Mental Health Policy and Service Guidance Package

CHILD AND ADOLESCENT MENTAL HEALTH POLICIES AND PLANS

"Children are our future. Through well-conceived policy and planning, governments can promote the mental health of children, for the benefit of the child, the family, the community and society."

World Health Organization

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Preface

This module is part of the WHO Mental Health Policy and Service Guidance Package, which provides practical information for assisting countries to improve the mental health of their populations.

What is the purpose of the guidance package?

The purpose of the guidance package is to assist policy-makers and planners to:

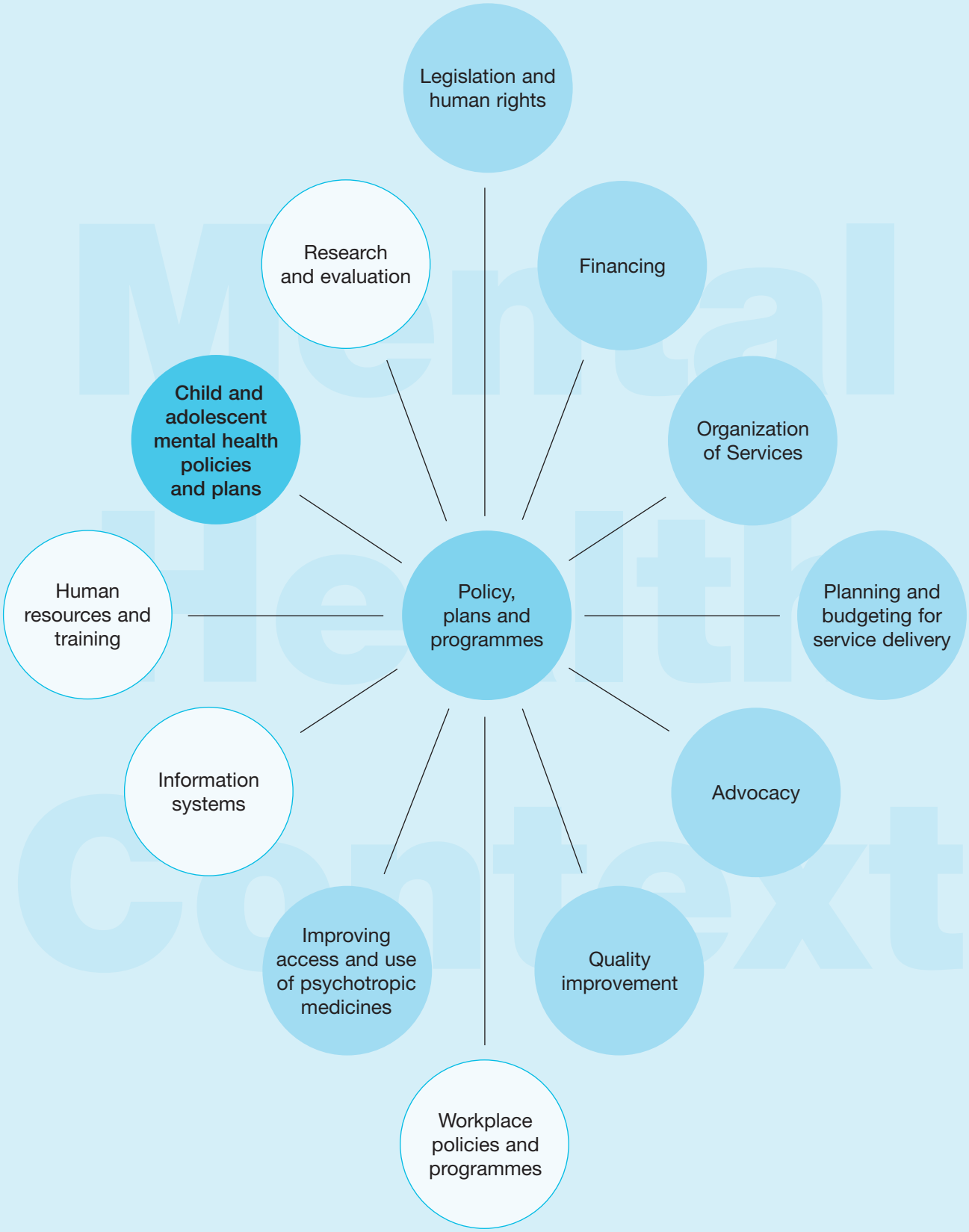
- Develop a policy and comprehensive strategy for improving the mental health of populations;
- use existing resources to achieve the greatest possible benefits;
- provide effective services to persons in need; and
- assist the reintegration of persons with mental disorders into all aspects of community life, thus improving their overall quality of life.

What is in the package?

The guidance package consists of a series of interrelated, user-friendly modules that are designed to address the wide variety of needs and priorities in policy development and service planning. The topic of each module represents a core aspect of mental health.

The guidance package comprises the following modules:

> The Mental Health Context
> Mental Health Policy, Plans and Programmes
> Mental Health Financing
> Mental Health Legislation and Human Rights
> Advocacy for Mental Health
> Organization of Services for Mental Health
> Improving Access and Use of Psychotropic Medicines
> Quality Improvement for Mental Health
> Planning and Budgeting to Deliver Services for Mental Health
> Child and Adolescent Mental Health Policies and Plans


Legislation and human rights
Research and evaluation
Financing
Child and adolescent mental health policies and plans
Organization of Services
Human resources and training
Policy, plans and programmes
Planning and budgeting for service delivery
Information systems
Advocacy
Improving access and use of psychotropic medicines
Quality improvement
Workplace policies and programmes
still to be developed

The following additional modules are planned for inclusion in the final guidance package:

- Mental Health Information Systems
- Human Resources and Training for Mental Health
- Research and Evaluation of Mental Health Policy and Services
- Workplace Mental Health Policies and Programmes

For whom is the guidance package intended?

The modules should be of interest to:

- policy-makers and health planners;
- government departments at federal, state/regional and local levels;
- mental health professionals;
- groups representing people with mental disorders;
- representatives or associations of families and carers of people with mental disorders;
- advocacy organizations representing the interests of people with mental disorders, and their relatives and families;
- nongovernmental organizations involved or interested in the provision of mental health services.

How to use the modules

- They can be used **individually or as a package**. They are cross-referenced with each other for ease of use. Country users may wish to go through each module systematically or may use a specific module when the emphasis is on a particular area of mental health. For example, those wishing to address the issue of mental health legislation may find the module entitled *Mental Health Legislation and Human Right*s useful for this purpose.

- They can serve as a **training package** for policy-makers, planners and others involved in organizing, delivering and funding mental health services. They can be used as educational materials in university or college courses. Professional organizations may choose to use the modules as aids for training persons working in the field of mental health.

- They can be used as a framework for **technical consultancy** by a wide range of international and national organizations that provide support to countries wishing to reform their mental health policies and/or services.

- They can also be used as **advocacy tools** by consumer, family and advocacy organizations. The modules contain information of value for public education and for increasing awareness amongst politicians, opinion-makers, other health professionals and the general public about mental disorders and mental health services.

Format of the modules

Each module clearly outlines its aims and the target audience for which it is intended. The modules are presented in a step-by-step format to facilitate the use and implementation of the guidance provided. The guidance is not intended to be prescriptive or to be interpreted in a rigid way. Instead, countries are encouraged to adapt the material in accordance with their own needs and circumstances. Practical examples from different countries are used throughout the modules.

There is extensive cross-referencing between the modules. Readers of one module may need to consult another (as indicated in the text) should they wish to seek additional guidance.

All modules should be read in the light of WHO's policy of providing most mental health care through general health services and community settings. Mental health is necessarily an intersectoral issue requiring the involvement of the education, employment, housing and social services sectors, as well as the criminal justice system. It is also important to engage in consultations with consumer and family organizations in the development of policies and the delivery of services.

Dr Michelle Funk

Dr Benedetto Saraceno

CHILD AND ADOLESCENT MENTAL HEALTH POLICIES AND PLANS

1. Context of child and adolescent mental health

Children and adolescents with good mental health are able to achieve and maintain optimal psychological and social functioning and well-being. They have a sense of identity and self-worth, sound family and peer relationships, an ability to be productive and to learn, and a capacity to tackle developmental challenges and use cultural resources to maximize growth. Moreover, the good mental health of children and adolescents is crucial for their active social and economic participation.

This module demonstrates the need to promote the development of all children and adolescents, whether or not they have mental health problems. In addition, it is important to provide effective interventions and support to the 20% of children and adolescents believed to be suffering from overt mental health problems or disorders. The burden associated with mental disorders in children and adolescents is considerable, and it is made worse by stigma and discrimination. In many situations, mental disorders are poorly understood, and affected children are mistakenly viewed as "not trying hard enough" or as troublemakers.

There are three compelling reasons for developing effective interventions for children and adolescents: (i) since specific mental disorders occur at certain stages of child and adolescent development, screening programmes and interventions for such disorders can be targeted to the stage at which they are most likely to appear; (ii) since there is a high degree of continuity between child and adolescent disorders and those in adulthood, early intervention could prevent or reduce the likelihood of long-term impairment; and (iii) effective interventions reduce the burden of mental health disorders on the individual and the family, and they reduce the costs to health systems and communities.

The mental health of children and adolescents can be influenced by a variety of factors. Risk factors increase the probability of mental health problems, while protective factors moderate the effects of risk exposure. Policies, plans and specific interventions should be designed in a way that reduces risk factors and enhances protective factors.

2. Developing a child and adolescent mental health policy

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. Several different systems of care (e.g. education, welfare, health) may need to be involved to ensure that services for youth are effective. An overriding consideration is that the child's development stage can influence his/her degree of vulnerability to disorders, how the disorder is expressed and how best treatment should be approached. Thus a developmental perspective is needed for an understanding of all mental disorders and for designing an appropriate mental health policy.

This section identifies the steps needed to develop a child and adolescent mental health policy. This policy may be part of an overall health policy, a child and adolescent health policy or a mental health policy. These are not mutually exclusive categories; indeed, more effective action is likely to result when the mental health of children and adolescents is addressed across all these policy dimensions.

Step 1: Gather information and data for policy development

The development of a child and adolescent mental health policy requires an understanding of the prevalence of mental health problems among children and

adolescents. Their needs are inextricably linked with their developmental stages. It is also important to identify the existing financial and human resources available, the existing service organization, and the views and attitudes of health workers in addressing child and adolescent mental health issues.

Step 2: Gather evidence for effective strategies

Pilot projects can provide information about successful interventions as well as why certain programmes may have failed. When evaluating pilot projects and studies in the international literature, it is important to consider the distinctions between efficacy (an intervention's ability to achieve a desired effect under highly controlled conditions) and effectiveness (an intervention's ability to achieve a desired effect within the context of a larger, non-controlled setting). The findings from a study using a well defined population group under highly controlled conditions may not necessarily be replicable in a "real life" setting; therefore caution is needed in directly applying findings from clinical trials into real life settings without appropriate consideration to implementation issues. Nonetheless, there are a number of effectiveness studies using adequate methodology, the findings of which are strong enough to adopt on a broader scale. Policy-makers should hold consultations with colleagues and nongovernmental organizations (NGOs) from other districts, provinces, countries or regions when deciding upon the appropriateness of programme models that meet reasonable standards of effectiveness, for incorporation into policy.

Step 3: Undertake consultation and negotiation

While consensus building and negotiation are important at every stage of the policy planning cycle, effective policy-makers will use the initial information gathering as an opportunity to begin building consensus. There are three reasons why it is important to hold consultation with a wide range of stakeholders: (i) the social ecology of children and adolescents is such that their interests and needs should be met in a range of settings; (ii) a consultation process can increase the buy-in of crucial stakeholders; and (iii) involvement in a policy development process may increase stakeholders' insights into the potential contributions of their sector to the mental health of children and adolescents.

Step 4: Exchange with other countries

International consultations can make an important contribution to policy development, especially when the consultants have experience in several other countries that are similar in terms of level of economic development, health system organization and governmental arrangements. National and international professional organizations can be instrumental in providing support and promoting networking. Both the headquarters and regional offices of the World Health Organization (WHO) can facilitate such exchanges with other countries.

Step 5: Develop the vision, values, principles and objectives of the policy

In this step, policy-makers develop the core of the policy, using the outputs of the first four steps. The vision usually sets high but realistic expectations for child and adolescent mental health, identifying what is desirable for a country or region. This would normally be associated with a number values and related principles, which would then form the basis of policy objectives. Many countries' policy-makers believe it is important to address the promotion of healthy development and the prevention of illness along with the treatment of child and adolescent mental disorders, although the emphasis placed on each differs across countries.

Step 6: Determine areas for action

In developing a mental health policy for children and adolescents, policy-makers need to coordinate actions in several areas (listed below) to maximize the impact of any mental health policy.

- Financing
- Organization of services
- Promotion, prevention, treatment and rehabilitation
- Intersectoral collaboration
- Advocacy
- Legislation and human rights
- Human resources and training
- Quality improvement
- Information systems
- Research and evaluation of policies and services

Step 7: Identify the major roles and responsibilities of different stakeholders and sectors

It is essential that all stakeholders and sectors have a clear understanding of their responsibilities. All those who were involved in the consultation process could be considered.

3. Developing a child and adolescent mental health plan

Once the mental health policy has been completed, the next step is to develop a plan for its implementation. The development of such a plan builds on the process already established for policy development as outlined above. Information about a population's needs, gathering evidence and building consensus are important in the formulation of such a plan. A plan consists of a series of strategies, which represent the lines of action that have the highest probability of achieving the policy objectives in a specific population.

Step 1: Determine the strategies and time frames

In developing and setting priorities for a set of strategies, it is often useful to conduct a SWOT analysis, in which the strengths, weaknesses, opportunities and threats of the current situation are identified. Following a SWOT analysis, a series of actions should be taken to develop and identify priorities for a set of strategies: (i) create a comprehensive list of potentially useful proposals for each of the areas of action developed during the policy formulation phase; (ii) brainstorm with key players to develop a set of strategies for implementing each of the proposals; (iii) revise and modify strategies based on a second round of inputs from key players so that there are two or three strategies for each area of action; (iv) establish a time frame for each strategy; and (v) develop details for how each strategy will be implemented. Details include setting indicators and targets, outlining the major activities, determining the costs, identifying available resources and creating a budget.

Step 2: Set indicators and targets

Each strategy should be accompanied by one or more targets which represent the desired outcome of the strategy. *Indicators* enable an assessment of the extent to which a target has been met.

Step 3: Determine the major activities

The next step should be to determine the actual activities that are necessary for each strategy. Each activity should be accompanied by a set of questions: Who is responsible? How long will it take? What are the outputs? What are the potential obstacles or delays that could inhibit the realization of each activity?

Step 4: Determine costs, available resources and the budget

The budget is the product of an assessment of costs in the context of available resources.

4. Implementation of child and adolescent mental health policies and plans

Step 1: Dissemination of the policy

Formulated policies must be disseminated to health district offices and other partner agencies, and, within those agencies, to individuals. The success of the dissemination of a policy, plan or programme will be maximized if children, adolescents and their families are reached at a variety of locations, such as schools, places of worship, streets, rural areas and workplaces.

Step 2: Generate political support and funding

No policy or plan, no matter how well conceived and well researched, has a chance of success without political support and a level of funding commensurate with its objectives. Because young people are often dependent on others to advocate on their behalf, advocates for child and adolescent mental health should seek to ensure the political and financial viability of a plan, independently of the persistent advocacy of the service users themselves. Advocates for mental health policy within a ministry of health will need to identify allies in other parts of the government, and in the community or country at large.

Step 3: Develop a supportive structure

The implementation of a child and adolescent mental health policy and plan requires the participation of a number of individuals with a wide range of expertise. Individuals with training or experience mainly applicable to adults may have to be assisted by other appropriate specialists to make planning applicable to children and adolescents.

Step 4: Set up pilot projects in demonstration areas

Pilot projects in demonstration areas, where policies and plans can be implemented relatively rapidly, can serve several useful functions: they can be evaluated more effectively and completely; they can provide empirical support for the initiative through their demonstration of both feasibility and short- and long-term efficacy; they can produce advocates from the ranks of those who participated in the demonstration area; and they can educate colleagues from the health and other sectors on how to develop policies, plans and programmes.

