providers of mental health care. In developing countries the potential of having professionals trained in social work, psychology, education and other fields is not utilized for mental health care of children and adolescents because of lack of supplemental training in child mental health⁹.

Child and adolescent mental health disorders are reported on in a country's annual health survey in 12 of 20 high income-countries and in only 3 of 16 low-income countries⁹.

Need for a specific policy for children and adolescents

Considering that about 80% of children and adolescents of the world live in developing countries and children below 18 years form a substantial part of the population in these countries (e.g. more than a third of India's population), there is an urgent need to develop mental health resources in developing countries.

The presence of informed, effective mental health policy is critically important for the mental health of children. Policy guides the development of child and adolescent mental health services, advocacy for care, the assurance of access to care, and the remediation of deficits in care. Policy can guide the mechanisms for evaluation and importantly provide oversight and accountability. The failure to develop child and adolescent mental health policy is in large part responsible for the demonstrable gaps in mental health services for children and adolescents, the persistence of barriers to care, and the failure to be able to ensure rational care¹¹.

A specific policy is required to support child and mental health services in an effective manner as an adult or general mental health policy often lacks a developmental framework, is not as reliant on support for intersectoral care and does not recognize the need to allow for the dependence of recipients of care¹¹.

Developing a mental health policy

The reason for the lag in development of policies and programmes for child and adolescent mental health compared to those for adult mental disorders are many, including widespread lack of knowledge about child development and childhood mental disorders, relatively weak advocacy, lack of training and in many parts of the world, and absent financial and professional resources for programme development and implementation¹².

Guidance on how to develop a child and adolescent mental health policy in developing countries has recently become available as a part of the WHO's Mental Health Policy and Service Guidance Package¹². The document on Child and Adolescent Mental Health Policies and Plans suggests that such a policy may be part of an overall health policy, a child and adolescent health policy or a mental health policy. An overriding consideration is that the child's development stage can influence his/her degree of vulnerability to disorders, how the disorder is expressed and how best treatment should be approached. Also, child and adolescent mental health problems and disorders need to be seen in their wider social context. Several different systems of care (e.g. education, welfare, health) may need to be involved to ensure that services for youth are effective. Policies must explicitly address strengthening capacity for addressing youth mental disorders in family settings, educational settings, in primary health care and in specialist mental health care¹².

The guidance package identifies the following steps as important in developing a child and adolescent mental health policy: collection of information (prevalence of mental health problems, financial and human resources, service organization, and the views and attitudes of health workers); evidence for strategies (pilot projects, international literature, consultations); consultation and negotiation; exchange with other countries; development of the vision, values, principles and objectives of the policy (e.g. emphasis on promotion of healthy development and prevention of illness along with the treatment of disorders); determination of areas for action (e.g. financing, organization of services, legislation and human rights, etc.); and identification of roles and responsibilities of different stakeholders and sectors. Evaluating the development of mental health policy is not common, although it is required. Also, as a part of mental health policy for children and adolescents there is need to develop strategies for intersectoral interventions¹².

Conclusions

The mental health needs of children and adolescents are often discussed, but, at present, the development of policy to support these needs is woefully inadequate. Child and adolescent mental health services have proven to be particularly vulnerable to

systems change (e.g. privatization, structural realignment, introduction of insurance schemes) and an easy target for budget reductions. Advancing policy development has become critical. The tools are now present to guide this process. Because young people are often dependent on others to advocate on their behalf, advocacy efforts of professionals for the formulation and implementation of policy for children and adolescents deserve special attention to generate the political will and sustainable financing¹¹.

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