Special Article JIACAM Vol. 1, No. 1, Article 3

Child and Adolescent Mental Health Around The World: Challenges for Progress

Myron L. Belfer

Department of Mental Health and Substance Abuse, WHO, Geneva
Department of Social Medicine, Harvard Medical School
Boston, Massachusetts, USA

Introduction

Child and adolescent mental health is an essential component of overall health and its importance is gaining increased recognition. Current events have heightened an interest in the mental health of youth. Unfortunately, too often this is due to concerns about the mental health consequences of war, prolonged conflict, natural disasters, AIDS, and substance abuse. Special populations of repatriated child soldiers and street children are a vivid reminder of the many children who have been deprived of an environment that could support healthy development. Further, there is an increased understanding that children who are not mentally healthy can have an adverse impact on the stability and economic viability of nations. Of particular importance throughout the world is the fact that positive mental health plays a role in supporting compliance and adherence to a broad spectrum of health regimens.

Yet, the almost universally expressed recognition of the importance for societies, as well as for the individual, to have children and adolescents attain adulthood with good mental health has not brought forth the economic and human resources necessary to meet the observable need. The reasons for this gap are several and include the world's ambivalent view of the worth of children in societies, the view of children as family property to be used for work, a lack of comprehension that children have a mental life, and a failure to understand developmental psychopathology (WHO, 2003). It is only now with progress being made in the eradication of infectious diseases and the improvement of nutritional status, and improved health education in many locales that it may become possible for societies to consider the mental health of children as a priority issue.

A major impediment to the development of child and adolescent mental health services and training is the virtual absence of child and adolescent mental health policy everywhere in the world (Shatkin & Belfer, 2004). Policy, when present, appears to be less at a national level than at a regional or local level thus leading to fragmented and unevenly funded services. The WHO (2005) through the development of a policy guidance module on child and adolescent mental health seeks to provide the tools needed for governments to develop policy and for advocates to have the information needed to derive appropriate policy.

Dimensions of child mental health problems

Determining the epidemiology of childhood mental disorders is a challenge throughout the world. Reporting systems are inadequate, the definition or recognition of disorders varies or has variable interpretations, and the cultural component of what constitutes a disorder is only now being more fully appreciated by epidemiologists and researchers. In studying the epidemiology of psychiatric disorders in children and adolescents, in developing and developed countries, it is important to define not only the prevalence and incidence of the disorders, but also the associated burden of disease as measured in terms of the cost of care over the lifespan and lost human potential. It must be recognized that the impairment associated with disorders may vary in different cultures.

World Health Organization studies of primary care clinicians showed that a significant proportion of patients seeking care had mental disorders and that their communities were aware of the problem (Harding, 1980). It is important to bear in mind the study of Giel & Van Lujik (1969) who found, counter to prevailing belief, that mental disorders were diagnosed more frequently than infectious diseases (in the pre-HIV/AIDS era) in health centers in Africa that they studied. However, there is no single study or consistent set of independent studies on the epidemiology of child and adolescent disorders in the past twenty years that can be identified as definitive or relevant across societies. Those studies carried out twenty years ago reflect the deficiencies noted above and certainly do not reflect the current realities of the countries from which the data were reported.

Thabet & Vostanis (1998) citing Nikapota (1991) express the once controversial view that child mental health symptoms do not differ significantly across cultures and that culture specific mental health disorders are rare. These views of comparability with western epidemiological data are at odds with older studies and may reflect the global impact of the media and new social and economic realities. Similarly, Fayyad et al, (2001) summarizing the significant international epidemiological studies concludes that the range and rates of psychiatric symptomatology in children in developing countries were similar to those in the developed world. There appeared to be universal risk factors including parental separation and divorce, psychological deprivation, and culture-specific factors, such as, polygamy which correlated with manifest psychopathology.

Most countries today have access to appropriate epidemiological study guidelines and it will be a matter of setting a national priority, and allocating resources to ascertain the data in developing countries. The recent delineation of "cultural epidemiology," combining classical epidemiology with the information derived from cultural anthropological study, offers a unifying approach that may advance the understanding of child and adolescent disorders as seen in developing countries and inform our understanding in clinical settings world-wide (Weiss, 2001).

Disorders

Which of the disorders such as ADHD, autism, and anorexia nervosa, are now occupying considerable attention in developed countries? In the case of eating disorders there is clear evidence that the incidence may be affected by Western influences (Becker, 1995).

There is little doubt that these disorders are seen, but what resources need to be invested in the treatment of these disorders in countries which have little access to the medications or programs that might be indicated? The diagnosis and treatment of these disorders highlights both a weakness and strength of having an international perspective. The recognition and labelling of disorders comes as a result of improved international communication. However, the process of assessment is most complex and must take into account cultural concepts of what is normal or abnormal, and how parents perceive the presence or absence of a diagnosable disorder (Hackett, 1999).