Step 5: Empower providers and maximize coordination

The chances of successful implementation of an intervention will be enhanced if service providers are sufficiently empowered and supported in terms of information, skills, ongoing support, and human and financial resources. A first step in this process is to identify which individuals, teams or organizations in the health or other sectors will be responsible for implementing the programme. All sectors have a stake in both the present and future physical and mental well-being of young people. Collaboration (including cost-sharing) around mental health initiatives produces win-win situations for everyone, most importantly for the young people involved. In addition to intersectoral collaboration, other stakeholders (such as officials in the areas of education and justice) need to interact on an ongoing basis to maintain support for and ensure the smooth delivery of mental health services.

Aims

1. Enable countries to develop and implement appropriate, evidence-based policies and plans for child and adolescent mental health.

2. Inform those ultimately responsible for developing, implementing and evaluating mental health policies, plans and programmes for children and adolescents of the unique challenges of working on behalf of these age groups.

3. Share workable solutions to common problems experienced by many people.

4. Identify other resources that offer additional tools or information.

The other modules in this series do not focus on specific age groups, but have relevance for children and adolescents. This module focuses specifically on children and adolescents, and highlights the areas pertaining to these age groups that do not receive sufficient attention in the other modules.

Target audience

1. Policy-makers and public health professionals in ministries of health or health departments of countries and large administrative divisions of countries (regions, states or provinces).

2. International, regional and national policy and advocacy organizations such as consumer groups, caregiver groups, WHO regions and professional organizations.

3. Professionals in child and adolescent mental health

1. Context of child and adolescent mental health

1.1 Introduction[1]

Children and adolescents are thinking and feeling beings with a degree of mental complexity that is only now being recognized. While it has long been accepted that physical health can be affected by traumas, genetic disturbances, toxins and illness, it has only recently been understood that these same stressors can affect mental health, and have long-lasting repercussions. When risk factors and vulnerabilities outweigh or overcome factors that are protective or that increase resilience, mental disorder can result. Child and adolescent mental disorders manifest themselves in many domains and in different ways. It is now understood that mental disturbances at a young age can lead to continuing impairment in adult life.

This guidance package addresses mental health in the prenatal period (conception to birth), childhood (birth to 9 years) and adolescence (10 to 19 years). It adopts a broad definition of child and adolescent mental health:

> *Child and adolescent mental health is the capacity to achieve and maintain optimal psychological functioning and well being. It is directly related to the level reached and competence achieved in psychological and social functioning.*[2]

An important emphasis of this module is on the need to promote the mental health of all children and adolescents, whether or not they are suffering from mental health problems.

Child and adolescent mental health includes a sense of identity and self-worth; sound family and peer relationships; an ability to be productive and to learn; and a capacity to use developmental challenges and cultural resources to maximize development (Dawes et al., 1997). Good mental health in childhood is a prerequisite for optimal psychological development, productive social relationships, effective learning, an ability to care for self, good physical health and effective economic participation as adults.

This module emphasizes the need to promote the mental health of all children and adolescents, whether or not they are suffering from mental health problems. This can be done by reducing the impact of risk factors on the one hand, and by enhancing the effects of protective factors on the other (see section 1.4).

An overall prevalence rate of about 20% has been documented for child and adolescent mental disorders.

However, a proportion of children and adolescents suffer from overt mental health disorders. A mental illness or disorder is diagnosed when a pattern of signs and symptoms is identified that is associated with impairment of psychological and social functioning, and that meets criteria for disorder under an accepted system of classification such as the International *Classification of Disease, version 10 (ICD-10, WHO, 1992) or the Diagnostic and Statistical Manual IV (DSM-IV, American Psychiatric Association, 1994)*.[3] Examples include: mood disorders, stress-related and somatoform disorders, and mental and behavioural disorders due to psychoactive substance use. Community-based studies have revealed an overall prevalence rate for such disorders of about 20% in several national and cultural contexts (Bird, 1996; Verhulst, 1995). The prevalence rates of child and adolescent disorders from selected countries are summarized in Table 1.

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[1] Much of this section is based on text provided by Professors A.J. Flisher and B.A. Robertson for the South African policy guidelines for child and adolescent mental health.

[2] Department of Health, Republic of South Africa, 2001: 4

[3] The terminology in this module is consistent with the former system.

Table 1. Prevalence of child and adolescent mental disorders, selected countries

Country	Study	Age (years)	Prevalence (%)
Brazil	Fleitlich-Bilyk & Goodman, 2004.	7–14	12.7
Canada (Ontario)	Offord et al., 1987.	4–16	18.1
Ethiopia	Tadesse et al., 1999.	1–15	17.7
Germany	Weyerer et al., 1988.	12–15	20.7
India	Indian Council of Medical Research	1–16	12.8
Japan	Morita et al., 1993.	12–15	15.0
Spain	Gomez-Beneyto et al., 1994.	8, 11, 15	21.7
Switzerland	Steinhausen et al., 1998.	1–15	22.5
USA	United States Department of Health and Human Services, 1999.	9–17	21.0

Prevalence rates of psychiatric disorders have been found to range from 12% to 29% among children visiting primary care facilities in various countries (Giel et al., 1981). Only 10%–22% of these cases were recognized by primary health workers, which implies that the vast majority of children did not receive appropriate services. It should be borne in mind that, in addition to those who have a diagnosable mental disorder, many more have problems that can be considered "sub-threshold", in the sense that they do not meet diagnostic criteria. This means that they too are suffering and would benefit from interventions.

Some difficult circumstances in which children and adolescents find themselves can be interrelated with mental health problems in a number of ways.

Some children and adolescents are in difficult circumstances; for example, they might experience physical, emotional and/or sexual abuse, experience or witness violence or warfare, suffer from intellectual disability, slavery or homelessness, migrate from rural to urban areas, live in poverty, engage in sex work, be addicted to substances such as alcohol and cannabis, or be infected or affected by HIV/AIDS. Difficult circumstances and mental health problems can be interrelated in a number of ways. They could, for example, serve as risk factors for mental health problems, such as post-traumatic stress disorder in a child who has been sexually abused. Alternatively, mental health problems could serve as risk factors in difficult circumstances; for example, when an adolescent uses alcohol or drugs to deal with depressive feelings. Whatever the nature of the relationship between mental health problems and difficult circumstances, specific intervention strategies are necessary to address children's and adolescents' needs.

There are advantages in regarding child and adolescent mental health services as a discrete area of health care. In many countries, child and adolescent mental health services are regarded as a subset of general mental health services or child health services, or as a minor extension of these services. The bulk of funding for mental health services is devoted to adult services, which makes it difficult to develop appropriate child and adolescent mental health services. If child and adolescent mental health services were to be viewed as a distinct category of health care with unique requirements, specific funding arrangements and policy development would be facilitated. However, in some countries, there may be advantages to adopting a more integrated approach. This needs to be taken into account when deciding whether and to what extent child and adolescent mental health services should be integrated or kept separate.

1.2 Stigma and discrimination

While all people with mental disorders suffer discrimination, children and adolescents are the least capable of advocating for themselves. Also, developmentally, children think more dichotomously than adults about categories such as “good” and “bad,” or “healthy” and “sick”. They are thus less likely to temper a negative remark with other more positive feedback, and may therefore more easily accept negative, misapplied labels. Stigma and discrimination include: bias, stereotyping, fear, embarrassment, anger and rejection or avoidance; violations of basic human rights and freedoms; denial of opportunities for education and training; and denial of civil, political, economic, social and cultural rights. Additionally, in contrast to physical illnesses where parents may receive community support, stigma often results in parents being blamed for the mental health problems of their children.

Stigma and discrimination include: bias, stereotyping, fear, embarrassment, anger and rejection or avoidance; violations of basic human rights and freedoms; and denial of civil, political, economic, social and cultural rights.

Behaviours associated with mental disorders are often misunderstood, or are considered to be intentional or deliberately wilful. For example, a depressed child who is acting badly may be punished for being naughty or may be told to “snap out of it.” An anxious adolescent may consume increasing amounts of alcohol in order to cope, but is told to “just say no!”. When a problem is misunderstood by others, it is more likely that the solutions applied will be inappropriate and ineffective, or possibly harmful to the health of the individual who is suffering. Social exclusion, punitive action and criticism leading to lowered self-esteem may result. A mistaken and inappropriate understanding of mental disorders can result in children and adolescents being deprived of the assistance they need. Stigmatization may result, with a range of negative impacts, including a reduction in the resources needed for treatment.

In certain countries, mental disorders may be attributed to spiritual causes, or to possession by the devil due to alleged evil acts or the neglect of spiritual duties. Epilepsy, for example, has a wide range of such putative causes worldwide, and is sometimes even considered contagious. Children or adolescents with epilepsy may be excluded from school for fear that others will contract their illness. Families may be ashamed of their children who suffer from a mental disorder or fearful that they may be physically abused. They may keep them locked up or isolated from the community. Such severe measures can have devastating effects on the physical and emotional development of these children and adolescents.

In certain countries, mental disorders may be attributed to spiritual causes, or to possession by the devil, due to alleged evil acts or the neglect of spiritual duties

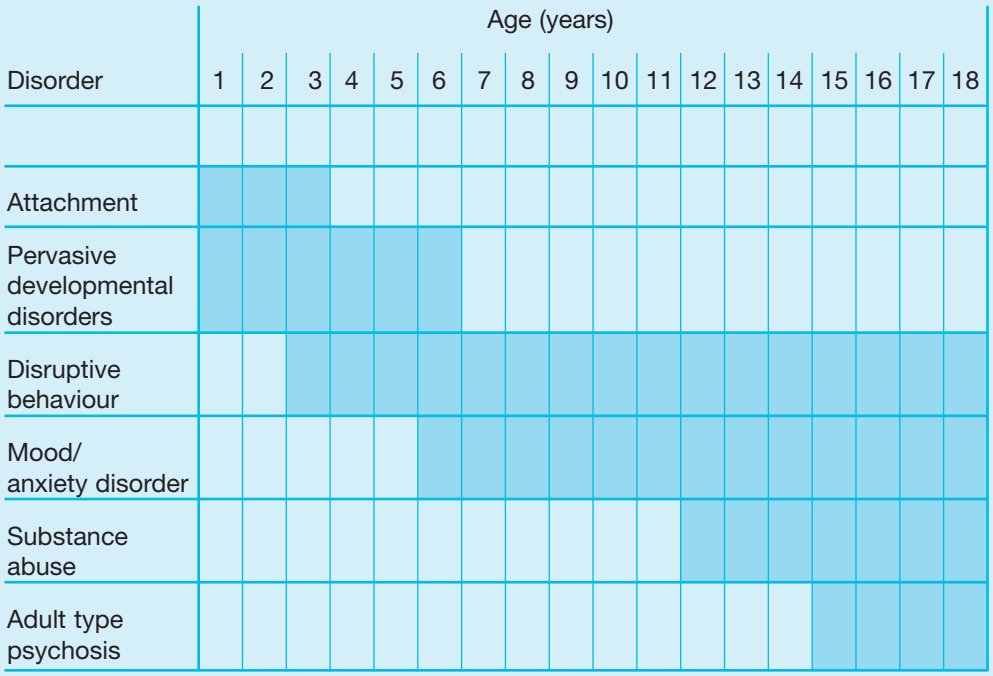
Unless children and adolescents with mental disorders receive appropriate treatment, their difficulties are likely to persist, and their social, educational and vocational prospects diminished. This results in direct costs to the family and lost productivity for society. It is also now known that individuals with untreated mental disorders represent a disproportionately large segment of the populations in the juvenile justice and adult criminal justice systems. For example, a study among youth in detention centres in Massachusetts, United States of America (USA), found that approximately 70% of the males and 81% of the females scored above the clinical cut-off on at least one of the scales of a screening instrument: alcohol/drug use, angry-irritable, depressed-anxious, somatic complaints and suicide ideation (Cauffman, 2004). These sequelae are particularly tragic because some mental illnesses are preventable, many are treatable, and children with psychiatric disorders could be living normal or near-normal lives if given appropriate treatment.

1.3 Development of mental disorders in children and adolescents

Service delivery can be planned on the assumption that, generally, specific mental disorders will be present at specific age ranges during the course of child and adolescent development (Figure 1). Screening programmes to detect mental disorders could be incorporated into existing health services.

Service delivery can be planned on the assumption that, generally, specific mental disorders will be present at specific stages of child and adolescent development.

Figure 1. Typical age ranges for presentation of selected disorders*



**Note that these ages of onset and termination have wide variations, and are significantly influenced by exposure to risk factors and difficult circumstances.*

Examples of the chronology of a few selected disorders are described below. It is important to emphasize that for each of these disorders effective interventions are available. Within the first few years of life, infants and young children can develop *attachment disorders*. These are characterized by a notable difficulty in bonding with parents, underregulation of emotions and poorly coordinated social development that is insensitive to others. This could be caused by child abuse or neglect by parents who are not sufficiently available. For example, a parent my be suffering from a mental disorder in the post-partum period or later, and thus be unable to give the child appropriate care and attention, or developmental or emotional deficits from a variety of causes may inhibit the capacity to care. A particularly difficult disorder to evaluate and treat is childhood *autism*, an example of a *pervasive developmental disorder* that can be diagnosed appropriately in the first three years of life by trained individuals. Accurate and early diagnosis can enable parents and educational authorities to seek and obtain optimal interventions.

Within the first few years of life, infants and young children can develop attachment disorders.

Between the ages of four and six years, the most common disorders include *hyperkinetic disorder and conduct disorders*. While their symptoms are categorized differently by clinicians from different cultures (Mann et al., 1992), in some countries these disorders are quite common in childhood, with a prevalence of approximately 10% among boys and 5% among girls (American Academy of Child and Adolescent Psychiatry, 1997).

Between the ages of four and six years, the most common disorders are disruptive, behavioural disorders.

Specific developmental and hyperkinetic disorders are major risk factors for *conduct disorders*, which have a profound impact on social development. If untreated, they frequently continue into adolescence and adulthood and lead to dropping out of school, antisocial behaviour, a poor employment history and poverty in adulthood. This impairs parenting and leads to a self-perpetuating, inter-generational cycle. Untrained health

workers in adult clinics may not suspect this childhood-onset disorder and may not refer families and children for help.

Children and adolescents seldom decide for themselves when to seek out health services for physical or emotional problems. Parents, teachers or other carers can easily recognize many physical conditions, but *emotional disorders* are often not so readily apparent. Examples of emotional disorders are *mood and neurotic disorders* (for example, depressive episodes and obsessive-compulsive disorder), which typically develop during the school-age years and are easily identifiable by staff trained to treat mental disorders in children. However, untrained individuals may not detect these disorders because they are subjective and internal. Children and adolescents are better reporters of internal, subjective states (for example, anxiety and depression) than their carers. But if no one asks them how they are feeling, their symptoms may remain unrecognized. It is estimated that by 2020, *depression* will be the second leading cause of disability worldwide (WHO, 2001).

Mood and anxiety disorders typically develop during the school-age years.

In later childhood, between the ages of 12 and 18 years, *mental and behavioural disorders* due to psychoactive substance use can emerge. In many cultures, children are particularly impressionable and extremely eager to conform to the social norms defined by their immediate peers. They are thus susceptible to experimentation such as drug abuse, and may unintentionally become addicted to drugs. Addictions can become entrenched at an early age, and, if untreated, can lead to a lifetime of struggle and despair.

Between the ages of 12 and 18 years, disorders related to substance abuse can emerge.

Finally, *psychotic disorders* (seen in adults) tend to become apparent in later adolescence. *Schizophrenia* alone affects approximately 1% of the world's population (Jablensky et al., 1987). While less prevalent than the disorders noted above, psychotic disorders can be particularly severe and unremitting if untreated; early detection and effective treatment can markedly improve the course of such illnesses.

Psychotic disorders can become apparent in later adolescence.

1.4 Risk and protective factors

There are a number of factors that can affect the mental health of a child or adolescent (Offord, 1998). Broadly speaking, these can be divided into risk and protective factors. The former refers to factors that increase the probability of occurrence of mental health problems or disorders, while the latter refers to factors that moderate the effects of risk exposure. As the term "bio-psycho-social" in the definition of mental health used earlier suggests, these risk and protective factors can exist in the biological, psychological and social domains. Table 2 provides examples of risk and protective factors in each of these domains.

