

practitioners that follows graduation from medical university does not include a mental health rotation. In our survey, only 2.3% of primary care physicians had had any postgraduate training in mental health.

In order to prepare primary care practitioners to provide services for patients with depression, ten master trainers from regional primary healthcare settings have been selected and educated to teach primary care doctors. The training is supervised by mental health professionals employed by Health Sector Reform Project Implementation Unit and is based on the Educational Programme on Depressive Disorders of the World Psychiatric Association (Maj *et al*, 2009), which has four modules:

- overview and fundamental aspects of depression
- physical illness and depression
- depression in specific population groups
- methods of training and education about depression.

The trainees learn general information about depression (epidemiology, clinical features, natural course and outcomes), application of the bio-psychosocial approach to depression, and contemporary classification of depressive disorders. Practical skills in the management of depressive disorders include their recognition, diagnosing depression with the Patient Health Questionnaire (PHQ-9), suicide risk assessment, developing a treatment plan, administering non-pharmacological interventions and antidepressant medications, and referral to specialist care. An emphasis was placed on addressing specific needs of patients (pregnancy, developmental aspects, ageing and comorbid physical illness). Doctors in training should develop proper attitudes

towards interpersonal functioning, suicidal ideation and adherence to treatment on the part of patients with depression. An important aspect of the training are the methods of teaching primary care doctors, which include case presentations, role-play, small-group discussions and evaluation of knowledge, skills and attitudes.

Along with this short-term training for already employed primary care doctors, the Department of Psychiatry, Azerbaijan Medical University, in cooperation with the World Health Organization Country Office, has introduced a training programme on the management of depression for graduates in primary care. It is expected that training of primary care doctors on the management of depression will result in the development of whole-person care, reduce the stigma accompanying mental illness and improve access to care for the most vulnerable population groups.

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SPECIAL PAPER

Global child mental health: what can we learn from countries with limited financial resources?

Norbert Skokauskas MD PhD and Myron Belfer BA MD AM MPA

Department of Psychiatry, Children's Hospital Boston, Harvard Medical School, MA, USA, email n_skokauskas@yahoo.com

In 1977 the World Health Organization recommended that every country throughout the world should have a national plan for child mental health. The United Nations Convention on the Rights of the Child has been another important stimulus for child mental health policies and services in many countries. Adopted unanimously by the United Nations General Assembly in 1989 and instituted as international law in 1990, the Convention is an agreement on the basic protections that should be accorded to children. Adopted in 1961, the European Social Charter is

the major European treaty that secures children's rights. In 1996 the Charter was revised and expanded to include a list of core obligations of the contracting parties relating to the recognition of social, legal and economic rights for children and young persons.

These three international initiatives stimulated governments worldwide to develop national child and adolescent mental health policies and legislation. The presence of informed, effective policy is critically important for the mental health of children. Without guidance on the development of child

and adolescent mental health policies and plans there is the danger that systems of care will be fragmented, ineffective, expensive and inaccessible (Belfer, 2008).

Obviously, it is not enough just to have a good policy: it is has to be properly implemented. Although an increasing number of countries have developed child mental health policies (World Health Organization, 2005), in the current climate of economic recession, implementation of these programmes poses a real challenge, as many governments are being forced to make stringent reductions in public sector expenditure. Child mental health services are under constant threat or have already suffered significant financial cuts in many countries.

Thus one of the most important questions these days is how to deliver adequate child and adolescent mental services with limited resources. The aim of this paper is not simply to present a literature review but also to point out that it has been a big challenge in recent times to implement child and adolescent mental health policies and to consider alternative approaches to improve child and adolescent mental health services.

Method

Relevant studies were identified by searching the PubMed, PsycINFO, EMBASE, Science Direct and Ovid online databases from inception through to October 2010. The search was confined to English-language articles. Selected articles, as a criterion for inclusion, had to describe an original study that provided alternative approaches to the improvement of child and adolescent mental health services in a low- or middle-income country.

Results

Higher-income countries even in the current financial crisis are spending more money on child mental health than the majority of low- and middle-income countries were before the crisis. Of course, the quality of and demand for such services in most cases are incomparable between rich and poor nations. However, there are a few countries which, with limited resources, were able to develop and implement progressive child mental health policies. That said, we have to admit that reports from low- and middle-income countries are not as thorough as those from high-income countries, and crucial data such as outcomes (including partial recovery, relapses and critical events) are not always recorded comprehensively. Moreover, resources and challenges in the former group of countries differ widely and uniform recommendations are difficult to make; however, positive tendencies, especially in so-called emerging economies, cannot be ignored.

South America

Successful child mental health policies have been implemented in a few South American countries, notably those which followed the World Health Organization's proposal to develop community mental health services through the integration of mental health into the existing primary care system

and the mobilisation of community resources. Integration is particularly useful when resources are limited and there is strong stigma around mental ill health.

