

Atlas

CHILD AND ADOLESCENT
MENTAL HEALTH RESOURCES

GLOBAL CONCERNS:
IMPLICATIONS FOR THE FUTURE



2005



World Psychiatric
Association



World Health
Organization



International Association for
Child and Adolescent Psychiatry
and Allied Professions

WHO Library Cataloguing-in-Publication Data

World Health Organization.

Atlas: child and adolescent mental health resources:
global concerns, implications for the future.

1.Mental health services – statistics 2.Child health services – statistics 3.Adolescent health services – statistics 4.Health resources – statistics 5 Health care surveys 6.Atlases
I.World Psychiatric Association. Presidential Global Programme on Child and Adolescent Mental Health II.International Association for Child and Adolescent Mental Health and Allied Professions III.Title IV.Title: Child and adolescent mental health atlas

ISBN 92 4 156304 4

(NLM classification: WM 30)

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Printed in

Designed by Tushita Graphic Vision Sarl, CH-1226 Thonex

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Foreword

For all of its sober language and meticulous attention to data where data exist, and to bounded estimates where they do not, this remarkable Atlas is a *cri de coeur*.

It demands of us that we attend to the enormous unmet needs in child and adolescent mental health, that we recognize the paucity of services precisely where needs are greatest, and that we insist on action to remedy the treatment gap. Some 30 years ago, Julian Tudor Hart, a primary care physician practicing in a low income community in Wales, proposed an *inverse care law*. It reads: "The availability of good medical care varies inversely with the need for it in the populations served." Nothing better illustrates this proposition than the data in this Atlas on how few child psychiatrists have been trained (and how few remain) in the developing world and how many children and adolescents are desperate for help.

Developing countries are triply disadvantaged. They suffer a growing toll from chronic non-transmissible diseases even though infectious diseases continue to be endemic. The prevalence of physical disease obscures awareness of a mental health burden that weighs no less heavily on their populations.

One is tempted to believe that the numbers will speak for themselves. But numbers never do. They must be understood in context. They must be translated into the individual cases of unhappiness and suffering they represent in the aggregate before they can arouse the compassion necessary for the public to demand governmental action.

The industrialized world bears a major responsibility for having created this state of affairs and a comparable duty to change it. The West has sufficient resources to provide aid to mitigate suffering. We must transform ourselves from consumers of trained professionals in low income countries into providers of training and care. Opportunities for our trainees to work abroad as trainers and carers in low income countries will enlarge their understanding and make them better practitioners when they return. The "brain drain" is not a cliché; it is a reality visible every day when we make rounds in Western institutions staffed by immigrants from countries in great need (there are more Indian child psychiatrists in the United States than there are in India!). The blame does not lie with the migrants. They leave because they cannot earn a minimally adequate income and have few opportunities for professional advancement. Financial assets must be transferred from the West to low income countries to bolster their ability to provide an environment in which mental health workers can flourish.

Failure to ensure delivery of care is a violation of human rights, whether children or adults are the victims. The consequences are particularly disastrous in the case of the young because adult capabilities are determined in early years. Opportunities lost may never be recouped. The final cost to society of an adult who fails to perform at his or her highest capability will be far greater than outlays for care in childhood and adolescence. The needs of children cannot be deferred while we wait for a more convenient time. In the words of the Chilean poet, Gabriela Mistral:

"Many things can wait.
The child cannot.
Now is the time
His blood is being formed,
His bones are being made,
His mind is being developed.
To him, we cannot say tomorrow,
His name is today."

Leon Eisenberg
Maude and Lillian Presley Professor of Psychiatry and Social Medicine,
Emeritus, Harvard Medical School, Boston, Massachusetts, USA

Preface

Mounting evidence suggests that antecedents of adult mental disorders can be detected in children and adolescents. The development of policies and programmes for child and adolescent mental health have lagged those for adult mental disorders. The reasons for the lag 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, absent financial and professional resources for programme development and implementation. It is evident with current knowledge that the state of affairs must be changed to meet the needs of contemporary civilization. With many children and adolescents growing in chaotic environments and subject to abuse and exploitation of many kinds there needs to be an appropriate response by societies based on reliable information.

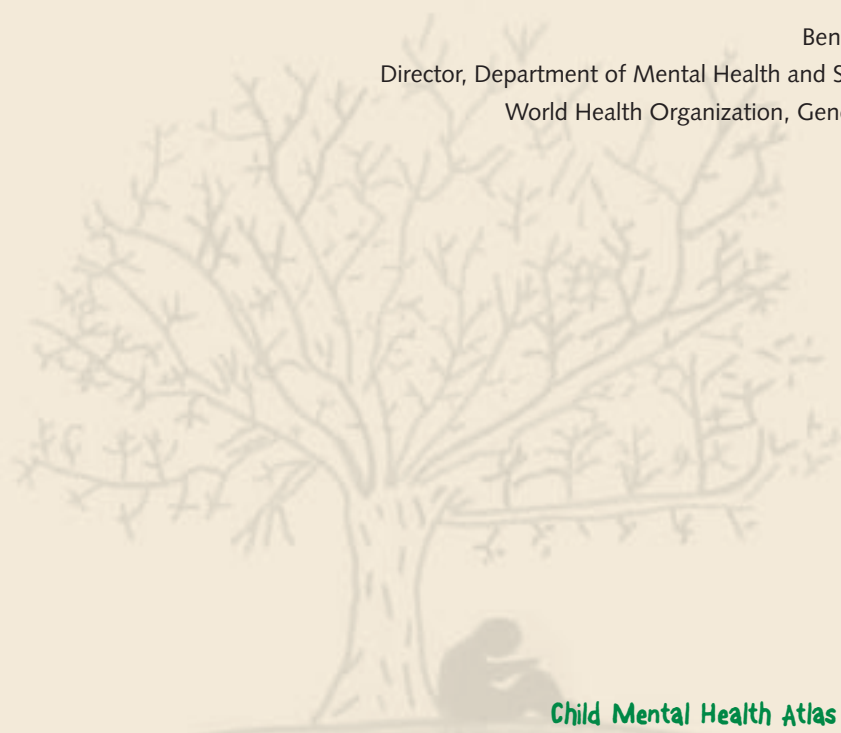
The World Health Organization, Department of Mental Health and Substance Abuse, has supported the development of the Atlas project. The project provides systematic information on country resources for mental health programme development including policy availability, professional resources and mechanisms for financing services. The child and adolescent mental health Atlas is a part of this series of publications. Obtaining relevant and accurate information for this Atlas was a challenge reflecting the relatively sparse resources that are available especially in the developing world.

We are hopeful that the child and adolescent mental health Atlas will stimulate debate on the development of child and adolescent mental health resources at the country level. The Atlas coupled with WHO's policy and service guidance package on child and adolescent mental health and WHO Assessment Instrument for Mental Health Systems provides previously unavailable tools to help governments and other interested parties to support the development of child and adolescent mental health services.

Continued neglect of the mental health needs of children and adolescents is unacceptable and must stop. WHO is ready to provide the support that can facilitate services development in both developing and developed countries. In partnership with other institutions and organizations, WHO will be part of the future efforts for improved services for children and adolescents.

The work on the Child and Adolescent Mental Health Atlas was carried out by WHO in close collaboration with the WPA Presidential Global Programme on Child Mental Health and with the International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP). WPA and IACAPAP are NGOs in official relations with WHO. The WPA has a history of longstanding and fruitful collaboration with WHO in the area of mental health. IACAPAP supported work in the area of child and adolescent mental health over many years. WHO is proud and privileged to have worked with these organizations on this publication.

Benedetto Saraceno
Director, Department of Mental Health and Substance Abuse
World Health Organization, Geneva, Switzerland



Acknowledgements

Atlas is a project of WHO, Geneva, supervised and coordinated by Shekhar Saxena. Vision and guidance for this project is provided by Benedetto Saraceno. The first set of publications from this project appeared in 2001. A series of Atlas publications has since been produced (See Appendix I).

The Child and Adolescent Mental Health Atlas is the result of a collaboration between the World Health Organization, the World Psychiatric Association Presidential Global Programme on Child Mental Health and the International Association for Child and Adolescent Mental Health and Allied Professions.

Myron Belfer was the overall project manager for the Child and Adolescent Mental Health Atlas with the guidance and support of Shekhar Saxena.

Key collaborators from WHO Regional Offices include: Therese Agossou, African Regional Office; Caldas de Almeida and Claudio Miranda, Regional Office for the Americas; R.S. Murthy, Eastern Mediterranean Regional Office; Matthijs Muijen, European Regional Office; Vijay Chandra, South-East Asia Regional Office; and Xiangdong Wang, Western Pacific Regional Office. They have contributed to planning the project, obtaining and validating the information from Member States and reviewing the results.

In the course of the project a number of colleagues at WHO provided advice and guidance. Significant among them are: Pratap Sharan, Pallab Maulik, Tarun Dua, and Jodi Morris. Thomas Barrett provided a review of the document. Sandrine Lo Iacono assisted in the completion of the project along with Yen-Ying Liu.

Collaborators from the WPA Presidential Global Programme included Ahmed Okasha (President, WPA), Peter Jensen, Kimberly Hoagwood, Laura Murray, and Kelly Kelleher. Norman Sartorius as Vice-Chairperson of the WPA Presidential Global Programme provided review and guidance. The Steering Committee of the Presidential Global Programme includes: Ahmed Okasha (Chair), Helmut Remschmidt, Sam Tyano, Barry Nurcombe, Peter Jensen, Tarek Okasha and John Heiligenstein.

Ms. Rosemary Westermeyer provided administrative support and assistance with production.

Vignettes and pictures were provided by: Dainius Puras, Brian Robertson, Füsün Cétin, Luis Diego Herrera Amighetti, Salvador Celia, Helmut Remschmidt, Linyan Su, Yi Zheng, Kang-E Michael Hong, and Malavika Kapur.

The key informants for the country responses are listed in Appendix II

The graphic design of this volume has been done by Ms. Tushita Bosonet.

Assistance with the world map was provided by WHO Graphics.

Introduction

Development of the ATLAS on country resources for child and adolescent mental health presented some unique challenges that reflect the current status of child and adolescent mental health services worldwide.