The mental health of a child or adolescent can be affected by risk and protective factors.

Table 2. Selected risk and protective factors for mental health of children and adolescents

Domain	Risk factors	Protective factors
Biological	Exposure to toxins (e.g. tobacco and alcohol) in pregnancy Genetic tendency to psychiatric disorder Head trauma Hypoxia at birth and other birth complications HIV infection Malnutrition Other illnesses	Age-appropriate physical development Good physical health Good intellectual functioning
Psychological	Learning disorders Maladaptive personality traits Sexual, physical and emotional abuse and neglect Difficult temperament	Ability to learn from experiences Good self-esteem High level of problem-solving ability Social skills
Social		
a) Family	Inconsistent care-giving Family conflict Poor family discipline Poor family management Death of a family member	Family attachment Opportunities for positive involvement in family Rewards for involvement in family
b) School	Academic failure Failure of schools to provide an appropriate environment to support attendance and learning Inadequate/inappropriate provision of education	Opportunities for involvement in school life Positive reinforcement from academic achievement Identity with a school or need for educational attainment
c) Community	Lack of "community efficacy" (Sampson, Raudenbush & Earls, 1997) Community disorganization Discrimination and marginalization Exposure to violence Lack of a sense of "place" (Fullilove, 1996) Transitions (e.g. urbanization)	Connectedness to community Opportunities for constructive use of leisure Positive cultural experiences Positive role models Rewards for community involvement Connection with community organizations including religious organizations

Evidence of early antecedents of adult mental disorders in childhood is now conclusive (Tsuang et al., 1995). This applies, *inter alia*, to mood disorders such as depressive episodes and bipolar affective disorder (formerly called manic depression), and psychotic disorders such as schizophrenia. Some childhood disorders, such as pervasive developmental disorders and hyperkinetic disorder, may only be recognized in adulthood by health professionals. If adult health professionals had increased

Evidence of early antecedents of adult mental disorders in childhood is now conclusive.

exposure to and training in child and adolescent mental health, they would be more likely to make these diagnoses earlier and be better able to understand their impact on a person's functioning.

Early intervention with children and adolescents, as well as with their parents/families, can reduce or eliminate the manifestations of some mental disorders and foster the integration into mainstream educational and health services of children and adolescents who would otherwise require specialized, intensive services.

The salience of specific risk and protective factors varies according to the developmental stage of the child or adolescent.

The salience of specific risk and protective factors varies according to the developmental stage of the child or adolescent. For example, the family is likely to be more influential during the earlier years, while in adolescence the impact of peers on mental health is likely to be particularly important. Intervention strategies that fail to recognize the different influences of risk and protective factors according to the developmental phase of the child or adolescent will either have less of an impact or be ineffective.

1.5 Importance of developmental stages

In designing child and adolescent mental health policies and plans it is important to ensure that specific developmental stages of emotional, cognitive and social development are taken into account. For example, a plan to prevent or treat conduct disorders in adolescents should devote particular attention to the influence of peers. Conversely, it is the family environment that should be given priority in an analogous plan for pre-pubertal children. Taking into account cognitive development, a plan for adolescents can assume a capacity to consider nuances of morality, risk-benefit ratios and causes and consequences. On the other hand, a plan for pre-pubertal children should make no such assumption.

It is important to recognize cultural differences when considering developmental stages.

It is also important to recognize cultural differences when considering developmental stages. There is no doubt that certain developmental stages are universally applicable, such as early language development and social reciprocity (Lewis, 1996), while others are culture-specific. The concept of adolescence itself is not universally recognized. In many cultures, for example in the Hmong culture, the age of 12 or 13 years denotes the end of childhood and the simultaneous onset of adulthood (Tobin & Friedman, 1984). There is no intermediate stage of adolescence. In Bangladesh, a child who goes to school and has no economic or social responsibilities will be regarded as a child up to the age of puberty. However, boys or girls who are employed will no longer be regarded as children, even if they start to work at the age of 6 years (Blanchet, 1996). Such differences can have a profound effect on how policies, plans and specific interventions are formulated and implemented. For example, interventions designed for societies that view adolescence as a period of continued dependence on parents will need to consider the important role that parents may play in seeking out, evaluating and consenting to services.

1.6 Economic costs of treating (or not treating) child and adolescent mental disorders

The *WHO Mental Health Policy and Service Guidance Package: The Mental Health Context notes that:*

> *Families and caregivers end up bearing nearly all or the majority of these economic costs, except in a few well-established market economies with comprehensive well funded public mental health care systems. Even when families do bear the economic burden, governments and societies ultimately pay a price in terms of reduced national income and increased expenditure on social welfare programmes. The economic logic is thus stark and simple – treating mental illness can be expensive, but leaving mental illness untreated is more expensive and a luxury that most nations can ill afford.*

For children and adolescents with mental disorders, families and societies incur significant costs. Both the children and adolescents and their parents/families are affected. The child may miss school, not be able to work in the family business or be able to bring in money from other sources, because of his or her condition. The family may incur debts as well as future lost productivity. Family members may also incur costs, as they often change or lose their jobs to stay home with their children or adolescents with mental disorders (SANE Australia, 1992).

For children and adolescents with mental disorders, families and societies incur significant costs.

Knapp, Scott & Davies (1999) have shown that children with depression and/or conduct disorder can generate high costs in childhood and adulthood (Knapp et al., 2002). Furthermore, children with co-morbid depression and conduct disorder have higher adult service use and costs than the general population or those with depression alone (Knapp et al., 2002). A related finding is that the costs of antisocial behaviour incurred by individuals from childhood to adulthood were 10 times greater for those who were seriously antisocial in childhood than for those who were not (Scott et al., 2001).

There is mounting scientific evidence to demonstrate the cost effectiveness of mental health prevention and treatment interventions (Keating & Hertzman, 1999; Durlak, 1998). For example, studies have shown that a family-based social work intervention for children and adolescents who deliberately poisoned themselves (Byford et al., 1999), and a diversion programme for children with conduct disorder (Greenwood et al., 1996), were cost effective. Even though these studies were carried out in the United Kingdom or the United States, this is likely to be the case in other countries as well. What has not yet been demonstrated is that interventions in childhood or adolescence will lead to cost savings in adulthood. However, it is reasonable to assume that costs will be reduced if impairment is lessened.

Emerging scientific evidence shows that mental health interventions are cost effective.

Key points

- Child and adolescent mental health policies should promote the mental health of all children and provide treatment and care for children and adolescents with mental health problems.
- Child and adolescent mental health problems and disorders need to be seen in their wider social context.
- Children and adolescents with mental health problems and disorders are particularly vulnerable to stigma and discrimination.
- Mental disorders in children and adolescents vary according to their developmental stage.
- Factors that affect the mental health of children and adolescents can be divided into risk and protective factors.
- Risk and protective factors can be targets for intervention.
- Mental health interventions need to be sensitive to the developmental stage of children and adolescents and should take into account social and cultural differences.
- There is increasing evidence that prevention and treatment interventions are cost effective.

2. Developing a child and adolescent mental health policy

A recent survey has revealed that no country in the world has a clearly defined mental health policy pertaining uniquely to children and adolescents (Shatkin & Belfer, 2004). However, 34 countries (7% of countries worldwide) were found to have identifiable mental health policies, which may have some beneficial impact on children and adolescents. This relative lack of policies is unfortunate, since an explicit policy for child and adolescent mental health can improve the quality and accessibility of services and promote the mental health of all children and adolescents within a country.

Several different systems of care (e.g. education, welfare, health) may need to be involved to ensure that services for children and adolescents are effective. An overriding consideration is that child development influences the vulnerability to disorders, how disorders manifest themselves and how best they may be treated. Thus a developmental perspective is needed for an understanding of all mental disorders and for the development of an appropriate child and adolescent mental health policy.

A developmental perspective is needed for an understanding of all mental disorders and for the development of an appropriate mental health policy.

A child and adolescent mental health policy should present the values, principles and objectives for improving the mental health of all children and adolescents and reducing the burden of child and adolescent mental disorders in a population. It should define a vision for the future and help establish a model for action. Such a policy would also underscore the priority that a government assigns to child and adolescent mental health in relation to overall health, social and other priorities.

It is important for the policy development process to culminate in the production of a written policy document. This is important for two reasons. First, it provides a reference point to which planners and other stakeholders can turn for assistance with decision-making or conflict resolution. Second, it serves a symbolic function as the concrete result of the policy development process, and establishes a basis for future improvements.

A key issue that needs to be resolved is whether a child and adolescent mental health policy should be part of a general mental health policy, part of a broader children's health policy, or developed as a stand-alone policy. An independent child and adolescent mental health policy will focus attention on the key issues, and ensure that the needs of this group are not lost in the development of a broader policy. On the other hand, a broader approach may allow for a more comprehensive response to the mental health needs of children and adolescents, and allow more diverse stakeholders to participate in the process.

This section provides a series of steps that can be taken to develop a child and adolescent mental health policy. These steps include gathering information and data for policy development; gathering evidence for effective strategies; consultation and negotiation; exchange with other countries; determining the vision, values, principles and objectives of the policy; determining the areas for action; and identifying the major roles and responsibilities of different stakeholders and sectors.

This section provides a series of steps that can be taken to develop a child and adolescent mental health policy.

2.1 Step 1: Gather information and data for policy development

The development of a child and adolescent mental health policy begins with the question: What are the needs of the population? This requires an understanding of the prevalence of mental disorders and, more specifically, mental health problems among children and adolescents. It is also necessary to know what resources are currently available.

Once this data is collected, it becomes easier to define the scope of the policy. For example, in some countries epilepsy and mental retardation will be included in a child and adolescent mental health policy, while in other countries they will be incorporated into other health policies.

It is important that policy be formulated with an understanding of the population's needs. Need can be identified in several ways, including through information about the prevalence and incidence of child and adolescent mental disorders, learning which problems communities have identified, and understanding how people seek help for child and adolescent problems (see also the modules, *Mental Health Policy, Plans and Programmes* and *Planning and Budgeting to Deliver Services for Mental Health).*

It is important that policy be formulated with an understanding of the population's needs.

In some situations, it may be more feasible to restrict attention to certain subsets of the total population, for example, children and adolescents with severe mental disorders, or street children who may be at high risk of developing a mental disorder.

The methods for collecting the above data vary, depending on the resources and time available. Epidemiological data is more scarce for children and adolescents than for adults. However, a disorder that has a higher prevalence rate does not necessarily indicate a greater degree of need. Indeed, a rare disorder that severely compromises the quality of life of the person, and which has high care demands and is easily preventable, may receive a higher priority than other disorders that do not share these characteristics.

Prevalence estimates are most commonly derived from an expert synthesis of the best available data. Such estimates will generally be good enough for planning purposes. Epidemiological data of good scientific quality in the area in which services need to be developed are rarely available. Generally, conducting such studies in contexts where resources are minimal will not be a cost-effective strategy.

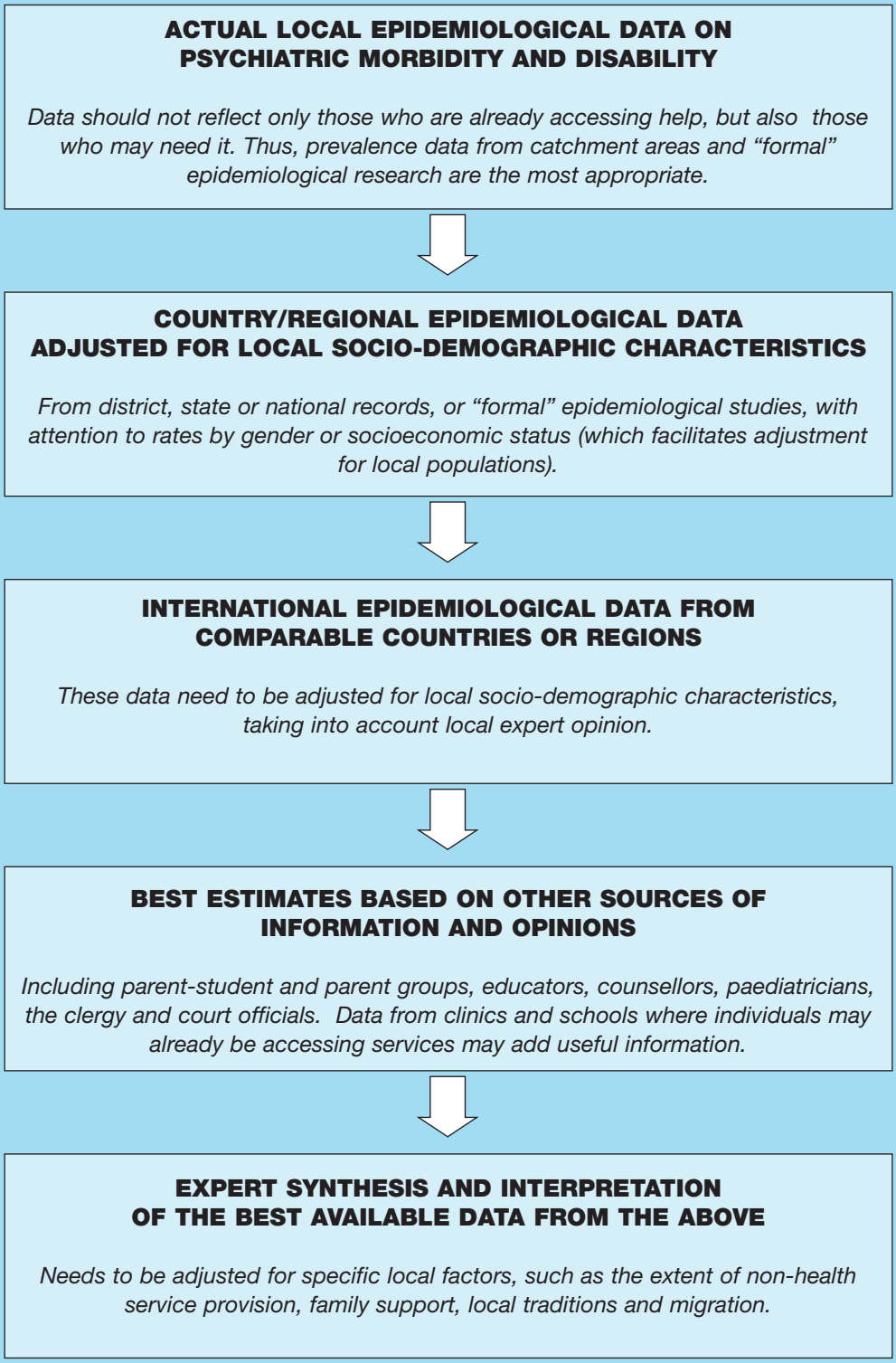
Prevalence estimates are most commonly derived from an expert synthesis of the best available data.

In addition to epidemiological studies, assessment can also involve *rapid appraisal* of the population. Relevant to child and adolescent mental health issues, interviews with educators, clergy and law enforcement may also be useful. Children and adolescents may be included in such an appraisal, when appropriate, to gain an additional insight from the potential target population regarding the acceptability of services.

Assessment can also involve rapid appraisal of the population.

Figure 2 lists sources of prevalence data.

Figure 2. Sources of epidemiological data (listed in order of decreasing reliability)



In addition to determining the prevalence of specific problems and disorders, it is helpful to identify the major risk and protective factors that have an adverse impact on the population concerned, and which have been identified by key community participants or experts. For example, where the need to increase agricultural production in many rural communities is associated with children's reduced school attendance

rates, programmes may be required to improve school education and enhance social development. Alternatively, increasing social isolation and demands for high academic performance in some developed communities may be associated with higher rates of depression, suicide and family conflict; this may necessitate programmes that are able to support more realistic academic goals and improve family communication.

Information on the population's needs should be supplemented with good data and understanding of the current status of child and adolescent mental health services in the country.

Information on the population's needs should be supplemented with good data and understanding of the current status of child and adolescent mental health services in the country. This includes information on the *human resources* available. For example, what is the role of primary care providers, what training have they received and what competencies do they have? Who supports mothers after childbirth? What is the role of traditional healers? How many specialist mental health workers are available in the country, and do they receive training in child and adolescent mental health? It is important to identify workers who may promote the mental health of children and adolescents (such as youth workers who work with street children), who may not be immediately identifiable as mental health workers.