A sophisticated child mental health programme based on a comprehensive primary care model exists in Chile. Experience from Chile indicates that the use of robust scientific evidence, combined with persistent public advocacy, civic education and media pressure, can facilitate the uptake of research into practical child and adolescent psychiatry (Pemjean, 2010). Today, one or more general practitioners with mental health training participate in mental health teams within every urban primary health centre. They work jointly with psychologists and social workers, receive referrals from other professionals at the same centre, and act as a first level of screening, making preliminary diagnostic and treatment decisions. There are over 60 community mental health centres, which work closely with the primary care centres, a system that has been evolving over the past 15 years. Staff in the two types of institution in many cases cooperate in the overall planning for mental healthcare and they are in frequent contact. This policy has meant that mental healthcare is a key aspect of the identity of primary care in Chile, and such services now serve more than 80% of the 500 000 people who receive mental healthcare in the whole of the public health system (Pemjean, 2010).

Strong advocacy programmes with government support at the highest levels exist in Brazil. Brazil's primary care system involves the deployment of family health teams (FHTs), who are responsible for primary and community-based healthcare in a defined geographical area. This includes the diagnosis and treatment of most diseases, together with promotion and prevention activities. Mental healthcare is now integral to the work of FHTs. Other mental health resources at community level include centres for psychosocial care (CAPS), which have been established in both urban and rural areas (although with some inequity between different regions of the country). These centres offer specialised mental health out-patient and, in some cases, day and limited in-patient care, as well as first-line emergency care. The CAPS, together with FHTs and mental health units in general hospitals, make up a comprehensive mental health network. This example demonstrates the value of a number of interlocking strategies: a strong system of family-centred primary care (particularly appropriate for mental healthcare), together with specialist mental health support delivered through collaborative care and a network of supporting mental health resources, including both hospital and community care (World Health Organization & World Organization of Family Doctors, 2008).

Africa

The integration of mental health into primary care has been a policy objective in Kenya for two or three decades, but there was no specific allocation of resources to implement this, and there was no continuing professional education on mental health for primary care staff. A few years ago, hundreds of front-line health workers were trained in a 5-day interactive course in mental health, using relatively small-scale funds, local trainers and a project management system embedded in a local training system, to achieve effective outcomes (Jenkins *et al*, 2010). Of course, the effectiveness of such a project needs to be carefully monitored.

Europe and Asia

Historical accidents may stimulate the development of child and adolescent mental health services. In Turkey, severe earthquakes in 1997 led to increased recognition, both inside and outside the country, of the need to increase services and to coordinate them better (Munir *et al*, 2004). For example, the mental health component of the Marmara Earthquake Emergency Reconstruction Project identified the need to develop community-based mental health services – including trauma-related interventions related to the earthquakes – initially in the north-west where the earthquakes occurred, and later across the remainder of Turkey, thereby ensuring that the country would be better prepared for similar disasters (Munir *et al*, 2004). In India, natural and human-made disasters have been followed by enhancement of emergency relief and mental health services; progress in rehabilitation and rebuilding has been slower (Rao, 2006).

In the past decade, Serbia has been exposed to many stressors, such as civil war, United Nations sanctions, several waves of refugees and internally displaced persons, always with a high percentage of children and youths (Lecic Tosevski *et al*, 2007). The Serbian national action plan for the development of mental healthcare and youth development was created to address some of these problems, by, among other things (Lecic Tosevski *et al*, 2007):

- expanding the preventive and therapeutic potential of primary healthcare services
- facilitating cooperation between youth health services, youth mental health services and tertiary psychiatric institutions
- supporting the programmes and projects of non-governmental organisations for the psychological care of youths
- training young people and developing peer support.

Incorporation of child mental health programmes into other programmes

Additional funding for child mental health programmes can be secured when child mental health issues are included in programmes dedicated to other important disorders. For example, in many parts of the world AIDS is now pandemic and special attention should be given to the consequences of AIDS on children and young people, including their mental health needs. There is a concern that the effects of AIDS on children and young people, including dementia, depression and other disorders, may go largely untreated. Moreover, the lack of recognition of depression, dementia and other mental illness in the context of HIV infection may contribute to the continuing spread of the epidemic. There is an interdependence and ‘vicious circularity’ between mental health and

HIV/AIDS. Mental health programmes are needed because of the vulnerability of people with mental disorders and substance misuse to contracting HIV, because mental ill health is an important health outcome of being infected with HIV and because mental health status affects the course of the disease in various ways. Access to mental health services has been shown to decrease AIDS progression and mortality.

Conclusions

The integration of child and adolescent mental health services into the primary care system can help to reduce the costs of services but also minimises stigma; however, convincing evidence of the effectiveness of such a combination in various socioeconomic and cultural settings still needs to be produced.

Rather than creating child and adolescent mental health policies and services after a disaster, it is likely to be cheaper and more convenient to develop and maintain them in advance. Such a strategy, and such arguments, could be used to secure funding for child and adolescent mental health services or at least to avoid cuts in funding.

Additional funding for child mental health programmes could be secured when child mental health issues are included in programmes dedicated to other important disorders, such as AIDS.

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africandivision@rcpsych.ac.uk
europeandivision@rcpsych.ac.uk
middleeastdivision@rcpsych.ac.uk
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