The Child and Adolescent Mental Health Atlas project, like the other ATLAS projects, is a systematic attempt to collect information from countries on existing services and resources. This project is led by the World Health Organization, Geneva, in collaboration with the WHO Regional Offices and partner organizations. In the case of the child and adolescent mental health ATLAS the project was assisted through collaboration with the International Association for Child and Adolescent Psychiatry and Allied Professions and the World Psychiatric Association Global Presidential Programme on Child Mental Health.

Difficulty in obtaining data related to child and adolescent mental health services worldwide is symptomatic of the challenge facing those interested in promoting child mental health and providing for those needing services. Despite concerted efforts, meaningful information could be obtained from less than half of all countries in comparison to the ability to find substantial data for adult mental health services in all 192 countries that are Member States of WHO (Mental Health Atlas – 2005, WHO). The most important reason for the lack of information is simply the lack of any services in a large number of countries. There are other reasons for the difficulties encountered in collecting information for the present Atlas:

- 1 absence of an identifiable national focal point for child and adolescent mental health services;
- 2 fragmentation in the service systems responding to the needs of children with mental disorders;
- 3 lack of appropriate systems for data gathering.

Specific issues related to the assessment of child and adolescent mental health services include:

- 1 **Definition of the need for services.** Assessing impairment in children and adolescents is a complex task involving the need for culture specific tools, agreement on criteria for impairment, and the implications of disorders for a reduction in the ability to be productive.
- 2 **Identifying the full range of services that might be provided to an affected individual in different service sectors.** Child mental health needs are often inter-sectoral or present in systems other than the health or mental health arena. Children with mental health problems are often first seen and first treated in the education, social service or juvenile justice systems. Since a great many problems of youth are identified in the education sector these problems may or may not get recorded as mental health problems or needs. Thus, since services are often under the jurisdiction of ministries other than health it is difficult to collect and aggregate this disparate data and correlate it with individual or community need for services. Further, some programmes are targeted to specific problems and come under the sponsorship of non-governmental organizations which often deliver services independent of government oversight.

A key to the development of all mental health services, especially child and adolescent mental health services, is the development of a country or regional commitment to provide appropriate needed services. This commitment is demonstrated through policy, legislation, and governance.

An important stimulus for child mental health services in many parts of the world has been the United Nations Convention on the Rights of the Child. It is used in many countries to advocate for the promotion of services for children and their families. Specific provisions of the Convention support the removal of barriers to care including discrimination, and the avoidance of potentially harmful care. There are notable examples throughout the world where the Convention has aided in the reform of archaic forms of institutional care that provided little or no treatment. The movement to community based care and the development of systems of care is facilitated by the Convention. As was demonstrated in gathering data for the child and adolescent mental health ATLAS, there is substantial worldwide knowledge of the Convention and its provisions, but varying levels of response by national governments.

This volume does not rely solely on data gathered through the ATLAS questionnaire, but also includes references to other published data that might confirm or contradict and certainly supplement ATLAS findings. Two especially rich sources of information that we have used are by Levav et al (2004) and Shatkin and Belfer (2004). These studies have been cited for original sources in the text. Further, in some instances examples of noteworthy programmes are provided to illustrate the possibilities for services development in the context of the issues being discussed.

The primary purposes of this report are to stimulate additional data gathering in a systematic fashion and to encourage the development of needed child and adolescent mental health policy, services and training. We very much hope that this initial publication will serve these purposes.

Myron L. Belfer

Senior Adviser for Child and Adolescent Mental Health

Shekhar Saxena

Co-ordinator, Mental Health: Evidence and Research

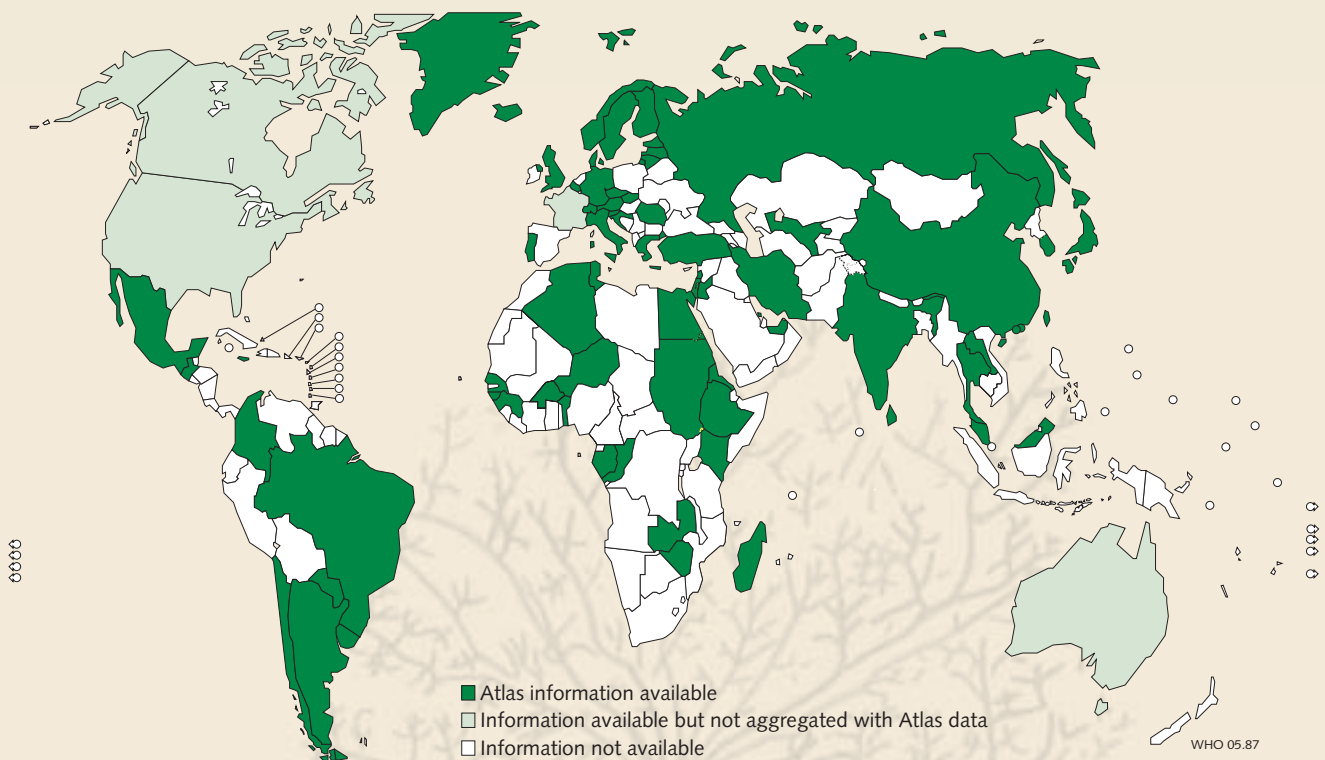


Methods and Limitations

The information gathered for the child and adolescent mental health resources ATLAS was collected through a survey instrument designed specifically to gain information on youth services, training activities, and provider resources in all regions of the world.

- ATLAS is not an epidemiological study and no attempt was made to determine the prevalence of disorders or problems, or to correlate services with specific diagnoses or treatments.
- Key informants were used to gather information rather than attempting to use any uniform or predefined source of data. This was done in an effort to obtain information from the individual(s) thought to be most informed about the available resources in their countries. Using key informants does create the potential of lack of uniformity and reliability; however, several strategies were used to minimize these. They included, using a glossary of terms, cross-checking the new information with already available information and supplementary questions and clarifications to the key informants.
- The information obtained was both quantitative and qualitative. The former has been used to compile aggregate numbers quoted in the text. The qualitative and descriptive information has been used in making additional observations in the text in order to enrich and contextualise the quantitative information.

Atlas: child and adolescent mental health resources



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Process

The Atlas questionnaire was developed by WHO in consultation with professional organizations and piloted in three countries. The final questionnaire and the accompanying glossary are given in Appendices III and IV respectively. The questionnaires were sent to selected key informants from all Member States of WHO. The list of key informants was developed based on information from multiple sources Appendix III.

- WHO child and adolescent mental health contacts within countries.
- WHO Regional Advisers for Mental Health
- The national societies belonging to the International Association for Child and Adolescent Psychiatry and Allied Professions.

The original English versions of the questionnaire and the glossary were translated into two other official WHO languages (French and Spanish). The most appropriate language versions were sent to the key informants. After two rounds of solicitation a third round was conducted in the context of the WPA Presidential Global Programme on Child Mental Health which elicited some additional responses.

Completed Atlas questionnaires were received from the following countries which are arranged by WHO Regions:

Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific
Algeria	Argentina	India	Austria	Bahrain	China
Benin	Brazil	Sri Lanka	Belgium	Egypt	China, Hong Kong SAR
Burkina Faso	Chile	Thailand	Croatia	Iran (Islamic Republic of)	Japan
Congo (the)	Columbia		Czech Republic (the)	Jordan	Republic of Korea (the)
Eritrea	Guatemala		Denmark	Lebanon	Lao People's Democratic Republic (the)
Ethiopia	Jamaica		Estonia	Sudan (the)	Malaysia
Gabon	Mexico		Finland	Tunisia	
Guinea	Paraguay		Germany	United Arab Emirates (the)	
Guinea-Bissau	Uruguay		Greece		
Kenya			Iceland		
Madagascar			Israel		
Niger (the)			Italy		
Senegal			Latvia		
Zambia			Lithuania		
Zimbabwe			Norway		
			Portugal		
			Romania		
			Russian Federation (the)		
			Slovakia		
			Slovenia		
			Sweden		
			Switzerland		
			Turkey		
			United Kingdom (the)		
			Uzbekistan		

It should be noted that the Australia, Canada, France and the United States of America are not identified as providing data for the Atlas. Considerable information is available in the literature (see References) from these countries on the resources for child and adolescent mental health; however, aggregate data at the national level could not be collated by WHO or by the potential key informants. The disproportionately large resource availability and the diversity that exists between large geographic areas within these countries also argued in favour of keeping information from these countries separate.

The numbers of countries that responded to the Atlas questionnaire are given below:

WHO region	Total number of countries*	Atlas questionnaire received from countries	Population of responding countries (percent)
Africa	46	15 (32.7%)	(34.4%)
Americas	35	9 (25.7%)	(46.8%)
South-East Asia	11	3 (27.3%)	(71.1%)
Europe	52	25 (48.1%)	(64.7%)
Eastern Mediterranean	21	8 (38.1%)	(38.5%)
Western Pacific	27	6 (22.2%)	(87.7%)

* A complete list of all countries within the WHO Regions is given in Appendix VI

Limitation

A limitation to the study was the use of key informants who were thought to be the most knowledgeable in their country but who might have come from differing perspectives.