It is important to understand the attitudes of health workers to the current system.

It is also important to understand the *attitudes* of health workers to the current system and possible changes in the system. The quality of child and adolescent mental health services depends on the knowledge and motivation of these workers.

Determining the financing of mental health services for children and adolescents is also necessary.

Determining the *financing* of mental health services for children and adolescents is also necessary. This includes identifying both the sources of funding (for example, through taxation or donor programmes) and the expenditure on services. In many countries there will not be a distinct budget for child and adolescent mental health. The module on *Mental Health Financing* provides more guidance on funding issues.

An assessment of the prevailing situation should involve gaining knowledge of the full range of settings where children and adolescents are educated, live and socialize.

The structure and focus of the existing *organization* of services for child and adolescent mental health should be examined so as to allow identification of its various components and enable eventual benchmarking. An assessment of the prevailing situation should involve gaining knowledge of the full range of settings where children and adolescents live, are educated and socialize. Such settings include: after-school programmes, clinics, community centres, day programmes, homes, inpatient units, orphanages, places of worship, prisons, schools, residential settings and the streets.

The needs of children and adolescents are inextricably linked with their developmental stage and the social and environmental context.

The needs of children and adolescents are inextricably linked with their developmental stage and environmental context. It is important to gather information on relevant age-specific issues. For example, a child's failure to develop may be the result of maternal depression affecting the ability to care. For such cases, it might be necessary to consider whether a home visiting programme or other mother-infant support programme can be identified to promote more appropriate mother-infant interaction, as well as facilitate the mother's access to needed psychiatric treatment (Beardslee, Versage & Gladstone, 1998; Lyons-Ruth, Wolfe & Lyubchik, 2000). Similarly, an adolescent suffering from a major depressive disorder needs to be able to access appropriate diagnostic facilities without barriers and with minimal stigma. Once diagnosed, adolescent-friendly services for treatment need to be available.

Box 1 presents an example of how gathering information and data contributes to policy development.

Box 1. Gathering information and data for policy development for young people at risk for suicide in New Zealand

As part of the development of best practice guidelines for the management of young people at risk of suicide, researchers at the Wellington School of Medicine completed a review of all young people who committed suicide during the period 1994–1999 (Smith, 1999). The review involved contact with Child, Youth and Family Services. It included all young people identified in the Child, Youth and Family Services register of young people who had died while in contact with the service, and an additional 22 young people from data matching the names from the New Zealand Health Information Service's register of suicides with those of the Child, Youth and Family data systems.

The results of this review show that 129 young people aged between 12 and 16 years died by suicide during the period 1994–1999. Of these:

- 43% (55 young people) had had previous contact with Child, Youth and Family Services at some stage in their lives;
- 33% (43 young people) were in current contact, or had been in contact within the last 12 months, with Child, Youth and Family Services;
- Additionally, 12 had had contact more than 12 months prior to killing themselves;
- The rate of deaths by suicide for young people in contact with Child, Youth and Family Services was 1 death in every 1,000 case files (per year) compared with 1 death for every 15,000 youth (per year) who had never accessed these services;
- Females in contact with Child, Youth and Family Services are 23 times more likely to die by suicide than females of the same age in the general population not accessing these services, and compared with males who are 5.4 times more likely;
- The review suggests that there are three groups amongst those youth who had contact with Child, Youth and Family Services and who died by suicide:
    - Young women who had low family support, high rates of abuse, high rates of suicide attempts and ongoing involvement of Child, Youth and Family Services;
    - Young men with a history of offending, particularly impulsive offending involving motor cars; and
    - Young men and young women with a history of alcohol and drug abuse and a history of previous suicide attempts.

This review suggests that targeted interventions for young people in contact with Child, Youth and Family Services has the potential to reach 50% of all young females and 25% of all young males aged under 17 years who would otherwise have killed themselves.

2.2 Step 2: Gather evidence for effective strategies

After collecting information about the needs of the population, the process now turns to gathering evidence on which strategies are effective for addressing those needs within the country or region, or elsewhere. Policy-makers have to know not only what works, but also under what circumstances it works and to what extent one can expect it to succeed. The more accurately the evidence reflects the needs of the specific target population, the more likely it is to be relevant.

Mental health interventions cover a spectrum of activities, ranging from mental health promotion (to build awareness and resilience) and universal and selective prevention (to reduce risk and vulnerability factors and build protective factors), as well as indicated prevention and early intervention strategies (for those with early signs of disorder), to treatment of varying intensity (for those with an established disorder) and extended care and rehabilitation programmes (for those with secondary impairments as a result of a disorder). There is varying but increasing evidence available for the efficacy and effectiveness of such interventions on particular populations.

Pilot projects are especially relevant at this stage of the policy planning cycle. Not only do they provide information about successful interventions, but they may also help reveal why certain programmes failed. Box 2 describes a pilot project to identify and manage mental health problems in schools.

Pilot projects are especially relevant at this stage of the policy planning cycle.

Box 2. Pilot project to provide mental health intervention in schools in Cambodia

In Cambodia, a team from the Center for Child Mental Health (CCMH) conducted a survey in four schools of Kandal province in order to assess the prevalence of emotional and behavioural problems amongst students. A Strength and Difficulties Questionnaire (SDQ) was used to assess: difficulties in relationships, conduct and emotional problems, hyperactivity and attention problems, and social skills. Of those surveyed, 20% of teachers and 13% of parents reported that the children had problems. The CCMH team interviewed all the "case positive children", counselled them at school, and referred a number to the CCMH if they required additional help. Class teachers were actively involved in the "school-based counselling", which strengthened the student-teacher relationship. The CCMH team conducted workshops on a School Mental Health Programme for the teachers, and they continue to sustain the programme in the four schools.

(Center for Child Mental Health, Caritas, Cambodia, 2004)

In addition to pilot projects using a controlled design and independent evaluation, often the people involved describe other interesting programmes. While the programmes may not have been formally designed or evaluated, they will often provide useful process information such as levels of programme or service acceptability, programme/service attendance, client satisfaction, difficulties in setting up and implementing programmes/services and perceived successes.

When evaluating studies in the international literature and pilot projects, a distinction should be made between *efficacy* (an intervention's ability to achieve a desired effect under highly controlled conditions) and *effectiveness* (an intervention's ability to achieve a desired effect within the context of a larger, non-controlled setting). The findings from a study using a well defined population group under highly controlled conditions may not necessarily be replicable in a "real-life" setting; hence caution will be needed in applying findings from clinical trials to real-life settings without giving consideration to implementation issues. Nonetheless, in a number of instances there could be sufficient "effectiveness" studies using an appropriate methodology and with findings strong enough to adopt on a broader scale (WHO, 2000; Eisenberg, 2000). Policy-makers should hold consultations with colleagues and nongovernmental organizations (NGOs) from other districts, provinces, countries or regions in deciding upon the programme models to be adopted, which meet reasonable standards of effectiveness worthy of being incorporated into policy (Nock et al., 2004).

A distinction should be made between efficacy and effectiveness.

2.3 Step 3: Undertake consultation and negotiation

Consensus building and negotiation are crucial at every stage of the policy planning cycle. For example, policy-makers can use the initial, information-gathering step as an opportunity to begin building consensus. Children and adolescents themselves may be motivated to provide information about their needs, and can be important contributors to the formulation of mental health policy. Parents and family members have an intimate knowledge of the impact of mental disorders on the functioning of the child or adolescent and the family. As always, the funding policies and plans affect what areas of consensus will ultimately become reality (Box 3).

Consensus building and negotiation are crucial at every stage of the policy planning cycle.

Box 3. A school-based participatory action research project

A community-based child and adolescent mental health programme, which was a participatory action research project, actively involved village leaders and families at each phase of the programme, from mapping to referral. Children and families in 15 villages in Kandal, Cambodia, and student health volunteers and teachers from four schools in Kandal province participated in the pilot programme. Fifteen psychology students volunteered to assess the "mental health needs" of the community, and a core group evolved to implement the programme. In all, 2000 families were contacted in the programme area. A Research Questionnaire for Children (RQC) was used to assess the prevalence of neuro-developmental and psychological problems in children and adolescents in the age group 2–18 years. The outcome of the research highlighted the need for psychosocial education and community-based initiatives to promote the comprehensive health and development of children.

Center for Child Mental Health, Caritas, Cambodia, 2004

It is critically important to maintain the involvement of all key stakeholders throughout the policy-making cycle. Box 4 provides a comprehensive list of stakeholders whose involvement could be sought and maintained in developing a child and adolescent mental health policy. However, not all stakeholder groups will be present or have the same level of importance in a country.

Box 4. Examples of stakeholders who could be consulted when developing a child and adolescent mental health policy

Academic institutions involved in the training of:
Child and adolescent psychiatrists/ psychologists
Paediatricians
School teachers
Social workers

Educational institutions:
Colleges
Early education training programmes
Schools
Universities

Government agencies, Heads of government, Ministries of:
Correctional services
Education
Employment
Environment
Finance
Health
Housing
Internal affairs
Justice
Police
Safety and security
Social Welfare
Trade and Industry

Health/mental health professionals working in community care or adult mental health services

Labour unions for mental health workers

Consumer groups, particularly those concerned with children and adolescents

Nongovernmental organizations

Organizations representing disadvantaged groups:
Indigenous peoples
Legal aid organizations
Refugees
Tribal minorities

Parents and other family members

Private mental health service providers

Service providers from:
Child and adolescent mental health units
Paediatric hospitals

Professional associations for:
Paediatricians
Psychiatrists
Psychologists
Social workers
Teachers

State institutions:
Agencies to combat drug abuse
Juvenile courts
Juvenile detention centres
Local governments
Parliament
Parole officers
Police

International agencies, e.g.
United Nations Children's Fund (UNICEF)
World Federation for Mental Health
World Health Organization

Faith-based organizations

Family/caregiver organizations

Youth assembled as youth parliaments

Consultation and negotiation frequently aim to garner support from a critical mass of stakeholders needed to generate sufficient political will among decision-makers. However, there are also other reasons why it is important to have consultation with a wide range of stakeholders. First, the social ecology of children and adolescents is such that their interests and needs should be met in a range of settings, such as the family, school and community. There are multiple pathways to sound psychological adjustment and good mental health, and each of the settings can contribute elements for a comprehensive child and adolescent mental health policy. It is generally those who are principally attached to a particular setting that are best placed to contribute policy elements that pertain to that setting. For example, a school-based mental health promotion policy is more likely to succeed if educators are involved in its formulation.

Consultation and negotiation frequently aim to garner support from a critical mass of stakeholders needed to generate sufficient political will among decision-makers.

The social ecology of children and adolescents is such that their interests and needs should be met in a range of settings.

Second, a consultation process can increase the buy-in of crucial stakeholders. If people have been actively involved in the development of a policy, they are more likely to have a vested interest in that policy's success and in ensuring that it "works". In contrast, when a policy is imposed on those whose commitment is necessary for its successful implementation, they may be resentful at not having been consulted, and may regard the implementation of the policy as an unwanted burden. Also, they may observe weaknesses in the policy that could reduce the motivation for making it succeed.

A consultation process can increase the buy-in of crucial stakeholders.

Third, while stakeholders may see the benefits of the mental well-being of children and adolescents, they may erroneously believe that mental health falls outside their realm. Involvement in a policy development process may increase their insight into the possible contributions their sector could make to the mental health of children and adolescents. This could result in an awareness and exploitation of opportunities for the enhancement of child and adolescent mental health that may arise in other projects or activities. Thus the benefits of involvement in a policy formulation process may be amplified in unpredicted ways.

Involvement in a policy development process may increase insight into the potential contributions of different sectors to the mental health of children and adolescents.

Consultation is an ongoing process, and the stakeholders who need to be consulted will differ according to the stage of development of the policy and plan.

2.4 Step 4: Exchange with other countries

Exchange with other countries can be mutually beneficial. It is essential that worldwide scientific advances and experiences of interventions inform child and adolescent mental health policies. This is more likely to occur when there is ongoing contact among those developing a child and adolescent mental health policy in various countries.

Exchange with other countries can be mutually beneficial.

International consultations can make an important contribution, especially when they reflect similarities in areas such as economic development, health system organization and governmental arrangements. In addition, more developed countries can be actively encouraged to share resources with less developed countries through sponsoring visiting consultants or exchange programmes for training, or funding joint training posts or joint development projects.

National and international professional organizations (such as the International Association of Child and Adolescent Psychiatry and Allied Professions, the World Association for Infant Mental Health and the World Federation for Mental Health) can be instrumental in providing support and promoting networking. WHO headquarters and regional offices are ideally positioned to facilitate exchange with other countries.

2.5 Step 5: Set out the vision, values, principles and objectives of the policy

In this step, policy-makers develop the core of the policy, informed by the outputs of the first four steps. It is important to address the twin goals of *responding to problems* (for example, the provision of psychosocial interventions to children and adolescents who suffer from mental disorders) and *promoting healthy development* (for example, the promotion of well functioning families and school-based life skills programmes).

It is important to address the twin goals of responding to problems and promoting healthy development.

Vision represents the positive expectations for the future mental health of children and adolescents. It should specify what is desirable and what goals should be strived to achieve. However, it should also be realistic about what is achievable in the economic and social context and realities of the country. The vision should serve to motivate and unite all stakeholders by appealing to their highest idealistic and altruistic motivations. An example of a vision for a child and adolescent mental health policy would be: Creating an environment which meets the psychosocial needs of children to enable their optimal development.

Vision represents the expectations of the future mental health of children and adolescents.

Values refer to intrinsic worth, quality or usefulness. They need to be consistent with the vision and flow from it. Certain values are widely held by policy-makers, planners, service providers and advocates engaged in the field of child and adolescent mental health. These include the values of *reducing suffering* and fostering *family cohesion*. Of course, even among those who subscribe to these values, there may be a divergence about their implications and meaning. A child psychiatric service, for example, may require all family members to be involved in the treatment plan for a child with a mental disorder, but mainly to ensure treatment adherence. In contrast, within a family therapy unit, most of the professional effort may be directed at altering the family structure, with almost no focus on the "index patient" whose problems precipitated referral to the agency.

Values refer to intrinsic worth, quality or usefulness.

Other values are more specific to cultural, economic and social circumstances, and to roles within the child and adolescent mental health services. *Social inclusion* might be a fundamental value for a consumer advocacy group. However, for a profit-driven health maintenance organization, social inclusion may not be a value to be considered in policy development. The key implication is that values need to be explicated and negotiated between all stakeholders with a view to achieving consensus. Subsequent policy development should consistently refer to these values to foster greater policy integrity, coherence, continuity and comprehensiveness.

Principles are broad actions that reflect the values; they are the action guidelines or behaviours that emerge from the values. For example, the principle that schools should be involved in policy development and service provision flows from an appreciation of the value of social inclusion. Provision of a mental health service for children and adolescents in primary care settings flows from the value of accessibility.

Principles can be regarded as the broad actions that reflect the values.

Box 5. Examples of values and principles in child and adolescent mental health policies*

Values	Principles
Protecting and supporting vulnerable groups in society	Specific mental health services for children and adolescents should be developed.
Considering mental health as indivisible from physical health	Child and adolescent mental health services should be integrated into general health services.
Assuring equity	Child and adolescent mental health services should be accessible to everybody, no matter what their socioeconomic status or geographical location.
Assuming responsibility for the prevention of psycho-logical, emotional and social harm	The health system should be oriented towards reducing risk factors for poor mental health and enhancing protective factors.
Promoting healthy development	Interventions should aim to promote the healthy development of all children and adolescents
Respecting the autonomy of children and adolescents	Children and adolescents should be involved in decision- making concerning the development and implementation of services and programmes.

** The examples are NOT specific recommendations for action.*
See boxes 12 and 13 for visions from which these values and principles might emanate, and objectives to which they might give rise.