Increasingly, it is the pharmaceutical industry that is now providing or influencing the education of providers in countries throughout the world. The focus on particular disorders of interest to the pharmaceutical industry, along with direct public education, may distort the presentation of children and adolescents for treatment in clinics and lead to misconceptions about the incidence and prevalence of disorders. There may be an indirect incentive for the over-diagnosis of disorders such as ADHD or anxiety. The ability to evaluate the impact of these practices is quite variable throughout the world. In resource rich countries there exists a treatment gap based on barriers to accessing care and under-diagnosis and treatment rather than over diagnosis and treatment as reported in some areas of the world.

Concerns about care

While it is now common in developed countries to focus on the development of "systems of care" for children with mental disorders, in the developing world the concept represents a long-term goal given the lack of resources. Too often countries have been dependent on institutions without a focus on quality control using antiquated and what would now be considered abusive methods of care. Encouragingly, with better communication about modern modes of treatment and the potential of treatments to work, a better balance in care and more humane care are now the goals in most countries. Of course, the ability to achieve this goal is limited by financial constraints and lack of trained professionals.

A disturbing trend in many countries is the move toward privatization. This might be seen as a progressive move, but in resource poor countries the move away from state subsidized care towards "private" care is leaving many without any care, and draining human resources from the care network with individuals moving into private practice.
Governments are also adopting for their health schemes "managed care" and insurance without understanding many of the negative consequences that have been seen in the West over time. Managed care has too often been focused on cost saving and not on a more laudable mission of improving the appropriateness and quality of care. With insurance it is often the desire of governments to rid themselves of the expenditures for mental health care, as little as there may be. Unfortunately, the insurance plans are rarely adequate to cover appropriate care.

Manpower issues

Child and adolescent psychiatrists are in developing countries, and other trained child mental health professionals vary in number and distribution in developing countries. The training of the individuals with recognized child mental health credentials varies widely in different parts of the world, and too often the training is inadequate to permit the "trained" individual to be a teacher of others or to lead programs in a progressive manner. Clinical practice often differs from that in more developed countries through the use of primary care health providers, family and non-familial community members, traditional healers and religious leaders. The primary care provider, with varying levels of training, has become central to the provision of services though the data on the effectiveness of primary care providers providing child and adolescent mental health services is negligible. There is a clear need for increasing trained personnel to work in the primary care sector, but adequate training has lagged. It is important to note that the competencies of the child and adolescent mental health clinician must fit the needs of the society in which they exist. For example, epilepsy and mental retardation clearly fall within the expected clinical competencies of child and adolescent psychiatrists in developing countries, but are not expected competencies of child and adolescent psychiatrists in developed countries.

When child psychiatry is a very scarce resource there may only be the opportunity for a consultative role, limited diagnostic capability, and an inability to be part of or stimulate discussion of national policy. At the same time, child and adolescent psychiatrists brought into developing countries may play a vital role in educating other professionals in medicine, psychology, education, social work, and nursing and in the volunteer community.

Special note must be taken of the potential for mental health providers to work with schools (Kapur, 1980). Schools are a relatively stable environment in which to reach children and the observations of the behavior of potentially at risk or affected children is often valuable in this venue. While there is much written about school consultation and the utilization of services in school settings in both the developed and developing world the potential has not been realized.

Impact of international issues on domestic practice

Due to increased migration of populations from one country to another for economic and political reasons, child and adolescent mental health professionals and those involved with family treatments need to be aware of the global issues impacting the mental health of children. Of even more concern in countries around the world are immigrant populations. They are presenting with child and adolescent mental health problems that are a direct extension of the traumatic experiences in their home countries, or are related to the difficult task of making an adjustment to a new country. Knowing about how to understand and treat these contemporary psychological problems is essential if one has an international perspective. Thus, knowing more about the culture of the patient and family is ever important as the presentation and likely response of the individual is more likely to follow the responses seen in the country of origin rather than that of the adopted country (Murthy, 2000).

Research

Research might seem like a luxury in resource poor countries, but it is essential to work towards the development of a local research capacity. Such capacity could well be in collaboration with other neighbouring countries or in partnership with well resourced institutions or countries in other regions of the world. The reason for the importance of a research capacity is to support evaluation, implement study of the cultural relevance of programs and treatments, and to stimulate the overall exchange of knowledge.

There currently exist the types of collaborative research initiatives mentioned. The research training has led to publication of studies that have shed light on child disorders in different cultures, and patterns of service delivery. Of equal importance is the development of a well trained academic core that can stimulate further training within countries. A problem that must be confronted is that when individuals become well trained and recognized, they often leave their native countries for better opportunities in other parts of the world. Incentives need to be put in place to retain these well trained individuals.