For a few countries multiple responses were obtained. In these cases, the information provided was reviewed and the most internally consistent response was incorporated into the survey database.

Concern with the low response rate was discussed with WHO's network of experts in this area and others involved in this type of studies. WHO was advised that it is particularly difficult to obtain responses in the area of child and adolescent mental health due to the factors noted in the introduction. It was decided to publish the results, in spite of all the limitations of the information, because it was felt that publication and dissemination of the available information will act as a catalyst to draw attention to this area and will lead to better information in future.



Rights of the Child and Adolescent

The **Brazilian Child and Adolescent Rights Act** of 1990 mandates the means to facilitate the implementation of rights through the establishment of a Child Rights Council and a Guardianship Council in every municipality. The impact of the Convention was dramatic in its first effects bringing all children and not just those who violated the law into the framework of legislation recognizing them as citizens, with their own interests, who should be treated as agents in society and not as passive recipients of philanthropic actions. Councils can now be found throughout Brazil. While the distribution is wide the impact of the Councils and their functioning remains more obscure to many. In the future research may document the impact of the Councils on children's health and wellbeing.

(PAHO, ReVista, 2004)

Fundacion Paniamor in San Jose, Costa Rica, has the stated mission to oversee and assure the verification of children's human rights (to prevent the violation of children's human rights). The focus of the work of the NGO is on prevention including information sharing, education, training, lobbying and public campaigns. Outcomes that have been seen include: 1) an increased awareness and prevention of child maltreatment; 2) the promotion and participation in the development of new legislation to improve the situation of children and to protect their human rights; 3) reintegration of high risk adolescents into school and/or train them to be employable; 4) creation of the largest database on child welfare in Central America.

Herrera Amightetti, 2003

The United Nations Convention on the Rights of the Child and Adolescent (CRC) is the most universally endorsed and comprehensive human rights treaty of all time (Carlson, 2001). Mental health is addressed from a broad perspective ranging from emotional well-being to mental illness and disorder. The CRC is recognized in both developing and industrialized countries. Article 3 articulates the principle of "the best interest of the child" which has a wide-ranging impact and provides a rallying point for advocacy and programme development.

While there has been almost universal ratification of the UN Convention on the Rights of the Child, and the ATLAS responses acknowledge the Convention, there is no evidence to suggest a correlation between the Convention's ratification and the development of child and adolescent mental health services to support access to care and the elimination of discrimination.



States parties

- recognize that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance, and facilitate the child's active participation in the community (Article 23.1);
- agree that the education of the child shall be directed to: a. the development of the child's personality, talents and mental and physical abilities to their fullest potential (Article 29 1.a);
- shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim...re-integration shall take place in an environment which fosters the health, peer-respect and dignity of the child (Article 39)

UN Convention on the Rights of the Child 1990

Policy and Programmes

Without guidance for developing child and adolescent mental health policies and plans there is the danger that systems of care will be fragmented, ineffective, expensive and inaccessible. (WHO, 2005)

- A policy document refers to a specifically written document of the government containing the goals for mental health care for children and adolescents.
- In 2002 a systematic survey of the literature and use of key informants found only 7% of countries worldwide (14 of 191) had a clearly articulated specific (stand alone) child and adolescent mental health policy (Belfer and Shatkin, 2004).
- 35% of the countries in the African region have limited local child relevant mental health policy and few have a dedicated child and adolescent mental health policy (Shatkin and Belfer, 2004) whereas the percentage of children under the age of 19 represents 55.0% of the population (UNDP 2000).

The child and adolescent mental health ATLAS documented in more detail the presence of child and adolescent mental health policy at the regional, country and local level and found the following according to income level and region (See tables).

World Bank income category	National policy	Child and adolescent mental health programme
1 (low)	25.0%	0.0%
2	72.2%	61.1%
3	92.3%	46.2%
4 (high)	88.9%	77.8%

WHO region	National policy	Child and adolescent mental health programme	Number of responses
Africa	33.3%	6.3%	15
Americas	77.8%	44.5%	9
South-East Asia	50.0%	62.5%	8
Europe	95.8%	66.7%	25
Eastern Mediterranean	100.0% *	33.3%	3
Western Pacific	66.7 %	83.3%	6

- The Atlas data demonstrate that having child and adolescent mental health policy, of any type or at any level of government, does not mean that a country or region has an identifiable child and adolescent mental health services programme.
- The fact that a country has ratified the UN Convention on the Rights of the Child does not make it more likely that they have a national policy for the provision of child and adolescent mental health services.



- The countries with the highest proportion of children and adolescents in their populations are the countries most likely lacking in a child and adolescent mental health policy in any form. (ATLAS figures)
- The identification of an increased number of child and adolescent mental health policies in the ATLAS survey results from the inclusion of national policies often integrated into human rights, social welfare, child protection or education.
- While the WHO AFRO region lags other regions in the identification of national child mental health policy it has, at the same time, some of the most comprehensive, model child mental health policies of any region notably in South Africa and Mozambique.

Since 1990 **Lithuania** started to develop a model of community based services with the strategic goal to introduce modern public health approaches and create an alternative to the traditional system of residential institutions for children with different mental and developmental problems. The Ministry of Health established a University affiliated Child Development Centre in the first half of 1990's to pilot programmes in the fields of early intervention for infants at risk, child psychiatry (inpatient, day care, crisis intervention services), and a telephone helpline with trained volunteers to consult with children and adolescents. The next phase, which is still ongoing involves the replication of model services throughout the country. Currently there are over 30 outpatient early intervention teams for infants and preschool children in Lithuania. A team of professionals (social pediatrician, psychologist, speech therapist, social worker and physical therapist) is working at the community level in close contact with parents as partners to develop an individual plan of early intervention for infants with a developmental disability (mental retardation, cerebral palsy, autism, developmental problems) and to prepare these children for social integration in a school. There are currently over 80 child and adolescent psychiatrists in Lithuania (3.5 million inhabitants) who are working in outpatient municipal mental health centres and inpatient units. Parent's involvement and a wide range of psychosocial interventions delivered by a team of professionals have been introduced to restore a balanced bio-psychosocial approach after excessive reliance of the earlier system on medications and institutionalization. After the WHO Ministerial conference in Helsinki, January 2005, a decision was made by the Minister of Health that mental health should be recognized as priority in health policy, and child mental health is considered to be one of the main priorities in the new national mental health strategy. Currently gaps in the system of child mental health services are identified. Lithuania as a country in transition has high rates of mental health problems, such as suicides (also among adolescents and youth), bullying and other forms of violence, as well as high number of children living in state residential institutions. Recommendations have been drafted to emphasize child mental health promotion and prevention, training of parents at risk to be competent parents; development a component of mental health services for adolescents, and strengthening the process of deinstitutionalization in the revised implementation plan.

Dainius Puras, Lithuania

- From the prior survey of Shatkin and Belfer (2004), where identified policies were classified, it is of interest that there is a worldwide variability in the presence of national policies or plans that recognize the unique mental health and developmental needs of children. So, countries with a longer history of service development and resources, such as, the Czech Republic, Denmark, Ireland, the Netherlands, New Zealand, Portugal, Chile, and the United Kingdom are identified along with developing countries, such as, Ghana, Lithuania and South Africa as having the most substantially developed child and adolescent mental health policies.

Information Systems

The development of a child and adolescent mental health policy and appropriate programmes requires an understanding of the prevalence of mental health problems among children and adolescents. Existing resources and outcomes from programme initiatives also need to be documented.

- The absence of sound epidemiological data related to child and adolescent mental disorders in the developing world is well documented in the scientific literature, and is confirmed by the ATLAS survey. In high income countries 8 of 20 countries report some form of epidemiological survey data. Only 1 in 16 low income countries report the availability of such data and that country is in Europe.
- 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 countries.
- No systematic data gathering for the assessment of child and adolescent mental health services outcomes exists in any country of the world at the national level.
- Eight of 20 high income countries report a health services data monitoring system, but only 1 in 16 low income countries report such a system.
- In the EURO region, regardless of income level, 17 of 25 countries report a child mental health services data gathering system, but only 4 of 40 countries outside the EURO region report such a system regardless of income level.
- As illustrated in the following vignette, there may be a disconnect between conventional epidemiological data and the ability to assess needs for services. Information from both the sources needs to be available to get an accurate picture of the needs.

Whereas a community epidemiological study of children and adolescents in **Khayelitsha (South Africa)** found that DSM-defined depressive and anxiety disorders were the most prevalent (Robertson et al, 1999), these disorders are the reason for attendance of only a small proportion of the children seen at the community mental health centre established in the wake of the study. The common mental health needs presenting for care at the centre are sexual abuse, antisocial behaviour and the effects of HIV/AIDS.

Brian Robertson, WHO, 2003



Need for Services

The **Child and Adolescent Mental Health ATLAS** documents that countries with the higher proportion of children in the world are the ones that lack both mental health policy addressing the needs of children and adolescents and services for the population.

Currently available epidemiological data suggest a worldwide prevalence of child and adolescent mental disorders of approximately 20%. Of this 20% it is recognized that from 4 to 6% of children and adolescents are in need of a clinical intervention for an observed significant mental disorder. (WHR, 2001). (HIGHLIGHT) Kessler et al (2005) report that half of all lifetime cases of mental disorders start by age 14.

Nowhere in the world is the documented need for child and adolescent mental health services fully met.

In high income countries child and adolescent mental health service need is identified for between 5 and 20% of the population. This is comparable to the range of estimated service need in the lowest income countries.

Levav et al (2004) in a European survey of 36 countries (70.5% of all European countries) showed that the degree of coverage and quality of services for the young were generally worse in comparison with adults.

In high income countries the service gap, while substantially less than in low income countries is still very high.

European countries, particularly in the Scandinavian region and certain countries, such as Israel with highly developed mental health services approach 80% provision, but others among the high income countries report as low as 20% provision of services.