Objectives are more specific than principles; they refer to the outcomes that the policy hopes to achieve and the manner in which the outcomes will be achieved. They should be measurable to allow progress to be monitored and to ensure accountability. WHO has defined three objectives for health policies: i) improving the health of the population; ii) responding to people's expectations; and iii) providing financial protection against the costs of ill health via subsidies, cost-sharing mechanisms and insurance. These objectives can also be applied to child and adolescent mental health.

Objectives are more specific than principles, and refer to what the policy sets out to achieve.

This description of the vision, values, principles and objectives suggests that the process of policy development proceeds through these steps in a linear manner. However, in practice, the process is not entirely sequential.

2.6 Step 6: Determine areas for action

Once the objectives have been defined, they need to be transformed into areas for action. A child and adolescent mental health policy should include coordinated actions in several areas to avoid isolated developments with limited impact. Actions in different areas should mutually reinforce each other. Two conditions are necessary for this to occur. First, there needs to be a clear grasp of how the actions fit within an overall child and adolescent mental health policy. This is more likely to be the case if Steps 1 to 5 have been followed. Second, there needs to be a high degree of intersectoral and interagency collaboration, so that opportunities for synergism can be grasped and unnecessary duplication avoided. Clearly, this is more likely if the stakeholder consultation process has been inclusive and exhaustive, and if participation has been maintained.

Actions in different areas should mutually reinforce each other in a synergistic manner.

Box 6 identifies some common elements from experiences of implementing policies in several parts of the world over the past few years.

Box 6. Areas for action for child and adolescent mental health

Financing
Intersectoral collaboration
Legislation and human rights
Advocacy
Information systems
Research and evaluation of policies and services
Quality improvement
Organization of services
Promotion, prevention, treatment and rehabilitation
Improving access to and use of psychotropic medicines
Human resources development and training

While there is general consensus that ministries of health need to take action in most of these areas in order to meet the overall objectives of a health policy, the emphasis given to each area, or the priorities within each area, will vary from one country/region to another. The mental health needs and demands of the population, the societal organization and culture, as well as public policies will determine the emphasis or priorities in each of these areas.

Financing

Adequate and sustained financing is one of the most important factors in the implementation of policy. It is a powerful tool that allows the ministry of health to transform the policy into reality (see module on *Mental Health Financing*).

Adequate and sustained financing is a powerful tool that allows the ministry of health to transform the policy into reality.

A budget needs to be established for child and adolescent mental health services, whether it is part of the overall health budget, an identifiable overall mental health budget, or a child and adolescent budget. If this does not occur, there is the danger that adult mental health services (which are generally underfunded) will pull funding away from child and adolescent mental health services. Similarly, there needs to be a process whereby expenditure can be monitored and reported regularly, so that comparisons can be made between the budgets and expenditures for children and adolescents and those for adults. This can contribute to greater transparency in allocation decisions, support more equitable resource distribution and help identify priority areas of need in ongoing planning.

Sustained financing is crucial, for two reasons: (i) some interventions for children and adolescents need to be available for an extended period of time; and (ii) the benefits from an intervention may become clear only after some years. Therefore, in order to ensure that budgets extend from one election cycle to the next, advocacy and educational efforts must ensure that financing is not based on short-term interests. In some countries, NGOs provide most of the services for children and adolescents. They should be encouraged to develop services that are sustainable in the long term.

Sustained financing is crucial.

Financing for child and adolescent mental health services needs to provide *incentives for collaborative efforts among potentially competing agencies*. The needs of the child or adolescent, rather than the needs of the programme, should be the priority for the provision of funding. Indeed, for children and adolescents with complex disorders, collaborative funding is desirable because they have contact with a range of agencies.

Financing for child and adolescent mental health services needs to provide incentives for collaborative efforts among potentially competing agencies.

One of the most common financial incentives for interagency collaboration is joint funding. For example, a programme to promote the mental health of street children could include the health (drug counselling services), education (school support) and juvenile justice (prison diversion for young offenders) systems, and so provide an incentive for the different agencies to work together to meet the objectives of the programme. Clearly, a collateral benefit from intersectoral collaboration is a greater awareness of the potential role for others to play in the promotion of mental health in their constituencies.

Funding needs to foster the development of a "*continuum of services*", which refers to the optimal mix of a broad range of biomedical and psychosocial services. Consumer choice should be taken into account when decisions are made about which services are offered. The extent of services available at different levels (primary care, community, general hospitals or psychiatric institutions) depends on financing decisions made at national and district levels (see module on *Organization of Services for Mental Health*).

Funding needs to foster the development of a continuum of services.

Financing of services should *incorporate some degree of flexibility* to allow for the cost of "outliers" – atypically expensive cases that can skew the average cost of care. Examples of such outliers include children or adolescents with schizophrenia or severe obsessive compulsive disorder. The response and duration of treatment of such child and adolescent mental disorders may be unpredictable and necessitate long-term care. Anticipating limited financial exposure for disproportionate utilization by a number of clients can avoid financial crises.

Financing of services should incorporate some flexibility to allow for the cost of "outliers".

Organization of services

The development of appropriate child and adolescent mental health services is a challenge, even in the most developed countries. However, the extent to which this challenge is met depends not only on the resources available within the country, but also on creativity and the will to enhance local strengths, pool resources and emphasize a commitment to the mainstreaming of children and adolescents with mental disorders in community settings.

WHO recommends an optimal mix of services, as illustrated in Figure 3. Table 3 provides examples of specific services related to this optimal mix. The largest proportion of mental health care ought to be self-care management and informal mental health services. This should be followed by services provided in primary care, community mental health services and services in general hospitals. Mental hospitals play a minimal role within this optimal mix of services. While the absolute need for such services is likely to vary between countries, the proportion required in countries is roughly the same.

The largest proportion of mental health care ought to be self-care management and informal mental health services.

Figure 3. WHO-recommended optimal mix of services

Source: adapted from WHO, 2003.

Table 3. Child and adolescent mental health services

Trier	Site	Personnel	Services
Informal community care	> Family > Schools > Prisons > Children's homes > NGOs	> Non-health workers > Volunteers	> Focus of services at this level to be on promotion of mental health and primary prevention of mental disorders
Primary health care	> Clinics > District hospitals > Maternity services > Family services	> Health workers > Doctors > Nurses	> Parental and youth education about general health and mental health issues > Screening for mental health problems (including suicidal tendencies) > Identification of young people at risk of mental health problems > Short-term counselling services for young people and their families > Basic management of behavioural disorders; follow-up and support for young people with chronic conditions.
Community mental health care	> Community mental health teams > Child guidance clinics > Child abuse units > Educational support services	> General mental health specialists, e.g. psychiatrists, psychologists, nurses, social workers > Multidisciplinary teams with additional training in child and adolescent mental health	> Investigation and treatment of severe problems referred from primary health care services > Consultation, supervision and training of staff at primary health care level > Link with other local and provincial sectors and NGOs in cross-sectoral prevention and promotion initiatives
General or paediatric hospitals	> Academic health complexes > Regional hospitals	> General mental health specialists, e.g. psychiatrists, psychologists, nurses, social workers > Child and adolescent mental health specialists > Multidisciplinary teams with additional training in child and adolescent mental health	> Investigation and treatment of severe problems referred from community mental health services > Consultation, supervision and training to community mental health service personnel > Links with other local and provincial sectors and NGOs in cross-sectoral prevention and promotion initiatives
Long-stay facilities and specialist services	> Chronic care institutions > Child and family units > Eating disorder units > Adolescent units > Abuse units > Private sector	> Child and adolescent mental health specialists	> Highly specialized diagnostic and treatment services > Support consultation and training to all levels of service > Rehabilitation services for subgroups such as autistic children and youth and those with psychotic disorders

Source: adapted from Dawes et al., 1997.

Where possible, child and adolescent mental health services should not be located alongside general child and adolescent health facilities. Moreover, there should be separate inpatient facilities for child and adolescent mental health care, as children and adolescents can experience fear and intimidation if they are treated alongside adults. Also, different tools, instruments and facilities are necessary for mental health work with children and adolescents, such as therapeutic games, progress assessment guides and observational data gathering forms. In some scenarios, it may be advantageous to combine services for children and adults. In the case of services for mothers suffering from post-partum psychiatric disorders, for example, it may be appropriate to attend to the mental health of the infant in the same setting.

Children and adolescents are generally best served by separate inpatient facilities for child and adolescent mental health care.

It is necessary to *coordinate* the different levels of treatment available for varying levels of severity of illness. For example, a drug rehabilitation unit that treats an adolescent for glue sniffing or opium smoking should contact the local addictions counsellor who may be treating the person after he or she has been discharged from the unit. Similarly, a health worker who screens and initiates treatment of a child with epilepsy should contact the traditional healer who has also been consulted.

It is necessary to coordinate the different levels of treatment available for differing levels of illness severity.

The concept of an organized system of care with a *continuum of services* has emerged to ensure that services are optimally linked. Such a system links services between the programmes offered by different agencies to provide for the needs of the child or adolescent in various settings, from the least restrictive community-based services (such as outpatient clinic therapy) to the most restrictive (such as inpatient care). In the absence of an organized system of care, there is likely to be poor communication, and therefore inefficient service utilization. Community-based systems of care facilitate access and allow children and adolescents to be treated in the context of their families, schools and local communities (see the module on *Organization of Services for Mental Health* for more details).

The concept of a continuum of services implies linkages of services.

It is crucial to involve parents/families and communities in planning mental health services for children and adolescents. For example, parents/families may be able to suggest changes that will improve existing services or indicate gaps in the existing continuum of services that can be addressed by new services, and that can provide essential support to a child or adolescent with a mental health problem. Box 7 illustrates treatment planning at a systems level, as well as the positive outcomes that can be achieved when parents/families are included in a young person's treatment plan.

It is crucial to involve parents/families and communities in planning mental health services for children and adolescents

Box 7. Treatment planning at a systems level and involving family members

Example 1 (Grimes, 2001)

The Massachusetts Mental Health Services Program for Youth (MaMHSPY) is supporting a “shared governance” model for addressing the mental health needs of adolescents and children. Six agencies are coordinating to focus on a group of “at risk” and ill children. “Blended funding” is used, meaning that each agency contributes a portion of funding for the programme. Family spokespersons and agency decision-makers participate in the MHSPY Steering Committee. Health as well as mental health concerns are addressed by this governance model. Eligibility criteria for the youth and families to be served was established by consensus using readily available scales for impairment (e.g. Child and Adolescent Functional Assessment Scale (CAFAS). The broad age range covered is 3 to 18 years, and priority is given to those with the greatest risk (scores of greater than 40) of “out of home” placement. Benefits include a long list of currently available services, seen as “usual care”, plus a list of other programmes developed in response to observed needs. Every family gets a Care Manager who works to set up a Care Planning Team made up of both professionals and non-professionals. The Team creates a “mission” for the child. A strength-based assessment

is done, needs identified, and interventions planned. The Care Manager delivers some care, links this to primary care and monitors all care; he/she has a close relationship with the family, but is not a therapist. The outcome measure of "days out of home" has dropped profoundly as a result of this intervention. School, family and community measures have improved. Service utilization has shifted to less costly and restrictive services, and satisfaction and programme retention is high.

Example 2 (Kamradt, 2000)

Anthony is a 15-year-old African American, who was placed in the mental health programme, Wraparound Milwaukee, because of multiple counts of criminal damage to property. He was diagnosed with attention deficit disorder and major depression. Anthony's family strengths included his parents' desire to keep him at home, a number of aunts and uncles who were interested in being resources for him at times of family stress, and his family's motivation for change. Anthony's personal strengths included his outgoing nature, affection for his siblings, a desire to find a job, and love for his parents.

His mental health team (called a Child and Family Team) included his mother, stepfather, aunt, a sibling, an in-home therapist, a probation worker, a volunteer mentor and his mental health worker (called his Care Coordinator). Formal services he received through the mental health programme included in-home treatment, day treatment, mentoring and job coaching. Anthony's aunt provided informal services – Anthony would stay with her during some of his crisis periods.

Anthony has been in the mental health programme for two years. He has had no further law violations, he has been an honour student in the alternative school programme, and will soon be returning to his neighbourhood school. He is also working part-time.

Promotion, prevention, treatment and rehabilitation

Policy-makers should consider all effective options for disease prevention, health promotion, treatment and rehabilitation. Disease prevention and health promotion among children and adolescents can have particularly far-reaching implications. For example, most mental disorders from which adults suffer have their origin in childhood or adolescence. One can therefore reduce the extent of long-term functional impairment by early recognition and prompt intervention. Health promotion interventions can focus on factors that determine or maintain mental ill health, such as poverty and stigma. Life skills programmes and child-friendly schools have been found to help promote sound and positive mental health (WHO, 1993; 1998). In New Zealand, the concept of recovery guides intervention. This concept underscores the need to support "the ability to live well in the presence or absence of one's mental illness" (see www.mhc.govt.nz/publications/2001/Recovery_Competencies.pdf).

Policy-makers should consider all effective options for disease prevention, health promotion, treatment and rehabilitation.

Priority should be given to vulnerable populations such as orphans, children with chronic medical illness, those with learning disabilities, refugees, the mentally handicapped, physically, sexually, or emotionally abused or neglected children, and children or youth in conflict with the law. Attempts should be made to offer interventions in settings frequented by young people, including schools, homes, workplaces, neighbourhood clubs, youth agencies and health services.

Box 8. School Mental Health Promotion Project in the Islamic Republic of Iran

The national mental health programme in the Islamic Republic of Iran was launched in 1988, and focused mainly on the integration of mental health into primary health care. In recent years, the rising number of young people (about 16.5 million school students) and the rapid process of urbanization, with its associated psychosocial consequences – as reflected in different surveys – has highlighted the specific need for mental health promotion in schools. A pilot project for school children and their parents was started in Damavand, a city north of Tehran. The intervention significantly helped improve students' and parents' attitudes towards mental health, increased student self-esteem, reduced fear of examinations, ended corporal punishment, reduced sexual assaults and led to a decline in smoking (Yasamy et al., 2001). The programme has since been extended to the whole country.

Medication for children and adolescents should be prescribed when clinically indicated, and generally as part of a more comprehensive management plan.

Medication for children and adolescents should be prescribed when clinically indicated, and generally as part of a more comprehensive management plan. The purpose of this module is not to provide guidance for clinical intervention. The judgment as to whether medication is clinically indicated should be informed by the available scientific evidence and the context of the particular child or adolescent. Concerning the use of medication, there are many widely available guidelines published by professional organizations and advisory groups (American Academy of Child and Adolescent Psychiatry, 2002). Policy needs to reflect the ongoing discussions on evidence for the effectiveness of various medications (Barkley, 2002). Every effort should be made to ensure that both the child or adolescent and his or her family understand and agree with a recommendation that medication is indicated.

It is important to ensure a regular supply of medication at treatment facilities.

An adequate budgetary allocation is essential to ensure a regular supply of medication at treatment facilities. The use of less expensive generic medications may contribute to cost containment (see module on I*mproving Access and Use of Psychotropic Medicines*).

Intersectoral collaboration

All the stakeholders that were consulted earlier can be sources of intersectoral collaboration.

Because children's and adolescents' well-being is apparent in and influenced by their participation in multiple sectors of society, mental health policy should foster collaboration between the different sectors concerned, such as education, welfare, religion, housing, correctional services, police and other social services. All the stakeholders that were consulted earlier can be sources of intersectoral collaboration (Box 4). This form of collaboration is important for the following reasons:

- It increases the comprehensive consideration of an issue;
- It encourages a continuum of care;
- Common risk factors drive some of the problems encountered in many different sectors (Durlak, 1998);
- It enables a range of different approaches to addressing an issue;
- Similar or identical issues can be addressed in various settings;
- It can increase efficiency and cost effectiveness by reducing duplication and enhancing synergy between sectors; and
- It increases awareness in other sectors of their potential role in implementing mental health promotion strategies.

Box 9 offers a number of suggestions for facilitating intersectoral collaboration.

Box 9. Suggestions for securing optimal intersectoral collaboration

Who should collaborate, and why?

- Initial planning should include a sensitive identification of who should be involved.
- All participants should reach a common understanding as to why they should work together, which is a crucial step in achieving the commitment needed for such work.