The focus of research in developing countries needs to shift from that of the past to embrace culture specific research that draws on issues raised by research in developing countries. This should not represent a simple replication of western studies. There is a need to initiate research that will answer questions about the specificity of diagnosis in the developing world, the ways in which systems or services can be developed, how treatments are best utilized, and how the burden of disease can be measured in the developing world.

Conclusions

Child and adolescent mental health has been aided by improved communication leading to an awareness of modern concepts of diagnosis and care, the presence of national problems impacting youth, and the empowerment provided by the UN Convention on the Rights of the Child. As there is forward movement there needs to be a concern with developing "rational care." Rational care implies the provision of appropriate care taking into consideration appropriate diagnostic procedures and the application of treatments that meet the needs of the individual child. There is an obligation to not exploit the vulnerable populations of children and adolescents and their families with mental disorders through the making of false promises of benefit from unproven or noxious treatments. With a continued effort to disseminate information, attempt to achieve a continuum of care, and the empowerment of families to seek appropriate care, the future for child and adolescent mental health is indeed one of promise.

References

Allwood, M.A., Bell-Dolan, D. & Husain, S.A.(2002) Children's trauma and adjustment reactions to violent and non-violent war experiences. Journal American Academy Child Adolescent Psychiatry, 41(4), 450-457.

Almquist, K. & Brandell-Forsberg, M. (1997) Refugee children in Sweden: post-traumatic stress disorder in Iranian preschool children exposed to organized violence. Child Abuse Neglect, 21, 351-366.

Becker, A. E. (1995) Body, Self, and Society: A View from Fiji. Philadelphia: University of Pennsylvania Press.

Fayyad, J.A., Jahshan, C.S. & Karam, E.G. (2001) Systems development of child mental health services in developing countries. Child Adolescent Psychiatric Clinics North America, 10, 745-762.

Giel, R. & Van Luijk, J.N. (1969) Psychiatric morbidity in a small Ethiopian town. British Journal of Psychiatry, 115, 149-162.

Hackett, R. & Hackett, L. (1999) Child psychiatry across cultures. Int. Review Psychiatry, 11, 225-235.

Harding, T.W., deArango M.V. & Balthazar, J. et al. (1999) Mental disorders in primary health care: a study of frequency and diagnosis in four developing countries. Psychological Medicine, 10, 231-141.

Kapur, M. & Cariapa, I.(1980) Evaluation of an orientation course for teachers on emotional problems among school children. Indian Journal of Clinical Psychology, 7, 103.

Malhotra, S. (1998) Challenges in providing mental health services for children and adolescents in India. In: Young J.G. & Ferrari P (eds) Designing Mental Health Services for Children and Adolescents: *A* Shrewd Investment. In Philadelphia: Brunner/Mazel, 321-334.

Murthy, R.S. (2000) Approaches to suicide prevention in Asia and the Far East. In: Hawton. K. & Van Heeringen K. (eds) International Handbook of Suicide and Attempted Suicide. London, John Wiley & Sons, Ltd., 625-637.

Nikapota, A.D. (1991) Child psychiatry in developing countries: a review. British Journal of Psychiatry, 158, 743-751.

Thabet, A.A.M. & Vostanis, P. (1998) Social adversities and anxiety disorders in the Gaza Strip. Arch Diseases Child, 78, 439-442.

UNICEF (2000) State of the World's Children, UNICEF.

Weine, S.M., Vojvoda, D. & Becker, D.F. et al (1998) PTSD symptoms in Bosnian refugees 1 year after resettlement in the United States. American Journal of Psychiatry, 155(4),562-564.

Weiss, MG (2001) Cultural epidemiology: an introduction and overview. Anthropology and Medicine 8(1), 5-30,.

World Health Organization (2001) World Health Report: Mental Health: New Understanding, New Hope. Geneva: World Health Organization.

World Health Organization (2003) Caring for children and adolescents with mental disorders: Setting WHO directions. Geneva: World Health Organization

World Health Organization (2004) WHO Atlas for country resources for child and adolescent mental health. www.who.int/mental_health/evidence/atlas/

World Health Organization (2005) WHO Mental Health Policy and Service Guidance Package: Child and Adolescent Mental Health Policy and Plans. Geneva: World Health Organization.

Address for correspondence:
Myron L. Belfer, MD, MPA
Senior Adviser, Child and Adolescent Mental Health
Department of Mental Health and Substance Abuse, WHO, Geneva

Professor of Psychiatry
Department of Social Medicine
Harvard Medical School
Boston, Massachusetts, USA