- The mental health Atlas – 2005 (WHO, 2005) showed that 23% of countries in Europe lacked specific programmes for child mental health.
- While a services gap exists in all countries in the Americas, 26% of countries lacked basic clinical mental health services for children and adolescents (Rohde, 2004).

The Child and Adolescent Mental Health ATLAS documents that countries with the higher proportion of children in the world are the ones that lack both mental health policy addressing the needs of children and adolescents and services for the population.

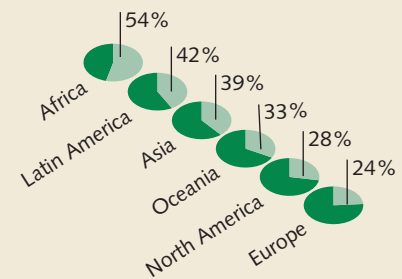
- In Africa and other countries with a high rate of HIV/AIDS deaths the population of young people will increase disproportionately in the coming years. (UNICEF, 2005) The number of AIDS orphans is currently estimated to be 14 million, and anticipated to rise to 20 million by 2010 (UNICEF).

Service System Gaps

The ATLAS highlights a need to focus on the development of the basic building blocks for service delivery, the need for integration and the improvement of quality and access where services do exist. Old systems that may violate basic human rights require change.

- In less than 1/3 of all countries it is possible to identify an institution or a governmental entity with clearly identifiable overall responsibility for child mental health programme in the country. It is typical that child and adolescent mental health services, not necessarily identified as such, are supported to varying degrees by ministries of education, social services and health with little or no coordination.
- 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. Community alternatives for care are rare in these countries.
- School-based consultation services for child mental health are not employed in either the developing or the developed world to the degree possible even though excellent "model programmes" have been implemented in some countries. This gap leads to a failure to reach children who otherwise might be helped to avoid many of the problems associated with school drop-out and other negative consequences due to mental health problems.
- In the European region only 17% of countries reported that there were sufficient numbers of school based services, and the presence of these programmes was almost exclusively in high income countries (Levav, 2004).
- Services focussed on specific disorders related to children were virtually non-existent from the data reported by Levav (2004) in the European region, but recent data reported from the Eastern Mediterranean region, the Americas and elsewhere report a trend toward the development of specialized services focussed on specific disorders, such as, Attention Deficit Hyperactivity Disorder and autism. The stimulus for disorder specific services can often be traced to parental advocacy, the dissemination of new knowledge, or the influence of the pharmaceutical industry.
- 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 need and this has further reduced access to whatever child and adolescent mental health services might have been available to low income populations.

0-9 Age-group by UN region, 2000



Integration of Services

In **Hangzhou City**, China with the rapid development of the economy, the mental health of the citizens is becoming a prominent public health concern and since 1998, mental health related activities on the official agenda. The Hangzhou “mental health work office” was set up to plan and manage mental health work in the whole city. Meanwhile, the municipal financial department has appropriated special funds for mental health. Through a three-year plan, Hangzhou has reformed the structure of urban mental health services in two ways.

Vertically, Hangzhou has established institutes for mental health work at three organizational levels: city, county (district) and town (street). A series of institutes, offices and health departments undertake the management and coordination of mental health work (implementing plans, monitoring programmes, and collecting data) within an administrative area. Horizontally, the Public Health Bureau of Hangzhou established mental health centres at appointed hospitals, and institutes for mental health consultation or mental health services. The Educational Committee has established a mental health tutoring centre for students, and schools at all levels established mental health tutoring and consulting institutes for students. Infants’ mental health tutoring centres were established in the kindergartens; the Youth League organized youth to carry out mental health training related to self-protection; and mental service stations were established to provide mental health services for officials, soldiers, and criminals in prison. All mental health services promote knowledge dissemination.

Linyan Su, WHO, 2003

There is good evidence to demonstrate that it is preferable to treat children and adolescents in the least restrictive environment as close to their communities as possible (Grimes, 2004). This principle requires that a range of services should be available to meet the needs of seriously emotionally disturbed children as outpatients, in partial care programmes and in hospital settings. In addition parents need the opportunity for respite and appropriate education must be provided. This has led to an understanding of the need to provide a “continuum” of services from outpatient, including possibly home-based services, to those in hospital inpatient settings.

- In only 7 of 66 countries were the elements of essential services identified that could be considered to represent the presence of a continuum of care.
- Public schools were identified almost universally as a primary site for the delivery of child and adolescent mental health services. Where the public sector did not provide the services it was indicated that the private sector provided such services. There was no identifiable pattern to this trend.
- In 18 of 66 countries there are designated child and adolescent mental health beds in pediatric hospitals. Pediatric hospitals that provide both primary care and mental health care are viewed as preferable to care in a mental institution for children and adolescents.
- There are no pediatric beds for mental health identified in low income countries. 50% of high income countries identify these hospital-based services.

- Thirty five of 66 countries identify specialized mental hospital beds for children and adolescents in some type of freestanding setting which might be considered an institution. In 18 of 66 countries an "institute" with child and adolescent mental health beds is identified.
- Contrary to popular belief it is reported that virtually no child and adolescent mental health beds are present in general hospitals or adult psychiatric facilities.
- Over 90% of all countries, regardless of the income level report the presence of an NGO related to child and adolescent mental health. The vast majority of these NGOs focus on advocacy and far fewer on treatment, prevention or policy development.
- The work of non-governmental organizations in the provision of care is reported to be rarely connected to ongoing country level programmes and often lacks sustainability because of the reliance on relatively short-term grants from donor agencies.



From Canela, Brazil, where an annual immunization campaign – “Babies’ Week” is also used to screen young children for developmental problems who are then followed up with home or clinic visits.

Most countries in **sub-Saharan Africa** fall into the low-income group. Of the 40 least wealthy countries in the world 32 are in Africa. Multi-sectoral provision of care is of critical importance in Africa and other developing regions where health ministries frequently do not provide dedicated systems of care. Only 40% of countries in Africa have special programmes in mental health for children.

Mental Health Atlas, 2005

There is a danger that formal and informal **systems of care** are seen as an either/or option, instead of complementary systems. Systems of care that are likely to be most successful are those where there is active coordination, collaboration, integration and mutual support between various state sectors, the private sector and the informal sector.

Robertson et al, 2004

Barriers to Care

Lack of transportation

While the needs of urban populations are obvious and deserving of focused attention, the plight of rural populations cannot be ignored. In fact, being able to diagnose and treat individuals in their local communities is not only appropriate, but will lessen the burden on urban centres and reduce the potential for urban “drift” of those marginalized in their communities.

Model

A mobile child mental health service in Marburg, Germany uses a team of three professionals (child psychiatrist, psychologist and social worker) who go through different towns and villages by car and hold consultation hours devoted to three tasks:

- Follow-up of patients who had been previously hospitalized;
- New child psychiatric consultations on site; and
- Supervision of institutions for children. Similar services have been developed in Thailand and elsewhere.

Remschmidt, WHO, 2003



Barriers to care for the mental health needs of children and adolescents exist in all countries and at all levels. Barriers identified as most important include transportation, limited financial resources, and stigma among others. Overcoming these barriers is essential for the delivery of services. Even when appropriate services exist barriers can keep children in need from being able to access appropriate services or following through for the required period of time.

In 2003, a WHO conference on Caring for Children with Mental Disorders identified the following barriers to care:

Lack of resources: Identified as a universal problem.

Stigma: Evident at all levels of society involving children and adolescents, families and treatment providers.

Lack of Transportation: A problem for rural populations, in particular, but also in urban settings.

Lack of Ability to Communicate Effectively in the Patient's Native Language: A challenge given the very limited opportunities for trained manpower in low and middle income countries.

Lack of Public Knowledge About Mental Disorders in Children and Adolescents: Knowledge of the advances being made in diagnosis and treatment are slow to reach communities, and sometimes distorted by special interests.

- Counter to prevailing belief, stigma is identified as a more significant barrier in high income countries (80.0 %) than in low income countries (37.5%), where transportation and lack of available treatment resources are identified as the most significant barriers to care. Overall stigma is identified as a barrier in 68.1% of countries.
- Few national programmes have been developed to highlight the mental health needs of children and these have been almost exclusively in developed countries.
- Public awareness of child mental health issues lags significantly behind other health related problems in all but the wealthiest countries.

Care Providers

Care providers are the crucial elements in mental health services for children and adolescents. The numbers and type of available providers are inadequate to develop and run needed services in all but a few high income countries.

- It is confirmed, as previously known, that child and adolescents psychiatrists are relatively rare outside developed countries and there are very few who are fully trained in the developing countries.
- A 1999 survey in the European region showed the presence of a child psychiatrist in countries to range from one per 5,300 to one per 51,800 (Remschmidt and van Engeland, 1999).
- In most countries of the African, the Eastern Mediterranean, Southeast Asian, and Western Pacific regions the presence of a child psychiatrist is in the range of 1 to 4 per million with a few notable exceptions.

On the **African continent**, only Algeria, South Africa and Tunisia have more than 1 psychiatrist per 100,000 population. And only Namibia and South Africa have more than 1 psychologist per 100,000 population (ATLAS, 2001). Of these only a few have formally trained child psychiatrists, and only South Africa has formal training programmes leading to a tertiary qualification in child and adolescent psychiatry.

Robertson et al., 2004

- While it could be assumed that other trained child mental health professionals exist in proportionately higher numbers this has been demonstrated not to be the case in many areas of the world with the exception of Europe (Levav, 2004) and the Americas. (HIGHLIGHT)
- 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.
- Professionals in the education or the special needs sector, such as, speech and language pathologists provide a high proportion of child and adolescent mental health services in developing countries. This is often not recognized. These professionals do not receive adequate training for mental health care that they need to provide in the absence of any alternatives.
- While speech therapists were identified as a major resource for the delivery of child mental health services only 31 of 66 countries reported that speech therapists received mental health training.
- 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 health and of career development opportunities.
- The Atlas finds that the development and use of "self-help" or "practical help" programmes, not dependent on trained professionals, in developing countries is reported far less frequently than would be expected. Indeed, self-help groups usually develop only after a certain level of professional services are already in existence.



Projects on the promotion of psychosocial development of rural school children.