Structural support

- Intersectoral collaboration should be institutionalized, and not be dependent on ad hoc arrangements and favours.
- The institutionalization can take the following forms: the creation of incentive and reward systems linked to intersectoral collaborative action; creating job opportunities that cross traditional boundaries; and staff development that focuses on preparing the sectors concerned to participate in a collaborative effort.

Addressing the different goals and perspectives

- The different sectors need to become aware of their common goals and tasks, and of how each of the areas of specialization can contribute to the fulfilment of these goals and tasks.
- Opportunities for bringing the different sectors together need to be provided. It is often in the "doing" that the benefits of intersectoral collaboration are naturally discovered.
- Institutionalization of intersectoral collaboration (highlighted above) helps to create structures that "force" the different sectors to work with one another and, through working together, realize their common goals and contributions.
- Highlighting a common experience in the different sectors can facilitate an intersectoral approach. In this regard, a settings approach (e.g. focusing on the development of health promoting schools) is one way to discuss common issues.
- The advantages and benefits of working together need to be identified, and fears and resistance addressed.
- The health sector needs to become aware of the multidimensional nature of its work, recognizing the importance of including other sectors in trying to address problems and needs.

Resources

- Fear of loss of resources needs to be addressed. Efforts should be made to show how the collaborative action is cost effective for all concerned.
- Resources (finances, posts, time) need to be allocated to intersectoral collaborative action.
- It is important to achieve clarity about who is responsible for what.

Power dynamics

- Clarification of responsibilities to deal with multiple accountability issues should be pursued.
- Representation and consultation issues need to be addressed to ensure that adequate communication is achieved throughout the system.
- Group dynamics need to be managed to ensure optimal participation.
- Efforts should be made to ensure that there is equity between the different sectors involved.

Political processes

- The political benefits of intersectoral collaboration to all the departments or ministries should be highlighted.
- There should be a formalized joint agreement between the ministry of health and other ministries.
- Successful intersectoral collaboration is dependent on the broader organization of government in the country – the manner in which departments and ministries link and communicate with each other will influence the manner and extent of intersectoral collaboration.

Source: adapted from Lazarus, Moolla & Reddy, 1996.

Advocacy

The purpose of advocacy is to change the major structural and attitudinal barriers to achieving positive mental health outcomes for the population. Methods include lobbying, awareness raising, education and training. The goals of advocacy efforts for child and adolescent mental health include:

The purpose of advocacy is to change the major structural and attitudinal barriers to achieving positive mental health outcomes for the population.

- Changing laws and government regulations to ensure the human rights of children and adolescents are respected;
- Ensuring equity of all services for children and adolescents with mental disorders;
- Improving the promotion of mental health and prevention of mental disorders among children and adolescents;
- Keeping children and adolescents out of psychiatric institutions when possible (particularly relevant for the care of young children in the wake of the HIV/AIDS epidemic);
- Putting child and adolescent mental health on governments' agendas;
- Reducing stigma and discrimination of child and adolescent mental disorders in communities; and
- Including mental health considerations in the development of policies and plans in other sectors (for example, welfare schemes need to consider appropriate childcare and housing to promote a healthy environment for child rearing).

Child and adolescent mental health advocacy by parents, professionals and government departments responsible for health and education have brought a new awareness to legislative bodies in developed countries of the need for child and adolescent mental health services. International research and clinical attention to specific disorders can prompt the creation of parent advocacy groups, such as the burgeoning autism initiatives. It is helpful to be supportive of these groups as allies in the development of policy for the following reasons: (i) parents of children and adolescents with mental disorders tend to have considerable knowledge about the disorder, which can be harnessed to achieve common goals; (ii) parent advocacy groups can be helpful in gaining NGO support for programme development; (iii) parent advocates can be effective lobbyists specifically for child and adolescent mental health; and (iv) these groups provide support for caregivers, who might otherwise not cope and thus cause the burden to shift to the State.

Child and adolescent mental health advocacy has brought a new awareness to legislative bodies in developed countries of the need for child and adolescent mental health services.

Adolescents can be important advocates of their own interests and concerns. They need to be recognized with respect and given a voice when developing policies and plans.

The establishment of a ministry or commission for children and adolescents with mental disorders or for child and adolescent mental health can ensure sustained, integrated activity across different government departments. It can also become an effective advocate for the needs of children and adolescents by constituting a strong voice in government.

Legislation and human rights

Child and adolescent mental health policy is most effective when it encompasses a framework that relates child and adolescent development to an understanding of the rights of the child or adolescent. Related to this is the role of legislation, which should codify and consolidate the fundamental principles, values and objectives of child rights as related to mental health.

Child and adolescent mental health policy is most effective when it encompasses a framework that relates child and adolescent development to an understanding of the rights of the child or adolescent.

Support for children's rights is broad. The *United Nations Convention on the Rights of the Child* (CRC) of 1989 commits signatories to ensuring that all children have the right to develop physically and mentally, and to be protected from abuse and exploitation. The CRC also stipulates that children must be consulted and heard in matters concerning them. It explicitly and implicitly supports the need for addressing the mental health needs of children. It is possible to incorporate many aspects of the CRC into policy or legislation. For example, Article A19 states that all appropriate measures to protect the child from all forms of physical and mental violence should be taken, and that a mentally or physically disabled child should enjoy a full and decent life in which participation in the community is facilitated. Other articles address issues that are relevant for child and adolescent mental health services, such as: (i) provision for confidentiality; (ii) provision of strict controls over involuntary commitment; (iii) ensuring access to family members; (iv) eliminating unnecessary coercive treatments, such as inappropriate electro convulsive therapy, sedation or restraint; and (v) protecting people with mental disorders from abusive treatment.

The United Nations General Assembly Resolution 46/119 on the *Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, adopted in 1991, represents another serious international effort to safeguard the rights of all people with mental disorders. There are 25 principles which fall into two general categories: civil rights and procedures, and access to and quality of care. Some of the main principles are: (i) statements of the fundamental freedoms and basic rights of people suffering from mental disorders; (ii) criteria for the determination of mental disorder; (iii) protection of confidentiality; (iv) standards of care and treatment, including involuntary admission and consent to treatment; (v) rights of people with mental disorders in mental health facilities; (vi) provision of resources for mental health facilities; (vii) provision of review mechanisms; (viii) provision for protection of the rights of offenders with mental disorders; and (ix) procedural safeguards to protect the rights of people with mental disorders.

Children are protected under all human rights instruments. Examples include the *International Covenant on Civil and Political Rights*, Article 7 of which protects everyone, including those with mental health problems, from torture, cruel or inhuman or degrading treatment or punishment, and the right not to be subjected to medical or scientific experimentation without free consent. Another instrument is the *International Covenant on Economic, Social and Cultural Rights*, which states (Section 10.3):

> *Special measures of protection and assistance should be taken on behalf of all children and young persons without any discrimination for reasons of parentage or other conditions. Children and young persons should be protected from economic and social exploitation. Their employment in work harmful to their morals or health or dangerous to life or likely to hamper their normal development should be punishable by law. States should also set age limits below which the paid employment of child labour should be prohibited and punishable by law.*

A particularly important issue concerning the rights of children and adolescents is the appropriate use of involuntary admission and treatment, as this decision may be deferred to a parent, guardian or family member. In some cases, psychiatrists or the legal system may make this decision. The rights of the child or adolescent need to be balanced with the need of society to provide treatment for those who, by virtue of a mental disorder, are at risk to themselves or to others, or who are unable to recognize the need for treatment.

Human resources and training

Human resource development and training is essential in the area of child and adolescent mental health. There are likely to be very few appropriately qualified workers within a country, and careful planning will be required to ensure that sufficient human resources are available to achieve policy objectives. It is essential that the needs for human resources development be assessed early in policy development, and that strategies be devised to increase the number of appropriately trained people.

General health workers, such as nurses and doctors, may need to be trained to provide some child and adolescent mental health services. The functions allocated to categories of staff at different levels of service need to make optimal use of available skills, given the shortage of child and adolescent mental health specialists.

General health workers may need to be trained to provide some child and adolescent mental health services.

To increase resources for the provision of specialized treatment, some individuals from different disciplines may be sent abroad for special skills training, which can then be taught to others if such training is not available at home. In some instances, particularly in relation to child and adolescent psychiatric services, there can be retraining or additional training of adult psychiatrists or other clinicians to at least meet some minimal competency requirements for the treatment and care of children and adolescents.

Table 3 illustrates the different roles of personnel. Training programmes should be geared to the functions that personnel will be undertaking. It is not sufficient, for example, for child and adolescent psychiatrists to be trained only for the direct delivery of services if a large part of their job description also includes research and service development. Similarly, many treatment programmes will require a multidisciplinary approach, which needs to be considered when developing training programmes (see module on Human Resources and Training for Mental Health). There has been an increasing recognition of the need to provide manuals to assist in the provision of training for specific interventions. A major effort in this regard has been undertaken in a collaborative manner between the World Psychiatric Association (WPA), the International Association for Child and Adolescent Psychiatry and Allied Professions, and the World Health Organization. Information about this programme is available on the WPA web site at: http://www.globalchildmentalhealth.com/.

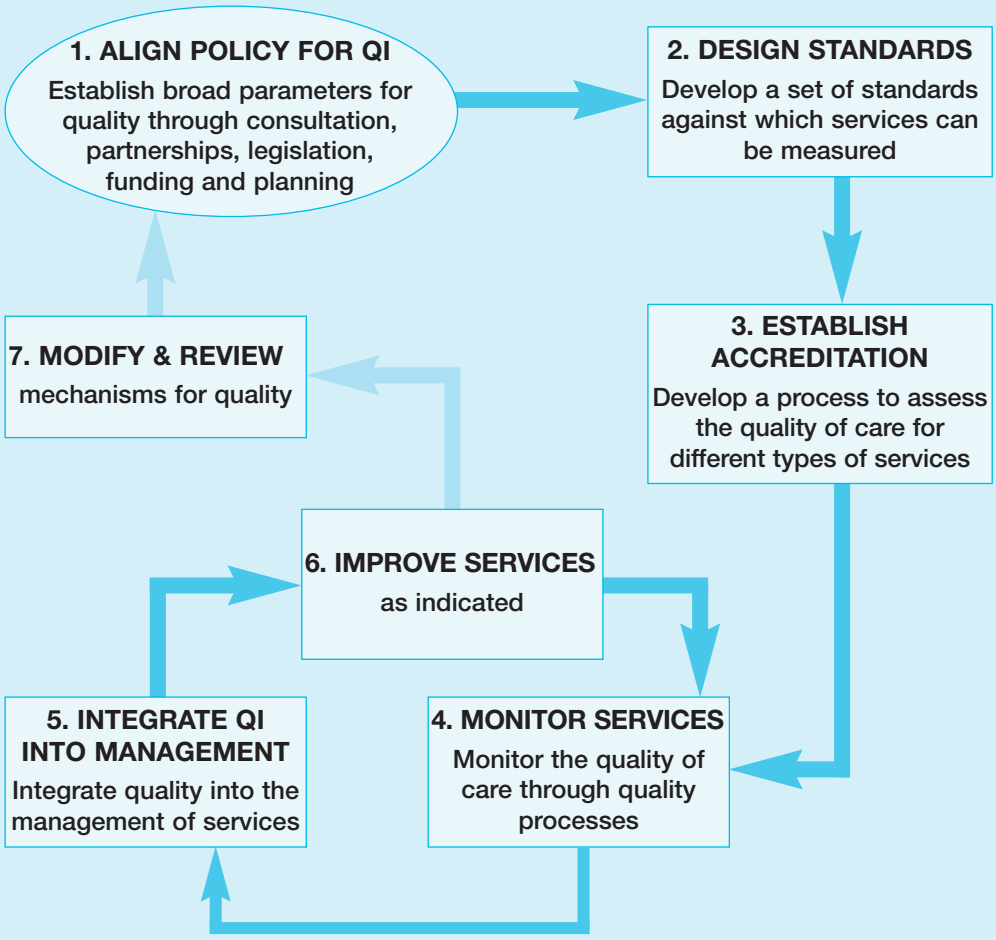
Quality improvement

Quality is a measure of whether services increase the probability of desired mental health outcomes and whether they are consistent with current evidence-based practices. Quality improvement (QI) is an ongoing, iterative process.

Quality is a measure of whether services increase the probability of desired mental health outcomes and whether they are consistent with current evidence-based practices.

The steps associated with ensuring quality, as summarized in Figure 4, are all relevant for child and adolescent mental health services (see also module on *Quality Improvement of Mental Health* for more detail). Quality improvement should include the meaningful participation (where appropriate) of children and adolescents who are receiving services, as well as their families, in designing, implementing and evaluating services. When evaluating services, measures assessing service satisfaction and individual and family outcomes should be included.

Figure 4. Steps in the quality improvement (QI) process
(For further detail see module on *Quality Improvement for Mental Health*)



There are two approaches to the design of a standards document for child and adolescent mental health services: a separate document can be compiled for children and adolescents, or the special issues pertaining to children and adolescents can be addressed in a document that covers all age groups. Whatever approach is followed, particular attention should be paid, among others, to the following:

- Ensuring the rights of child and adolescent service users, which includes aspects such as the provision of age-appropriate services, protection from abuse and neglect, protection within the criminal justice system, separate facilities for children and adolescents (compared to adults), and the right to education;
- Recognition that the child's or adolescent's developmental stage influences his or her optimal response to treatment;
- Ensuring confidentiality of communication and identity; and
- Involvement of parents where appropriate.

Information systems

Information systems are of immense value in the formulation of policy and the monitoring of its implementation. Where possible, funds should be allocated for establishing and operating a database. Such databases can vary enormously in complexity and comprehensiveness. At one extreme, an information system might consist of a list of the names of service users with some basic information such as diagnosis. At the other extreme, it might be a technologically sophisticated database

Information systems are of immense value in the formulation of policy and the monitoring of its implementation.

comprising many of the input, process and outcome indicators for child and adolescent mental health services listed in Table 4. However, the information systems should not be too time-consuming or costly, or too challenging to maintain from a technical standpoint and in relation to the resources available. In addition, providers from different settings should have ready access to the systems in order to ensure continuity of care across such settings. The data need to be relevant and meaningful from the policy point of view. All this should be achieved while assuring the rights of children, adolescents and their families to confidentiality. Indeed, confidentiality concerns should be codified for the protection of children, adolescents and their families.

Table 4. The mental health matrix, with particular reference to child and adolescent mental health services

Temporal dimension →

Geographical dimension ↓

	Input*	Process**	Outcome***
(1) Country/ regional level	Bed/population ratio Community/hospital ratio (staff) Expenditure on child and adolescent mental health Government policies Mental health laws Staff/patient ratio Staff/population ratio Treatment protocols and guidelines	Bed occupancy rate Admission rate Average length of stay Readmission rate Community/ hospital ratio (utilization) Default rate Minimum standards of care Patterns of service use Audit procedures Pathways to care and continuity Targeting of special groups	Divorce rate Homelessness rate Imprisonment rate School dropout rate Suicide rate
(2) Local level (catchment area)	Availability of medication Community/hospital ratio (staff) Hospital and community services Local service budget for child and adolescent mental health Staff numbers and mix Working relationships between services (intersectoral collaboration)	Admission rate Average length of stay Bed occupancy rate Community/hospital ratio (utilization) Default rate Readmission rate Subjective quality of treatments	Outcomes aggregated at local level Physical morbidity Suicide rate
(3) Patient Level	Assessment of individual needs Content of treatment Demands made by patients and families Information for patients/care-givers Staff skills and knowledge	Continuity of care Continuity of clinicians Extent of involvement of parents and schools Frequency of appointments Pattern of care process for individual patients	Disability Impact on caregivers Needs Percentage of days children and adolescents are absent from school Percentage of time parents spend at work Quality of life Satisfaction with services Symptom reduction

Source: Thornicroft & Tansella, 1999; some contents of the table have drawn on Lund, 2002.

**Input refers to the resources invested in a system.*
***Process refers to the way in which service items are delivered, including the service items themselves.*
**** Outcome refers to the changes in functioning, morbidity and mortality among those to whom the service is delivered (Thornicroft et al., 1999). Key indicators for change need to be agreed upon by all stakeholders, so that they can be clear as to whether or not expected outcomes are achieved.*

Research and evaluation of policy and services

The *World Health Report 2001* (WHO, 2001) identified five priority research areas for mental health. These areas, which are also relevant for child and adolescent mental health, are: epidemiological research; treatment, prevention and promotion outcome research; policy and service research; economic research and research in developing countries; and cross-cultural comparisons. Box 10 lists some specific research priorities in each of these areas.