Rural school children in classes one to nine were provided psychosocial stimulation through play, art and other activities, one hour a day, six days a week for five weeks. The intervention significantly enhanced attention, intelligence, creativity, language and arithmetic skills. Teachers were sensitized to child development, and child mental health and disabilities through five one-day workshops. They were trained to identify, refer and manage when possible, psychiatric problems. Other initiatives involved the education, health and social welfare sectors to develop better service delivery. Primary health care workers and anganawadi (community) workers received orientation programmes. Camp programmes for children with multiple disabilities were held.

Malavika Kapur, Bangalore, India.

Supported by the National Council of Rural Institutes, Department of Welfare of the Disabled, Karnataka and the National Institute of Mental Health and Neurosciences, Bangalore.

Training for Care



It is obvious from the ATLAS that the expectations for the training of individuals to deliver services whether in specialty areas or as part of primary care have not been realized.

- Despite a number of training programmes in the European region a lack of both specialized and in-training personnel were noted (Levav et al, 2004). The situation is far worse in the rest of the world.
- In all of the African continent outside of South Africa, fewer than 10 psychiatrists can be identified who are trained to work with children.
- In the African region outside of South Africa, no child and adolescent psychiatry training programmes were identified. In the Eastern Mediterranean region few programmes were identified and the training periods were short compared with accepted training standards in Europe or the Americas.
- In the Americas, in Europe and in selected countries throughout the world national or regional standards for training exist for child psychiatrists. However, training in child psychiatry for adult psychiatrists, paediatricians and general practitioners is highly variable and lacks standards for competence.
- The initiatives to train primary care providers to deliver child and adolescent mental health services or to recognize child and adolescent mental disorders lags significantly behind those for the provision of adult focused services.
- Counter to prevailing beliefs, in the majority of the responding countries, less than 10 per cent of child and adolescent mental health services are provided by primary care providers. This percentage is approximately the same in all regions of the world.
- While psychiatric nurses are identified as a resource throughout the world, specialization in nursing to work with children was identified in only 25 of 66 countries. In the majority of those countries less than 30% of the nurses were trained for work with children and adolescents and 12 of 66 countries identified 5% or fewer so trained.
- The gap in meeting child mental health training needs worldwide is staggering with between 1/2 and 2/3rds of all needs going unmet in most countries of the world, with significantly higher proportions of unmet need in low and middle income countries.
- The expectation that resource poor countries would implement training to utilize non-medical resources to provide mental health literacy to primary care physicians, psychologists and social workers is not demonstrated in the information obtained from countries.
- In many countries, particularly in Eastern Europe and parts of the Eastern Mediterranean, there are relatively adequate numbers of psychiatrists with training and/or experience for work with adults. This potential resource remains untapped for child and adolescent mental health care due to a lag in re-training or supplementary training. (Mental Health Atlas, 2005)

Child and Adolescent Psychiatry was established as a separate discipline in medicine in 1989 in Turkey. The discipline emerged with an increasing number of academicians, residents and fellows, and child and adolescent mental health subjects (both developmental and clinical) being included in the medical school curriculum. Currently, child and adolescent mental health courses in the first year of medical school cover psychosocial and cognitive development and introduction to developmental psychopathology. In the third year the students are introduced to some of the clinical syndromes and in the fifth year they spend two weeks in the Department of Child and Adolescent Psychiatry where both theoretical and practical classes are held on psychiatric evaluation of various age groups, clinical syndromes and their presentation at different developmental stages, and consultation-liaison issues. The Doctor – Patient Relationship Course of the medical curriculum is also prepared and run by the academic staff of this department in three levels.

Interns are given a course called 'Integrative Approach in Child and Adolescent Psychiatry' integrating medical, social, economic and political issues involved in primary care practice.

A standardized curriculum is prepared by the Child and Adolescent Mental Health Association, the official organization of child and adolescent psychiatrists in the country, in accordance with the requirements of the Union of the European Medical Specialists (UEMS). Specialization training is given over a period of 5 years including a year in adult psychiatry and six months in pediatric neurology.

The Child and Adolescent Mental Health Association of Turkey also organizes continuing medical education courses for all discipline professionals in the field and carries on postgraduate education programmes for teachers and counsellors, social workers and primary care physicians in collaboration with schools, Ministry of Health and Ministry of Education. Public education in this area is carried on mainly by the Child and Adolescent Mental Health Association in collaboration with various NGOs, radio and TV companies.

Füsun Çuhadaroğlu Çetin, M.D.

Professor, Hacettepe Faculty of Medicine Department of Child and Adolescent Psychiatry
President, The Child and Adolescent Mental Health Association of Turkey



Financing of Care

As part of movement toward privatization in developing countries **insurance schemes** are being put in place along with managed care. The introduction of insurance as a way to control costs and reduce government expenditures is difficult at best in societies accustomed to health care as an entitlement. The adoption of insurance schemes developed in the West need careful scrutiny for applicability in developing countries which have few resources and the potential to see great inequalities in care emerge. The absence of an infrastructure to support a well managed and financed insurance programme can lead to significant disruptions, the flight of professionals and the inadvertent denial of care to some of the most needy. An exception to the negative view is the report from South Korea that in implementing a new mental health plan they have realized a 30% supplement for child mental health care!

Hong, WHO, 2003

Faced with the evidence for the need for child and adolescent mental health services, there has been a universal failure to provide the needed financial resources. Too often there continues to be a reliance on "soft money" to support child services and rarely are demonstration services brought to scale.

A key factor is the lack of political will (Richmond, 1983) brought about by the fact that children do not vote and that the outcome from child programmes are often not evident in the usual political life cycle.

- Child and adolescent mental health services funding is rarely identifiable in country budgets and in low income countries services are most often "paid out of pocket" identified as "private" financing. Out of pocket expenditures for child mental health services, where identifiable, are 71.4% in African countries versus 12.5% in Europe.

Principle mode for financing child and adolescent mental health services:

World Bank Income Category	Consumer/ Family	Tax-based/ government	International Grants	NGO	Other
High	0/20	2/20	10/20	4/20	1/20
Low	6/16	1/16	2/16	0	1/16

- The table indicates that child and adolescent mental health services are largely funded by temporary and vulnerable sources rather than by more stable government funding in both high and low income countries. It is remarkable that international grants play such a significant role in funding services in high income countries where there might be the expectation of government funding as a dominant source for services support.
- None of the low income countries that reported has social insurance – insurance provided by governments for its neediest citizens to access health care and other rehabilitative services – as a method of funding child and adolescent mental health services, whereas 21.0% of middle and high income countries support services by these means.
- 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.

Availability and Use of Medication

In an era when there is great enthusiasm for better understanding of the biological underpinnings of mental disorders and use of medications for treatment, it must be remembered that the goal for the care of children and adolescents is to provide rational treatment. Treatment must be based on the provision of an appropriate, comprehensive diagnostic evaluation and the utilization of therapies that have been demonstrated to have a positive affect and that do no harm.

- In more than 70% of the countries surveyed there is no essential drug list for child psychotropic medication. The Model List of Essential Drugs, first published by WHO in 1977 and regularly updated contains a list of medications for the safe and effective treatment for the majority of communicable and non-communicable diseases.
- Rarely is there any indication of a national system for the control of the prescription of psychotropic medications for children and adolescents.
- Although worldwide there is a great interest in Attention Deficit Hyperactivity Disorder, in 45% of countries psycho-stimulants are either prohibited or otherwise unavailable for use. (This version of the Atlas did not distinguish this difference).
- In 8 of 20 high income countries and 3 of 16 low income countries medication is available without cost to the family. 31 of 66 countries provide some form of subsidy for medication. No regional differences appear significant. Newer classes of medication are generally either not available or too expensive in low income countries.

Although there is still a debate over the appropriateness of using **medication in the treatment** of children and adolescents with mental disorders, the benefit of the rational use of this approach cannot be denied in the case of some specific mental disorders. It must be stressed that the vast majority of psychopharmacological treatments remains “off label” or without official sanction. The use should be governed by the regulations of individual countries and international sanctioning bodies. This acquires special relevance when considering the transfer of technology and training of primary health care personnel.

WHO, 2003



The Future

The WPA Presidential Global Programme on Child Mental Health carried out in collaboration with the WHO and IACAPAP is an unprecedented worldwide activity which addresses three key elements in furthering the development of child and adolescent mental health services: awareness (anti-stigma), intervention (treatments) and prevention. The manuals and background papers prepared under this initiative will provide a global framework for advancing child and adolescent mental health.

www.wpa-cairo2005.com

The International Association for Child and Adolescent Psychiatry and Allied Professions is the umbrella organization for over 60 national societies of child and adolescent psychiatrists and allied professions. IACAPAP fosters education and training, advocacy, and communication regarding child and adolescent mental disorders. National organizations represent resources for information and programme development. IACAPAP is a NGO in official relations with WHO.

www.iacapap.org

Child and adolescent mental health is receiving heightened attention due to increasing awareness of unfortunate consequences of poor mental health among youth and the advances being made in diagnosis and treatment of these disorders. Demands from families and communities for appropriate services are also being heard increasingly.

In addition to the demands posed by the expected prevalence of mental health disorders and problems of children and adolescents, there are unprecedented needs and challenges as the world faces the enormous impact of HIV/AIDS on future generations of orphaned children (UNICEF, 2003), and the consequences of massive displacements of children due to conflicts and war.

The Child and Adolescent Mental Health ATLAS provides some initial information to direct attention to gaps in care that can and should be addressed to improve the state of child and adolescent mental health services. Notably the ATLAS identifies the clear and urgent need for:

- **Enhanced Information:** Enhanced systematic information gathering is an essential component of planning. Countries need to generate essential information on child and adolescent mental health problems and disorders and the resources available to provide care. Implementation of WHO's Assessment Instrument for Mental Health Systems (WHO-AIMS) (WHO, 2005) can assist this process. New initiatives can be tailored to demonstrated needs and indicators of success identified at the outset. WHO child and adolescent mental health related documents are listed in Appendix V.
- **Policy:** The gap in policy noted in so many countries can be addressed by ministers of health and other interested parties with the new *WHO Child and Adolescent Mental Health Policies and Plans Manual* which provides a detailed guide to developing policy and establishing appropriate governance.
- **Training:** It is evident that there are gaps in training. Guidance for the development of training is available and needs wider dissemination. Of even more significance is the demonstrated failure to make use of potential resources. ATLAS has shown that primary care providers, educators and others are not trained to the degree that they should be in child and adolescent mental health. Training for these professionals would greatly enhance resources and allow for the desired goals of early identification and intervention.
- **Financing:** The need for sustained and sustainable financing of services is evident from the data. It is not possible to build lasting systems of care with grants or out of pocket payment from clients. Non-governmental organization support is important, but too often it fails to support the development of a sustainable service or provider base. Where funding exists from governmental sources there is a universal absence of parity between adult and child mental health service and training support. Lastly, child and adolescent mental health services are by their nature inter-sectoral and collaboration with other sectors is critical for effective service delivery.

Systems of care for children and adolescents can be enhanced in the coming years with attention to the issues raised by the data gathered from the ATLAS project. Atlas can also assist in monitoring progress made over the coming years.

Initiatives of particular note for advancing the cause of child and adolescent mental health are coming from a number of health, mental health and education sectors in countries around the world. Non-governmental organizations and professional initiatives are also taking up the challenge. Among these are organizations that contributed to the child ATLAS (WPA Global Programme and IACAPAP) and many others throughout the world.



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Atlas publications

ATLAS: Mental Health Resources in the World 2001, Order no. 1930191

ATLAS: Country Profiles on Mental Health Resources 2001, Order no. 1930192

ATLAS: Country Resources for Neurological Disorders 2004, Order no. 11500609

ATLAS: Mental Health Atlas-2005, Order no. 11500632

ATLAS: Epilepsy (*in preparation*)

ATLAS: Intellectual Disabilities (*in preparation*)

ATLAS: Psychiatric Training (WPA and WHO) (*in preparation*)

ATLAS: Role of Nurses in Mental Health Care (WHO & ICN) (*in preparation*)

ATLAS: Substance Abuse (*in preparation*)



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China, Hong Kong SAR	Tang Chun Pan
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Croatia	Vlasta Rudan, Ivan Begovac
Czech Republic (the)	Ivana Drtilkova
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United Arab Emirates (the)	V. Eapen
United Kingdom (the)	Sue Bailey
Uruguay	Gabriela Garrido Candela, Miguel Cherro Agurre
Zambia	Petronella Mayeya

Atlas Questionnaire

Project ATLAS – child & adolescent version: Country Resources for Child & Adolescent Mental Health

World Health Organization, Department of Mental Health and Substance Abuse

Name of Country: _____

Date of Form Completion: Month _____ Year _____

Contact Details of Person Responsible for Answering Questionnaire:

Name: _____

Title/ Position: _____

Mailing Address: _____

Telephone: _____ Fax: _____

E-mail: _____

Please provide your best estimate to questions for which official data is unavailable.

1. Demographics

1.1 What is the country's total population? _____

1.1.1 As of which year? _____

1.2 In this same year, how many people were less than 18 years old? _____

1.2.1 What percentage of these *needed* mental health services? _____ %

1.2.2 What percentage of these *received* mental health services? _____ %

2. Child and Adolescent Mental Health Policy and Legislation

2.1. Is child & adolescent mental health addressed in any official national policy?

No – Please go to question 2.2.

Yes* – In which type of policy is it addressed? Check all that apply:

Health Human Rights Child Protection

Mental Health Social Welfare Other: _____

**Please enclose a photocopy of the relevant policy section(s).*

2.2. Does any official national policy acknowledge the rights of children and adolescents?

No – Please go to question 2.3.

Yes – Which rights does it acknowledge?

2.3. Does any law specifically strive to protect children & adolescents in terms of:

2.3.1. Abuse or exploitation by adults Yes No

2.3.2. Confidentiality of health care services and records Yes No

2.3.3. Informed consent (direct or via primary caregiver) Yes No

2.3.4. Other: _____ Yes No

2.4. Comments: _____

3. Child and Adolescent Mental Health Financing

3.1. How are child and adolescent mental health services *mainly* funded? Choose only one of:

Consumer/ Patient/ Family

Private insurance

Tax-based Government Funding

Social insurance

International Grants

Other: _____

Non-Governmental Organization: _____

3.2. What percentage of total child and adolescent mental health funding does this primary source of funding represent?

100% 66% 33% 0%

75% 50% 25% Other: _____%

3.3. Are there other sources of funding for child and adolescent mental health services?

No – Please go to question 3.4.

Yes – Please list the top three other sources: *

1. _____ %

2. _____ %

3. _____ %

* Please note total % adding 3.2 and 3.3 should not exceed 100%

3.4. What role, if any, does the source of funding play in determining which child and adolescent mental health services are provided?

3.5. What subsidized or free government benefits are provided to a family who has a child or adolescent with a mental illness? Please indicate amounts (in local currency), where applicable.

No benefits are provided – Please go to question 3.6.

Disability Pension (_____ /month)

Institutional Care

Specialized Education Programmes

Parental Training or Education

Respite/ Practical Help for Caregiver

Stipend (_____ /month)

Medical (including Psychiatric) Care

Other: _____

3.6. Comments: _____

4. Child and Adolescent Mental Health Services

4.1. Does the country have a *child and adolescent* mental health programme?

No – Please go to question 4.2.

Yes

National?

Regional/Provincial/State?

What are the components of this programme (s)?

4.1.1. Regulations on type of care provided Yes No

4.1.2. Regulations on competency of care providers Yes No

4.1.3. Guidelines regarding access to services Yes No

4.1.4. Public education(raising awareness of issues) Yes No

4.1.5. Other: _____ Yes No

4.2. What barriers exist to the provision of *child and adolescent* mental health services? Check all that apply, and circle the most significant barrier:

Transportation

Financial (for government)

Stigma of mental illness

Religious/ spiritual beliefs

Lack of trained treatment providers

Financial (for families)

Lack of mental health awareness

Other: _____

4.3. Is there a child welfare or child protection system?

No – Please go to question 4.4.

Yes – Does this system have access to child and adolescent mental health services?

Yes

No

4.4. Is there a juvenile justice system for delinquent children and adolescents?

No – Please go to question 4.5.

Yes – Does this system have access to child and adolescent mental health services?

Yes

No

4.5. What percentage of all child and adolescent mental health services are provided in: (*Total should equal 100%*)

4.5.1. Public-sector _____ %

4.5.2. Private-sector _____ %

4.5.3. Joint public-private sector ventures _____ %

4.6. What percentage of all child and adolescent mental health services are provided by: (*Total should equal 100%*)

4.6.1. Primary care physician _____ %

- 4.6.2. Primary health care worker (non-physician) _____ %
- 4.6.3. Psychiatrist (general or child & adolescent) _____ %
- 4.6.4. Pediatrician _____ %
- 4.6.5. Other: _____ %
- 4.7. Are there specialized educational services available for children and adolescents with:
- 4.7.1. Behavioural problems Yes No
- 4.7.2. Learning disabilities Yes No
- 4.7.3. Speech and language delay Yes No
- 4.7.4. Social skills problems Yes No
- 4.7.5. Mental retardation Yes No
- 4.7.6. Other: _____ Yes No
- 4.8. What percentage of these specialized educational services are within:
(Total should equal 100%)
- 4.8.1. Public-sector schools _____ %
- 4.8.2. Private-sector schools _____ %
- 4.8.3. Other public-sector agencies _____ %
- 4.8.4. Other private-sector agencies _____ %
- 4.8.5. Other locations: _____ %
- 4.9. Is there a system of providing community-based *outpatient* care for mental ill *children and adolescents*?
- 4.9.1. Outpatient departments in hospitals Yes No
- 4.9.2. Private offices of specialists Yes No
- 4.9.3. Public health/ primary care clinics Yes No
- 4.9.4. Mobile (Outreach) outpatient services Yes No
- 4.9.5. Day patient programmes Yes* No
*Country-wide maximum capacity: _____ children
- 4.9.6. Group homes Yes* No
*Country-wide maximum capacity: _____ children
- 4.9.7. Foster care placements Yes* No
*Country-wide maximum capacity: _____ children
- 4.9.8. Respite care placements Yes* No
*Country-wide maximum capacity: _____ children
- 4.9.9. Other: Yes* No
*Country-wide maximum capacity: _____ children
- 4.10. Is there a system of providing *inpatient* mental health care for mentally ill *children and adolescents*? Please indicate total number of beds countrywide.

4.10.1. General Hospitals

 No Yes: Total beds allocated to *children/adolescents*: _____Total beds allocated to *mentally ill children/ adolescents*: _____

4.10.2. Pediatric Hospitals

 No Yes: Total beds: _____Total beds allocated to *mentally-ill*: _____

4.10.3. Mental Hospitals

 No Yes: Total beds allocated to *children/adolescents*: _____4.10.4. Specialized Inpatient Psychiatric Institution (defined) for *children and adolescents with mental disorders* No Yes: Total number of beds: _____ Average length of stay: _____

Type: _____

4.11. If initial attempts at providing mental health care (inpatient or outpatient) are insufficient, is there access to specialist consultation? Check all that apply.

 No – *Please go to question 4.13.* Yes, but only if family is easily able to pay for it themselves Yes, but only if family lives in an urban centre Yes, with equal access regardless of financial situation Yes, with equal access regardless of geographical location

4.12. What is the average time from a referral to a specialist visit?

4.12.1. Referral to a General Psychiatrist _____

4.12.2. Referral to a Child and Adolescent Psychiatrist _____

4.12.3. Referral to a Pediatrician (for a mental health problem) _____

4.13. What is the average travel time a referred family must endure in order to visit a specialist?

_____ hours (or) _____ days

4.14. Is there a publication or reference that tells about child and adolescent mental health services in your country?

Please give the reference and/or attach a copy of the publication(s) _____

4.15. Comments: _____

5. Child and Adolescent Mental Health: Human Resources

5.1. How many *psychiatrists* practice child and adolescent psychiatry? _____

5.1.1. What percentage of these psychiatrists has received *specialized* training in *child and adolescent psychiatry*?
_____ %

5.1.2. Do you have an in-country child and adolescent psychiatry training programme?

Yes No How many? _____

5.1.3. What is the duration of the training programme? _____

5.1.4. Does the programme lead to a certificate of specialization? Yes No

5.2. How many *pediatricians* see patients who have *mental health*-related problems? _____

5.2.1. What percentage of these pediatricians has received *specialized* training in *child and adolescent psychiatry*?
_____ %

5.3. Which other professionals work with *children and adolescents* who have *mental health*-related problems?
Please check all that apply, and estimate the percentage for each profession.