The following are areas of priority for research: epidemiological research; treatment, prevention and promotion outcome research; policy and service research, economic research and research in developing countries; and cross-cultural comparisons.

Box 10. Research priorities for child and adolescent mental heath research*

Epidemiological research

- Prevalence and burden of major child and adolescent mental and behavioural disorders, both in communities in general and in populations at high risk.
- Longitudinal studies to examine the course of major child and adolescent mental and behavioural disorders and their relationship with psychosocial, genetic, economic and other environmental determinants.
- Relationships between psychopathology and risk behaviours, such as sexually risky behaviour and interpersonal violence.

Treatment, prevention and promotion outcome research

- Efficacy and effectiveness of pharmacological and psychosocial interventions, including interventions that have been shown to be efficacious or effective with adult populations.
- Factors affecting treatment adherence, including family factors.
- Implementation or dissemination research, which examines the uptake of effective interventions.
- Efficacy and effectiveness of various models of school-based mental health services.

Policy and service research

- Outcomes and cost effectiveness of different community care interventions, for example, residential care, day programmes and ambulatory services.
- Training requirements for child and adolescent mental health service providers, including different models for supplementing existing generic training to equip practitioners to include child and adolescent mental health services in their range of service provision.
- Ways in which interventions by traditional healers can contribute to improving the mental health of child and adolescent populations.
- Advantages and disadvantages of different modes of intersectoral collaboration.
- Optimal ways of integrating child and adolescent mental health services into general mental health services and paediatric health services.
- Impact of policy decisions on access, equity and outcomes.

Economic research

- Economic impact of child and adolescent mental health interventions, both short- and long-term, and in terms of health service costs and costs in other domains.
- Cost-benefit analysis of different interventions, for example integrated into adult services vs. not; school-based vs. clinic-based.

Cross-cultural comparisons

- Influence of cultural context on psychopathology.
- Impact of cultural factors on reliability and validity of research instruments.
- Development of appropriate methodologies to study mental health across and within cultures.

Source: adapted from WHO, 2001.

There are a number of barriers to conducting research on child and adolescent mental health services. In Box 11 several steps that could be taken to improve the quality and quantity of such research are suggested.

Box 11. Selected steps to improve the quality and quantity of child and adolescent mental health services research*

- Develop a child and adolescent mental health research web site that includes a bibliography of child and adolescent mental health research in developing countries.
- Develop a network of institutions that are involved in child and adolescent mental health research, which can serve as resource centres for research and training.
- Develop an inventory of potential sources of funding for research.
- Improve child and adolescent mental health research training in professional curricula of
  - child and adolescent psychologists and psychiatrists
  - child-care workers
  - paediatric nurses
  - paediatricians
  - public health practitioners
- Provide a range of research training options for child and adolescent mental health practitioners in the country and elsewhere, for example:
  - distance learning
  - doctoral and postdoctoral fellowships
  - full degree programmes
  - mentoring
  - short courses
- Organize exchange visits between child and adolescent mental health researchers and centres of research excellence in developed and developing countries (including some WHO collaborating centres).
- Dedicate a proportion of research funding to child and adolescent epidemiological and health services research.

Source: adapted from Patel, 2002.

2.7 Step 7: Identify the major roles and responsibilities of the different stakeholders and sectors

It is essential for all stakeholders and sectors to have a clear understanding of their responsibilities.

It is essential for all stakeholders and sectors to have a clear understanding of their responsibilities. All the stakeholders identified earlier can play an important role in implementing the child and adolescent mental health plan. For example the ministry of health may have the major responsibility for the development of treatment services; the ministry of education may have the major responsibility for developing mental health programmes in schools; academic institutions can assist with developing training programmes; and general health workers can assist in defining the responsibilities for child and adolescent mental health in primary care. However, ideally, all stakeholders should participate in planning so as to take advantage of the unique skills and experiences of each sector.

2.8 Examples of policies

Boxes 12 and 13 present summarized child and adolescent mental health policies for two fictitious countries, one with a low level of resources for child and adolescent mental health, and the other with a medium level of resources. It should be noted that these examples are provided for heuristic purposes only, and should not be regarded as recommendations. These examples will be developed in the three subsequent sections of this module.

Box 12. Example of a child and adolescent mental health policy for a country with a low level of resources (population = 10 million)*

Situation analysis

Interviews with health workers and community leaders concluded that:

- The main child and adolescent mental health challenges were disruptive behaviour disorders (especially attention deficit hyperactivity disorder and conduct disorder), effects of exposure to violence, and intellectual disability resulting in poor scholastic progress.
- The only services available were at two university clinics and in the private sector, to which only 10% of the population had access due to economic and transport barriers.
- The ratios of psychiatrists, clinical psychologists and psychiatric nurses per 100,000 population were 0.6, 1.0 and 10 respectively. However, a total of about 50% of the time of these personnel was spent in the university clinics and private sector.

*Note: Data is derived from the WHO ATLAS project and can be accessed at: http://www.who.int/mental_health/evidence/atlas

Child and adolescent mental health policy

Vision

Child and adolescent mental health services will deliver comprehensive, integrated, community-based promotion, prevention and treatment services, with an emphasis on disruptive behaviour disorders, minimizing the effects of violence and mental retardation.

Values → principles

- Vulnerable groups in society should be protected and supported → specific mental health services for children and adolescents should be developed.
- Mental health is indivisible from physical health → child and adolescent mental health services should be integrated into general health services.
- Children and adolescents with mental health problems are entitled to receive the same high standard of treatment and care provided to other groups in society.

Objectives

- To reduce the prevalence of common mental health problems in children and adolescents (especially disruptive behaviour disorders, and the effects of exposure to violence and intellectual disability), and reduce the level of associated suffering, impairment and disability.
- To reduce children's and adolescents' exposure to violence, and support the scholastic progress of those suffering from mental disorders as a consequence of violence.
- To ensure equitable access to mental health services for all children and adolescents.

Areas for action

- Intersectoral collaboration: Improve communications between the health and education systems to facilitate early recognition *and* the implementation of appropriate school-based interventions.
- Legislation and human rights: Liaise with the legal system to ensure that evidence by children and adolescents against alleged perpetrators of violence against them is provided without the presence of the alleged perpetrator.
- Research and evaluation: Evaluate an existing best practice model of school-based intervention programmes to reduce disruptive behaviour disorders and enhance school performance.
- Organization of services: Provide training and secondary consultation to primary health care workers.

** This example is provided for heuristic purposes only, and is not a recommendation for action.*

Box 13. Example of a child and adolescent mental health policy for a country with a medium level of resources (population = 10 million)*

Situation analysis

Interviews with health workers and community leaders concluded that:

- The main unmet child and adolescent mental health challenges were adolescent risk behaviours such as unsafe sexual behaviour (resulting in a high prevalence of HIV and other sexually transmitted infections), alcohol, tobacco and other drug use, and interpersonal violence.
- Conversely, there were low rates of health promoting behaviours (such as healthy eating and exercise).
- In the cities, mental health services were relatively accessible through an extensive primary health care system, supported by consultation and provision of hospital-based services.
- In the rural areas, there were few child and adolescent mental health services.
- There was very little interaction between the health and education systems.
- The ratios of psychiatrists, clinical psychologists and psychiatric nurses per 100,000 population were 10, 16 and 100 respectively. The majority of these professionals were employed in the public sector.

*NOTE: Data is derived from the WHO ATLAS project, and can be accessed at: http://www.who.int/mental_health/evidence/atlas

Child and adolescent mental health policy

Vision

Comprehensive, age-appropriate, community-based child and adolescent mental health services will be available for the whole population. Those services will work closely with other sectors to reduce the impact of risk factors for mental disorders and to enhance protective factors.

Values → principles

- Responsibility to prevent psychological, emotional and social harm → the health system should be oriented towards reducing risk factors for poor mental health and enhancing protective factors.
- Promotion of healthy development → interventions should aim to promote the healthy development of all children and adolescents.

- Respect for the autonomy of children and adolescents ' children and adolescents should be involved in decision-making relating to the development and implementation of services and programmes.

Objectives

- To provide comprehensive, age-appropriate community-based mental health services.
- To improve academic outputs among adolescents by reducing the prevalence of risk behaviours and increasing the prevalence of health promoting behaviours.
- To enhance access to preventive and promotive interventions for children and adolescents living in rural areas.

Areas for action

- Information systems: Develop an information system to monitor the extent of risk and protective behaviours among school students.
- Organization of services: Develop and implement a school-based mental health promotion intervention.
- Research and evaluation: Evaluate the outcome of interventions that aim to reduce the extent of risk behaviours or increase the extent of promotive behaviours.
- Human resources and training: Develop training in school-based health promotion interventions for child and adolescent mental health service providers and educators.

** This example is provided for heuristic purposes only, and is not a recommendation for action.*

Key points

- A child and adolescent mental health policy begins with the gathering of information and data for policy development.
- Evidence is needed to identify effective strategies.
- Consensus building and negotiation are crucial at every step of the policy planning cycle.
- A child and adolescent mental health policy should include a vision, values, principles and objectives.
- A number of different areas for action are likely to be required to realize the objectives within the policy.

3. Developing a child and adolescent mental health plan

Once development of the mental health policy is completed, the next step is to develop a plan to implement its objectives. *A plan consists of a detailed schema for implementing strategic actions that favour the promotion of mental health, the prevention of mental disorders, treatment and rehabilitation.*

Ideally, the policy should have been approved at all necessary levels before the plan is developed. This improves the likelihood of enthusiastic cooperation of all key stakeholders.

Ideally, the policy should have been approved at all necessary levels before the plan is developed.

The development of a plan builds on the process already established for policy development outlined in section 2 of this module. Obtaining information about the population's needs, gathering evidence and building consensus remain important to the creation of a plan.

3.1 Step 1: Determine the strategies and time frames

Strategies represent the lines of action which are thought to have the highest probability of success in implementing the mental health policy for a given population. Strategies are also referred to as "strategic plans".

Strategies represent the lines of action which are thought to have the highest probability of successfully implementing the mental health policy for a given population.

In developing and setting priorities for a set of strategies, it is often useful to begin with a SWOT analysis, in which the strengths, weaknesses, opportunities and threats of the current situation are identified. Table 5 presents examples of each of the points that could emerge from a SWOT analysis.

In developing and establishing priorities for a set of strategies, it is often useful to commence by conducting a SWOT analysis.

Table 5. Examples of strengths, weaknesses, opportunities and threats in a SWOT analysis

Strengths	Weaknesses
> Awareness of relevant child and adolescent mental health issues > Buy-in from family and consumer organizations, schools and advocacy groups > Favourable laws > High degree of motivation of human resources > High levels of intersectoral collaboration > Successful pilot experiences	> Inadequate information systems > Mental health workers poorly trained in child and adolescent mental health > Perceived insignificance of child and adolescent mental health issues (e.g. depression) compared to other health issues (infant mortality) > Poor coordination between different levels of care > Poor intersectoral collaboration > Poor quality improvement processes > Scarce allocation of resources to child and adolescent mental health
Opportunities	**Threats**
> Availability of the current module > Election of politicians with an interest in the mental well-being of children and adolescents	> Budgetary crises > Certain cultural practices > Personnel shortages

- International initiatives that are relevant for child and adolescent mental health (for example, the Mental Health Global Action Plan (mhGAP) and Tobacco Free Initiative of the WHO)
- Public alarm about relevant issues such as substance use among adolescents
- Recent current events highlighting a specific area of need (for example, suicide among adolescents, child abuse)
- Treaty obligations that accord priority to child and adolescent health (for example, the UN Convention on the Rights of the Child)
- Public focus on non-mental-health issues or adult mental health
- Public ignorance about child and adolescent mental health needs
- Stigma about mental health problems among children and adolescents
- Political crises such as civil war

Following a SWOT analysis, the following actions can be taken to develop and establish priorities for a set of strategies.

First, a comprehensive list of any potentially useful proposals should be devised for each of the areas of action that were developed during the policy formulation phase. At this stage one should be as inclusive as possible, and consider all proposals, even if at first they do not appear to be feasible or necessary. The list should include which stakeholders or sectors will be responsible for each strategy.

A comprehensive list of any potentially useful proposals should be devised for each of the areas of action.

Second, brainstorm with key role players to develop a set of strategies for implementing each of the proposals listed. When devising a plan for child and adolescent mental health, brainstorming sessions should include child and adolescent service providers, educators, service users (for example, youth and family members) and representatives from advocacy groups. The latter could include those that focus on young people in general, or on young people with specific mental health needs in particular. The SWOT analysis is particularly relevant for this stage.

Brainstorm with key role players to develop a set of strategies for implementing each of the proposals listed.

Third, the strategies identified in step 2 need to be pruned, so that there are two or three strategies for each area of action. It is recommended that key stakeholders and sectors be involved in this process.

Identify two or three strategies for each area of action.

A time frame should be established for each strategy. This is important to ensure the timely and accountable development of guidelines for budgeting, achieving a consensus on realistic expectations and developing appropriate criteria for evaluation. Some strategies might be implemented continuously and indefinitely, while others might operate for a limited time period.

A time frame should be established for each strategy.

Once a decision has been made about which strategies to pursue and how much time should be allocated for each strategy, it is necessary to develop details of how each strategy will be implemented. These details include setting indicators and targets, and determining the major activities and their costs, available resources and the budget. These issues are addressed in the next three sections. Although they are presented in a linear fashion, it is important to emphasize that the process is iterative and circular. For example, the activities will influence the targets and indicators, which in turn will be dependent on the availability of resources.

It is necessary to develop details of how each strategy will be implemented.

Examples of strategies are presented in Boxes 14 and 15. These are continuations of Boxes 12 and 13, which introduced countries with low and medium levels of resources respectively.

Box 14. Example of strategies and activities in a child and adolescent mental health plan for countries with a low level of resources* (continuation of Box 12)

Area of action

Intersectoral collaboration

Strategies

1. Establish regular meetings between key managers in the health and education systems.

2. Organize workshops for educators that aim to facilitate: (i) early recognition of youngsters suffering from disruptive behaviour disorders, mental handicap and other mental disorders, and (ii) implementation of appropriate school-based interventions for such students.

3. Provide readily accessible consultation to educators in follow-up to workshops.

Target

Every school should have at least one educator who has attended a workshop.

Indicator

Percentage of schools where at least one educator has attended a workshop

Activities

> Make contact with each school and secure its collaboration with the strategy;
> Identify a contractor to organize the logistics (including liaison with the schools, venues, transport, food) and secure a contract with the subcontractor;
> Develop the content of the workshops;
> Prepare sufficient copies of the teaching materials (for example, workbooks);
> Recruit personnel to facilitate the workshops;
> Train facilitators;
> Implement workshops;
> Identify a consultant for the school;
> Monitor implementation of the workshops; and
> Consider a plan for repeating the workshops, or for advanced workshops.

Area of action

Legislation and human rights

Strategies

1. Arrange a multimedia campaign with a key message that violence should be stopped.
2. Establish a pilot project in which evidence by children and adolescents against alleged perpetrators of violence against them is provided without the presence of the alleged perpetrator.

Target

Establish such a pilot project at courts at each of the three levels of the judiciary.

Indicator

Number of levels/pilot projects established.

Activities

> Obtain information from other countries about the operation of such courts;
> Lobby within the departments of justice for the establishment of the pilot projects;
> Obtain funding for the necessary equipment, such as digital recording devices;
> Identify specific courts where the pilot project can be implemented;
> Hold discussions with the members of the judiciary at these courts to ensure that they support the introduction of concealed witnesses, and to obtain agreement about a commencement date;
> Locate a venue at each court where the evidence can be provided;
> Provide training for the members of the judiciary who will be required to implement the project;
> Monitor the implementation of the project; and
> Obtain feedback from all key stakeholders as to the functioning of the system.

Area of action

Research and evaluation

Strategies

1. Document the rates at which youngsters are referred for interventions for mental disorders prior to the workshops (mentioned above) and after them.