5.3.1. Psychiatric nurses Yes _____ % No

5.3.2. Psychologists Yes _____ % No

5.3.3. Social workers Yes _____ % No

5.3.4. Speech and language therapists Yes _____ % No

5.3.5. Other: _____ Yes _____ % No

5.4. Is there a child & adolescent mental health training module incorporated into the education of all *in-country* trained:

5.4.1. Psychiatrists Yes No None trained

5.4.2. Pediatricians Yes No None trained

5.4.3. Primary care physicians Yes No None trained

5.4.4. Nurses Yes No None trained

5.4.5. Health care workers Yes No None trained

5.4.6. Psychologists Yes No None trained

5.4.7. Social workers Yes No None trained

5.4.8. Speech and Language Therapists Yes No None trained

5.4.9. Teachers Yes No None trained

5.4.10. Other: _____ Yes No None trained

5.5. Comments: _____

6. Non-Governmental Organizations (NGOs)

6.1. With which child & adolescent mental health activities have NGOs been involved? Check all that apply.

- None – Please go to question 7.
- | | |
|---|--|
| <input type="checkbox"/> Advocacy | <input type="checkbox"/> Treatment/ "Field Work" |
| <input type="checkbox"/> Promotion | <input type="checkbox"/> Rehabilitation |
| <input type="checkbox"/> Policy and systems development | <input type="checkbox"/> Prevention |
| <input type="checkbox"/> Training | <input type="checkbox"/> Other: _____ |

6.2. Please list two of these NGOs:

NGO-1: _____ NGO-2: _____

6.3. Have NGOs collaborated with your country regarding their child and adolescent mental health programme development?

- Yes Partially No

6.4. Have NGOs linked their efforts with existing child and adolescent mental health services?

- Yes Partially No

6.5. Have NGOs ensured programme maintenance/ continuity even after they withdraw from your country?

- Yes Partially No

6.6. Are NGO-sponsored child and adolescent mental health programmes accepted by the communities they were meant to serve?

- Yes Some programmes Some communities No

6.7. Comments: _____

7. World Health Organization (WHO)

7.1. Has WHO (directly or through its regional or country office) provided any assistance in the development and/ or maintenance of child and adolescent mental health services?

- No – Please go to question 8.
 Yes – What type of assistance has it provided?

7.1.1. External consultants Yes No

7.1.2. Research Yes No

7.1.3. Clinical Training Yes No

7.1.4. Other: _____ Yes No

7.2. Has WHO collaborated with your country regarding its child and adolescent mental health programme development?

- Yes Partially No

7.3. Has WHO linked its efforts with existing child and adolescent mental health services?

- Yes Partially No

7.4. Has WHO ensured programme maintenance/ continuity even after it withdraws from your country?

Yes Partially No

7.5. Are WHO-sponsored child and adolescent mental health programmes accepted by the communities they were meant to serve?

Yes Some programmes Some communities No

7.6. Comments: _____

8. Data Collection and Quality Assurance

8.1. Are *child and adolescent* mental health disorders included your country's Annual Health Reporting system?

Yes No

8.2. Is there any *epidemiological* data collection system for *child and adolescent* mental health disorders?

Yes No

8.3. Is there any *service* data collection system for *child and adolescent* mental health disorders?

No – Please go to question 8.4.

Yes – Is there monitoring of service outcomes?

Yes No

8.4. Are there national minimal standards of care expected from professionals working in child and adolescent mental health?

No – Please go to question 9.

Yes – How are standards maintained? Check all that apply.

Professional certification and maintenance of competency

In-service training

Clinical supervision of workers

Usage of clinical practice guidelines

Other: _____

8.5. Comments: _____

9. Care for Special Populations

9.1. Which subgroups of *children and adolescents* have access to specially designated mental health services, tailored to the subgroup's unique needs?

None – Please go to question 10.

Minority groups

Indigenous people

Orphans

Runaways/homeless

Refugees

Disaster-affected populations

"Seriously emotionally disturbed"

Other: _____

9.2. Comments: _____

10. Medications and Other Treatment Modalities

10.1. Is there a national Essential Drug List of medications for *children and adolescents*? Yes No

10.2. Are there specific provisions made to control prescribing practices of medications used for *children and adolescents*?

No – Please go to question 10.3.

Yes – What are these provisions? Check all that apply:

Narcotics Control Board

Level of training required

Prescription auditing/ reviews

Other: _____

10.3. Which of the following pharmaceutical drug categories are available to the primary health care system for use in *children and adolescents*? Check all that apply; answer the additional questions where applicable.

Psychostimulants

Are they consistently available? Yes No

Generic name of most prescribed: _____

What is it mainly used for? _____

Tricyclic antidepressants

Are they consistently available? Yes No

Generic name of most prescribed: _____

What is it mainly used for? _____

MAOIs

Are they consistently available? Yes No

Generic name of most prescribed: _____

What is it mainly used for? _____

Selective serotonin reuptake inhibitors (SSRIs)

Are they consistently available? Yes No

Generic name of most prescribed: _____

What is it mainly used for? _____

Other newer antidepressants

Are they consistently available? Yes No

Generic name of most prescribed: _____

What is it mainly used for? _____

Antipsychotics

Are they consistently available? Yes No

Generic name of most prescribed: _____

What is it mainly used for? _____

Mood stabilizers

Are they consistently available? Yes No

Generic name of most prescribed: _____

What is it mainly used for? _____

Antiepileptics

Are they consistently available? Yes No

Generic name of most prescribed: _____

What is it mainly used for? _____

Anxiolytics/sedatives

Are they consistently available? Yes No

Generic name of most prescribed: _____

What is it mainly used for? _____

Adrenergic agents (such as propranolol or clonidine)

Are they consistently available? Yes No

Generic name of most prescribed: _____

What is it mainly used for? _____

10.4. What is the price of these medications for the patient? Check all that apply.

Free of cost

Subsidized prices, equal amount of subsidy for all patients

Subsidized prices, sliding scale of subsidy based on family finances

Subsidized prices, based on other:

Market prices

10.5. What other treatment methods are routinely used in *child and adolescent* mental health care? Check all that apply.

Herbal medicines

Traditional medicines

Naturopathic medicines

Spiritual guidance

Behavioural modification training

Social skills training

Learning assistance/educational supports

Parental training

Childcare worker/home supports

Foster care placement

Speech/language training

Counselling/Advice

Psychotherapies

Other: _____

10.6. Comments: _____

Please return completed questionnaires and policy photocopies (if indicated) at your earliest convenience to:

Dr. Myron Belfer
Department of Mental Health and Substance Dependence
World Health Organization
20 Avenue Appia
CH-1211, Geneva
27, Switzerland
Tel. (41 22) 791 26 12
Fax. (41 22) 791 41 60
E-Mail: belferm@who.int

Thank you for your assistance!



Atlas Glossary

For use in the context of the Phase One Questionnaire on Country Resources for Child and Adolescent Mental Health

Definition of mental health

Mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

Achieving mental health and maintaining it consists of two functions. One is about preventing and treating mental disorders, and the other is about fostering or promoting mental health and wellbeing. The WHO definition of health implies that mental health cannot be achieved merely by preventing and treating disorders. It must address the broader issues affecting the mental wellbeing of all sectors of society.

For the purpose of the present questionnaire, mental disorders includes mental and neurological disorders, and mental retardation.

Mental health policy

A National mental health policy refers to a specifically written document of the government or Ministry of Health containing the goals for improving the mental health situation of the country, the priorities among those goals, and the main directions for attaining them.

Child and adolescent mental health policy

Refers to an easily identifiable section of a country's overall mental health policy or a freestanding child and adolescent mental health policy document.

Substance abuse policy

Document(s) of the government or Ministry of Health containing goals Prevention and treatment activities related to the use, abuse and dependence of alcohol, prescription and non-prescription including illicit drugs.

National mental health programme

A national mental health programme consists of a national plan of action and includes the broad and specific lines of action required in all sectors involved to give effect to the policy. It describes and organizes a set of actions aimed at the achievement of the objectives. It indicates what has to be done, who has to do it, during what time frame and with what resources.

Mental health legislation

Mental health legislation dealing with legal provisions for the protection of the basic human and civil rights of people with mental illness (including those concerned with the restraint and protection of individual patients, regulation of compulsory admission, discharge procedures, appeals, protection of property etc), and those promoting or prescribing facilities, personnel, professional training, and service structures.

Financing and budget

Budget line

The regular source of money available and allocated for actions directed towards the achievement of mental health objectives.

Out-of-pocket payments

Payment made by the consumer or his family as the need arises.

Tax based funding

Money for mental health services is raised by taxation, either through general taxation, or through taxes that are earmarked specifically for mental health services.

Social insurance

Everyone above a certain level of income is required to pay a fixed percentage of his or her income to a government-administered health insurance fund. In return, the government pays for part or all of consumers' mental health services, should it be needed.

Private insurance

The health care consumer voluntarily pays a premium to a private insurance company. In return, the insurance company pays for part or all of the consumer's mental health services, should it be needed.

Public disability benefits

Benefits that are payable, as part of legal right, from public funds in cases of mental illness which reduces the person's capacity to function.

Mental health services

Primary health care

Refers to the provision of basic preventive and curative mental health care at the first point of entry into the health system. Usually this means that care is provided by a non-specialist who can refer complex cases to a higher level.

Community based care

Any type of care, supervision and rehabilitation of mental patients outside the hospital by health and social workers based in the community.

Psychiatric beds

A psychiatric bed is one maintained for continuous (24 hours) use by mentally ill in-patients. The facilities in which such beds are located include public and private psychiatric hospitals, general hospitals and hospitals for special groups such as the elderly and children.

Institution

A facility that may be managed by or sponsored by a social service agency or governmental agency that cares for children who may have mental disorders in addition to their primary reason for being in the institution. These facilities may take care of orphaned or abandoned children, or juvenile delinquents.

Human resources

Child and Adolescent Psychiatrists

Refers to psychiatrists who have completed a recognized training programme in child and adolescent psychiatry as a specialty. The recognized specialty training usually is the equivalent of two full years, but in some instances full training may be considered as the result of a shorter training period.

Psychiatrists

A psychiatrist is a medical doctor who has at least two years of postgraduate training in psychiatry in a recognized teaching institution.

Neurologists

A neurologist is a medical doctor who has at least two years of postgraduate training in neurology in a recognized teaching institution.

Neurosurgeons

A neurosurgeon is a medical doctor who has at least two years of postgraduate training in neurosurgery in a recognized teaching institution.

Psychologists

A psychologist is a graduate from a recognized school of psychology at university level with specialization in psychology, registered at the local Board (or equivalent) of Psychologists and working in a mental health setting.

Psychiatric nurses

A registered psychiatric nurse is a graduate from a recognized Nursing School at university level with specialization in psychiatric nursing and registered at the local Board (or equivalent) of Nursing and working in a mental health setting.

Social workers

A certified social worker is a graduate from a recognized School of Social Work at university level, registered at the local Board (or equivalent) of Social Workers and working in a mental health setting.

Non-governmental organizations (NGOs)

Non-governmental organizations include voluntary organizations, charitable groups, and service user or advocacy groups and professional associations that are involved in various mental health activities.

Advocacy

Refers to a combination of individual and social actions designed raise awareness and to gain political commitment, policy support, social acceptance and health systems support for mental health goals.

Modalities

Promotion

Is a process of enabling people to increase control over the determinants of their mental wellbeing and to improve it.

Prevention

Prevention is a term that refers to all organized activities in the community to prevent occurrence as well as the progression of mental disorders. It also means the timely application of means to promote the mental wellbeing of individuals and of the community as a whole, including the provision of information and education.

Treatment

Includes relevant clinical and non-clinical care aimed at reducing the impact of mental disorders and improving the quality of life of patients.

Rehabilitation

Care given to mentally ill patients in the form of knowledge and skills to help them achieve their optimum level of social and psychological functioning.

Information/Data collection system

An organized information gathering system for service activity data. Usually incorporates admission/discharge rates, outpatient contacts, community contacts, incidence and prevalence rates. Can also include patients at risk and patients subject to mental health legislation.

Annual reporting system

Preparation of annual health reports related to all health services functions and use of allocated funds.

Special groups

Programmes that address the mental health concerns, including the social integration, of the most vulnerable and disorder-prone groups of population such as refugees, disaster affected, indigenous people and minorities. It also refers to populations needing special care such as the elderly and children.

Therapeutic drugs

National drug policy

A national drug policy is a written commitment endorsed by the Minister of Health or the Cabinet for ensuring accessibility and availability of essential therapeutic drugs. It contains measures for regulating the selection, purchase, procurement, distribution and use of essential and appropriate drugs including those for mental and neurological disorders. It can also specify the number and types of drugs to be made available to health workers at each level of the health service according to the functions of the workers and the priority conditions they are required to handle. Under the national policy, drugs may be supplied free of charge to all or selected groups.

Essential drugs list

The officially approved list of essential drugs that the country has adopted. It is usually adapted from the WHO Essential list of Essential Drugs. The official WHO list is of limited use in identifying psychotropic medications for use with children and adolescents and therefore the related questions refer to country specific lists.

Psychopharmacologic drugs for children and adolescents

Refers to medications specifically used for the treatment of disorders in children. It is recognized that few medications are approved specifically for use in children and adolescents by approval bodies and that most medication use is "off label" or based on "community standards of practice."

WHO Documents Related to Child and Adolescent Mental Health

Mental Health and Psychosocial Care for Children Affected by Natural Disasters. Department of Mental Health and Substance Abuse. Geneva, World Health Organization. 2005. (Web access www.who.int/mental_health)

Child and adolescent mental health policies and plans. Department of Mental Health and Substance Abuse. Geneva, World Health Organization, 2005.

Caring for Children and Adolescents with Mental Disorders: Setting WHO Directions. Department of Mental Health and Substance Abuse. Geneva, World Health Organization, 2003.

Mental Health in Emergencies: Mental and Social Aspects of Health of Populations Exposed to Extreme Stressors. Department of Mental Health and Substance Abuse. Geneva, World Health Organization, 2003.

Prevention and Promotion in Mental Health. Department of Mental Health and Substance Abuse. Geneva, World Health Organization, 2002.

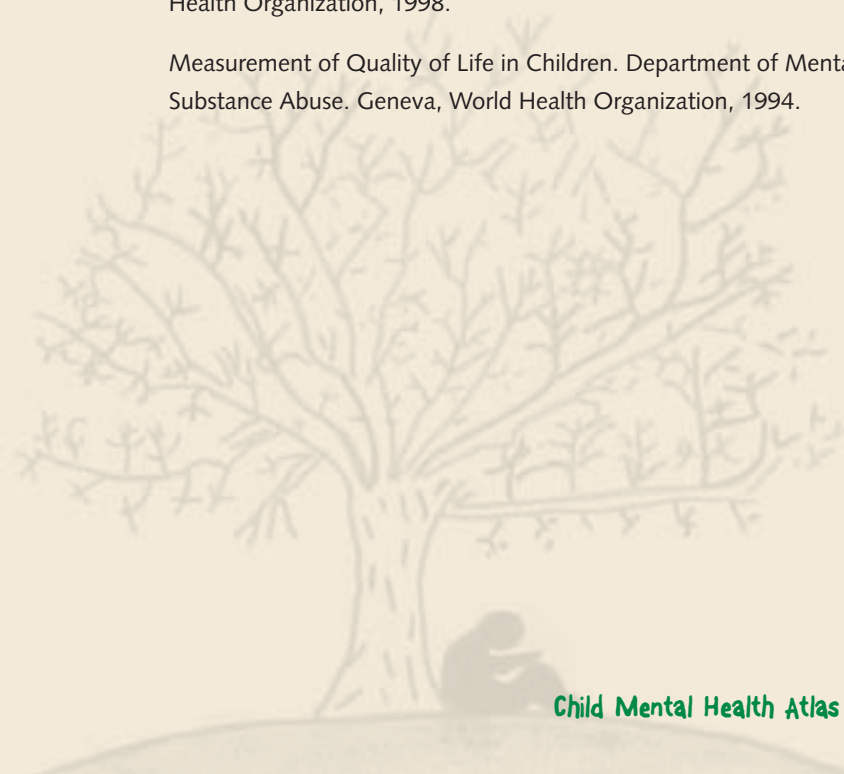
Through Children's Eyes: A collection of drawings and stories from the WHO Global School Contest on Mental Health. Department of Mental Health and Substance Abuse. Geneva, World Health Organization, 2001.

Behavioural Factors in Immunization. Department of Mental Health and Substance Abuse. Geneva, World Health Organization, 2000.

Partners in Life Skills Education. Department of Mental Health and Substance Abuse. Geneva, World Health Organization, 1999.

Improving Mother/child Interaction to Promote Better Psychosocial Development in Children. Department of Mental Health and Substance Abuse, Geneva, World Health Organization, 1998.

Measurement of Quality of Life in Children. Department of Mental Health and Substance Abuse. Geneva, World Health Organization, 1994.



World Health Organization Regions

WHO African Region (AFRO)

Algeria
 Angola
 Benin
 Botswana
 Burkina Faso
 Burundi
 Cameroon
 Cape Verde
 Central African Republic
 Chad
 Comoros
 Congo
 Côte d'Ivoire
 Democratic Republic of the Congo
 Equatorial Guinea
 Eritrea
 Ethiopia
 Gabon
 Gambia
 Ghana
 Guinea
 Guinea-Bissau
 Kenya
 Lesotho
 Liberia
 Madagascar
 Malawi
 Mali
 Mauritania
 Mauritius
 Mozambique
 Namibia
 Niger
 Nigeria
 Rwanda
 Sao Tome and Principe
 Senegal
 Seychelles
 Sierra Leone
 South Africa
 Swaziland
 Togo
 Uganda
 United Republic of Tanzania
 Zambia
 Zimbabwe

WHO Region of the Americas (AMRO)

Antigua and Barbuda
 Argentina
 Bahamas
 Barbados
 Belize
 Bolivia
 Brazil
 Canada
 Chile
 Colombia
 Costa Rica
 Cuba
 Dominica
 Dominican Republic
 Ecuador
 El Salvador
 Grenada
 Guatemala
 Guyana
 Haiti
 Honduras
 Jamaica
 Mexico
 Nicaragua
 Panama
 Paraguay
 Peru
 Saint Kitts and Nevis
 Saint Lucia
 Saint Vincent and the Grenadines
 Suriname
 Trinidad and Tobago
 United States of America
 Uruguay
 Venezuela

WHO South-east Asia Region (SEARO)

Bangladesh
 Bhutan
 Democratic People's Republic of Korea
 India
 Indonesia
 Maldives
 Myanmar
 Nepal
 Sri Lanka
 Thailand
 Timor-Leste

WHO European Region (EURO)

Albania
Andorra
Armenia
Austria
Azerbaijan
Belarus
Belgium
Bosnia and Herzegovina
Bulgaria
Croatia
Cyprus
Czech Republic
Denmark
Estonia
Finland
France
Georgia
Germany
Greece
Hungary
Iceland
Ireland
Israel
Italy
Kazakhstan
Kyrgyzstan
Latvia
Lithuania
Luxembourg
Malta
Monaco
Netherlands
Norway
Poland
Portugal
Republic of Moldova
Romania
Russian Federation
San Marino
Serbia and Montenegro
Slovakia
Slovenia
Spain
Sweden
Switzerland
Tajikistan
The former Yugoslav Republic of Macedonia
Turkey
Turkmenistan
Ukraine
United Kingdom
Uzbekistan

WHO Eastern Mediterranean Region (EMRO)

Afghanistan
Bahrain
Djibouti
Egypt
Iran (Islamic Republic of)
Iraq
Jordan
Kuwait
Lebanon
Libyan Arab Jamahiriya
Morocco
Oman
Pakistan
Qatar
Saudi Arabia
Somalia
Sudan
Syrian Arab Republic
Tunisia
United Arab Emirates
Yemen

WHO Western Pacific Region (WPRO)

Australia
Brunei Darussalam
Cambodia
China
Cook Islands
Fiji
Japan
Kiribati
Lao People's Democratic Republic
Malaysia
Marshall Islands
Micronesia (Federated States of)
Mongolia
Nauru
New Zealand
Niue
Palau
Papua New Guinea
Philippines
Republic of Korea
Samoa
Singapore
Solomon Islands
Tonga
Tuvalu
Vanuatu
Viet Nam