2. Conduct an outcome study of the efficacy of primary health care interventions for mental disorders

Target

Completion of study.

Indicator

Stage of project completed:
> Protocol
> Fieldwork
> Analysis
> Write-up

Activities (assuming the intervention has been developed)

> Assemble a group of scientists and service managers to oversee the research;
> Obtain funding;
> Hire a project manager;
> Develop a protocol;
> Write a detailed description of what is required by the fieldworkers;
> Hire and train fieldworkers;

> Monitor the progress of the fieldwork;
> Enter and refine the data;
> Conduct a statistical analysis; and
> Write a report.

Area for action

Organization of services

Strategies

1. Design and implement an in-service training programme for nurses working at the primary care level.

2. Ensure that identified professionals are available to receive referrals from nurses and other professionals working at the primary health care level, and that lines of communication are efficient.

3. Introduce a system whereby psychiatrists and clinical psychologists working in the university clinic volunteer to spend half a day per week providing consultation-liaison (CL) services for primary health care (PHC) staff

Target

Eighty per cent of psychiatrists and clinical psychologists spending half a day per week providing CL services for PHC staff

Indicator

Percentage of psychiatrists and clinical psychologists spending half a day per week providing CL services for PHC staff

Activities

> Obtain the necessary support and approval from the university authorities;
> Hold a seminar for the psychiatrists and psychologists working at the university clinic to: (i) inform them about the current situation with regard to PHC mental health services; (ii) motivate them to volunteer to provide CL services for half a day per week; and (iii) explore what the nature of these services should be;
> Make the necessary logistical and practical arrangements for the new service;
> Inform PHC staff of the new service and secure their support;
> Develop a system of referrals;
> Monitor the implementation of the new service; and
> Approach psychiatrists and clinical psychologists who have not volunteered with a view to motivating them to do so.

** This example is provided for heuristic purposes only, and is not a recommendation for action. The target, indicator and activities are provided only for the last strategy for each area of action.*

Box 15. Examples of strategies and activities in a child and adolescent mental health plan for countries with a medium level of resources (continuation of Box 13)

Area of action

Information systems

Strategies

1. Establish a system for recording rates of sexually transmitted infections (including HIV infection) among adolescents.
2. Ensure that mortality data for adolescents are available and accessible in domains dealing with areas such as suicide and homicide.
3. Conduct regular surveys with large representative samples of school students with the aim of documenting prevalence rates of a range of health risk and promotive behaviours.
4. Establish a database to record academic outputs such as examination results and school dropout rates.

Target

The database should be established in all 24 education districts.

Indicator

Number (percentage) of education districts with a database.

Activities

> Secure the collaboration of the managers of all the education districts;
> Identify one person in each education district who will take responsibility for creating and managing the database;
> Constitute a working group to decide upon the kind of data to be recorded;
> Develop a system to gather the data at each school;
> Create a process to enable the school-level data to be summarized in the form of district-level data; and
> Institute a data quality control system.

Area of action

Organization of services

Strategies

1. Form an intersectoral working group to decide on the nature and format of the proposed school-based health promotion programmes.

2. Develop and implement a pilot programme in a small group of schools.

3. Disseminate the programme (informed by the results of the pilot project) to all schools in the country.

4. Access funding from within the health and education sectors as well as from outside.

Target

To raise 2 million MUs (monetary units)

Indicator

Amount of money raised

Activities

> Gather evidence of the cost effectiveness of school-based health promotion programmes;
> Lobby within the health and education sectors for additional funds or funds that can be reallocated from existing budgets;
> Attempt to persuade politicians of the cost effectiveness and other advantages of school-based health promotion interventions;
> Compile a list of potential sources of funding;
> Prepare funding applications for the potential sources of funding; and
> Institute the appropriate financial mechanisms to deposit and disburse the funds.

Area of action

Research and evaluation

Strategies

1. Arrange focus groups with school students to ascertain the culture-specific aspects of risk and protective behaviours among adolescents in the country.

2. Evaluate the pilot project, including inputs, process and outcome.

3. Evaluate the intervention, including the three aspects mentioned above.

4. Evaluate the extent to which dissemination has taken place (reach of the dissemination).

Target

Completion of dissemination evaluation

Indicator

Stage of research (see box 14 for more details)

Activities

> Assemble a group of scientists and service managers to oversee the research;
> Obtain funding;
> Hire a project manager;
> Develop a protocol;
> Write a detailed description of what is required by the fieldworkers;
> Hire and train fieldworkers;
> Monitor the progress of the fieldwork;
> Enter and refine the data;
> Conduct a statistical analysis; and
> Write a report.

Area of action

Human resources and training

Strategies

1. Arrange workshops for educators in which the etiologies of risk behaviours and the key elements of school-based health promotion are conveyed.

2. Provide support from within the health sector for educators who are implementing school-based health promotion programmes.

Target

Support for each of the educators (possibly 50) who are involved in implementing school-based health promotion programmes.

Indicator

Number (percentage) of educators involved in implementing school-based health promotion programmes who receive support from the health sector.

Activities

> Identify a group of health professionals who are motivated to work in collaboration with educators;
> Give the health professionals the necessary training to carry out this function;
> Provide the educators with the necessary information about the health professionals and what they can contribute to their work;
> Implement a system that links the educators with the health professionals; and
> Monitor the implementation of the new system

** This example is included for heuristic purposes only, and is not a recommendation for action. The target, indicator and activities are provided only for the last strategy for each area of action.*

3.2 Step 2: Set indicators and targets

Each strategy should be accompanied by one or more targets, *which represent the desired outcomes of the strategy*. The example in Box 17 indicates that in the area of intersectoral collaboration, the proposed strategy was to provide support from within the health sector for educators who are implementing school-based health promotion programmes. A target for this strategy might be that support is provided to 50% of all educators in a defined geographical area by an individual from the health sector who is specifically trained for the purpose of implementing a school-based mental health promotion programme.

Each strategy should be accompanied by one or more targets, which represent the desired outcomes of the strategy.

Such a target cannot be established in isolation from strategies in other areas of action that are necessary to achieve this target. The targets for the different strategies may need to be aligned to ensure that all of them can be met.

Indicators provide information that enables an assessment of the extent to which a target has been met. One needs to know the extent to which a target has been met in order to determine whether the strategy has been implemented successfully. In the

Indicators provide information that enables an assessment of the extent to which a target has been met.

example above involving educators' workshops, a suitable indicator would be the percentage of schools from which at least one educator has attended a workshop. The indicator should be in a format that is directly comparable with the target.

Ideal targets and indicators are: (i) quantitative (i.e. measurable); (ii) easy and economical to measure; and (iii) closely related to the strategy (i.e. reflect the immediate consequences of the strategy, as opposed to consequences that depend on additional intermediate outcomes).

3.3 Step 3: Determine the major activities

The next step is to determine the actual activities that are necessary to achieve each strategy. This is important for two reasons. First, it ensures that important steps are not omitted, and that each activity necessary to meet the objective is carefully thought out. Second, it enables identification of successes. If strategies are difficult and time-consuming to achieve, it can be demoralizing if milestones on the path to achieving the strategy are not identified. Completing an activity will serve to motivate people to complete the other activities necessary to successfully implement the strategy.

Completing an activity will serve to motivate people to complete the other activities necessary to successfully implement the strategy.

For each activity, it is important to clarify the four issues described below.

Who is responsible? It is essential to identify which agents are best placed to implement the activities with maximal efficiency and effectiveness and minimal expense.

How long will it take? Planners should define time frames in advance, thus creating a realistic timetable for each activity. By designing a plan on a monthly or other periodic basis it is possible to: (i) determine which activity has to follow another, and which can be done simultaneously; (ii) assess whether a plan is realistic and feasible; (iii) ensure that activities are spread throughout the year, as opposed to having some extremely busy patches followed by periods of relative inactivity; and (iv) facilitate regular reviews of progress towards completing each activity.

Children and adolescents have a rapid developmental trajectory. This implies that for some activities time frames may be somewhat shorter than they would be for adults in terms of evaluating effectiveness. Positive or negative outcomes will be apparent at a relatively early stage. For example, the acquisition of many academic skills occurs in specific and fairly short time periods. Thus the effects of treating a mental health problem that interferes with the acquisition of academic skills (such as attention deficit hyperactivity disorders) should be visible fairly quickly.

What are the outputs? The outputs for an activity correspond to the targets for a strategy – they define the desired results. If all the activity outcomes are achieved, this should automatically result in the strategic targets also being met. If this is not the case, it implies that there were errors in the formulation of the plan.

What are the potential obstacles or delays that could inhibit the realization of each activity? It is important to anticipate and address obstacles or delays. Identifying these has the additional benefit of clarifying the reasons why certain time periods were allocated for the completion of an activity.

These issues can be summarized in a matrix, as exemplified in Boxes 16 and 17, which refer to the countries with low and medium levels of resources described in previous boxes.

Box 16. Examples of detailed activities for selected strategies (Refers to a country with a low level of resources, as in Box 14)

Area of action
Human resources and training
Strategy 2
Arrange workshops for educators that aim to facilitate: (i) early recognition of youngsters suffering from disruptive behaviour disorders, mental handicap or other mental disorders, and (ii) implementation of appropriate school-based interventions for such students.
Target
Provide 10 workshops for educators from 50 schools.
Indicator
Percentage of schools where at least one educator has attended a workshop.

Activity	Month when activity is implemented												Responsible person	Output	Potential obstacles
	J	F	M	A	M	J	J	A	S	O	N	D			
Make contact with each school and secure its collaboration													Education official (name)	Schools contacted Collaboration secured	Difficulty in contacting schools Schools unwilling to participate
Identify a contractor to organize the logistics, and establish a contract													Project manager	Contractor identified Contract signed	No suitable person available No agreement on terms of reference
Develop the content of the workshops (including teaching materials)													Education official (name)	Workshop contents & materials available	Education official not able to complete task on time
Prepare sufficient copies of the teaching materials													Project manager	Sufficient copies available	Insufficient resources Master copies not available on time
Recruit personnel to facilitate the workshops													Project manager	Correct number of appropriate facilitators obtained	Unable to recruit sufficient number of qualified facilitators
Train facilitators													Project manager, education official	Facilitators all able to achieve desired outcomes	Facilitators do not arrive for training Training not completed on time
Implement the workshops													Facilitators, contractor	Workshops take place	Venues not suitable Poor attendance by educators
Monitor implementation of the workshops													Project manager, research assistant	Collection of data regarding workshops and attendance	Difficulty in contacting facilitators

Box 17. Examples of details of activities for selected strategies (Refers to a country with a medium level of resources, as in Box 15)

Area of action
Intersectoral collaboration
Strategy 4
Provide support from within the health sector for educators who are implementing school-based health promotion programmes.
Target
Support for educators, who are involved in implementing school-based health promotion programmes from 50 schools.
Indicator
Percentage of schools with at least one educator who is involved in implementing school-based health promotion programmes that received support from the health sector.

Activity	Month when activity is implemented												Responsible person	Output	Potential obstacles
	J	F	M	A	M	J	J	A	S	O	N	D			
Identify a group of health professionals who are motivated to work in collaboration with educators													Health sector manager (name)	Group of health professionals identified	Health professionals not motivated to participate
Provide the health professionals with the necessary training to carry out this function													Health sector manager (name)	Training provided to the health professionals	Impossible to find a time and venue convenient for most of the health professionals
Provide the educators with the necessary information about the new project													Education sector manager (name)	The educators become sufficiently informed to make good use of the new service	Educators reluctant to receive help from health professionals
Implement a system that will link the educators with the health professionals													Health and education sector managers	A set of processes developed and pilot tested	Impossible to develop a system that is efficient and effective owing to logistical difficulties
Monitor implementation of the new system													Research assistant	Data collected on the extent to which the new system is operating	Unable to recruit a suitable research assistant

3.4 Step 4: Determine the costs, available resources and the budget

It is important to establish the *costs* for each year as well as for the total duration of time for which the strategy will be implemented. There are three principal resource inputs necessary to implement strategies for child and adolescent mental health (as for other areas of health).

Human resources are often the most expensive component of the health-care system. They represent recurrent expenditures throughout the duration of a plan. Capital investment is also necessary to educate and train people. This may involve supplementing the training of professionals with additional exposure in the field of child and adolescent mental health. Many clinical psychologists, general practitioners, nurses and psychiatrists, for example, do not receive sufficient training in child and adolescent mental health during their professional training. This can be addressed by short courses, fellowships, or ongoing supervision and training (see module on *Human Resources and Training for Mental Health*).

Human resources are often the most expensive component of the health-care system.

Physical capital refers to buildings, equipment and vehicles, which are purchased through capital investments. Usually, these are not annual expenses. However, a common error is to fail to budget for ongoing maintenance to prevent rapid deterioration and early replacement.

A common error is to fail to budget for ongoing maintenance to prevent rapid deterioration and early replacement.

Consumables refer primarily to medication. Table 6 indicates the resource inputs that may be necessary for the implementation of a school-based epilepsy prevention and treatment programme. This example can also be used to illustrate how the availability of resources shapes the time frame. Year 1 may involve preparing training materials, to be used during Year 2 by personnel who will begin screening during the second part of Year 2 or thereafter. If training materials are already available, or if the personnel already have sufficient expertise at the outset to obviate the need for training, the time frame can be shortened.

Table 6. Resources required for school-based epilepsy screening/treatment programme*

Country type	Human resources	Capital resources	Consumables
Low income	School staff (for screening) Health workers to staff mobile health teams (for treatment) Nurses or physicians (for consultation)	Training materials for staff Locations for screening (could be existing buildings) Vehicles	Antibiotics Antiepileptics EEG machines
Middle income	Health workers (for screening) Nurses to staff mobile health teams (for treatment) Physicians (for consultation)	Training materials for staff Locations for screening (could be existing buildings) Vehicles	Antimicrobials Antiepileptics CT scanners EEG machines
High income	Nurses (for screening and referral) Medical doctors and neurologists (for treatment)	Training materials for nurses Adequate space at health clinics	Antimicrobials Antiepileptics CT scanners EEG machines MRI machines

**These examples are NOT specific recommendations.*

Determining the *available resources* involves assessing the funding that is available from all sources. Within the mental health sector, funds can be accessed through State funding (from general taxation), social resources, donors, private insurance, and out-of-pocket payments. Additional resources could possibly be accessed from other sectors such as education and justice.

The *budget* is the product of the available resources and the expected costs of the planned services, programmes and projects. In most cases, the costs will need to be cut to bring them in line with available resources. This can involve reducing the number of strategies, increasing the amount of time that is allocated for the achievement of a particular strategy, and reducing the number or intensity of activities for one or more strategies. It is necessary to be realistic about what can be achieved. In fact, it is preferable to promise less and deliver more than the converse.

The budget should be reviewed at least on an annual basis, and preferably more frequently. Once the implementation of a strategy is under way, it may be possible to make more accurate estimates of future expenditures on the basis of the costs that have already been incurred.

The time frame and resources need to be considered together to emphasize their mutual dependence. Each strategy should be linked to a time frame that is attainable with the available resources. Some strategies will need to be pursued indefinitely, while others will operate only for a limited period of time. A common error is to attempt to achieve too much in the first year of implementation of a strategy. This error is due to planners tending to underestimate the amount of time required to assemble a team, establish procedures, infrastructure and financial mechanisms, and transfer the funding from its source to an account that can be accessed for strategy implementation activities.

Key points

- A child and adolescent mental health plan is a detailed, pre-formulated scheme for implementing strategic actions that favour the promotion of mental health and the prevention and treatment of mental disorders.
- Strategies and time frames need to be determined to establish guidelines for budgeting, set realistic expectations and develop criteria for evaluation.
- Each strategy should include one or more targets.
- Activities need to be identified, and the costs, available resources and budget established.

4. Implementation of child and adolescent mental health policies and plans

This section identifies the steps for successful implementation of child and adolescent mental health policies and plans. These steps include disseminating the policy; generating political support and funding; developing a supportive structure, setting up pilot projects in demonstration areas; and maximizing coordination.

It is also important to consider the evaluation of child and adolescent mental health policies and plans. While a comprehensive discussion of evaluation issues is beyond the scope of this module, Table 4 provides a summary of some of the areas to be included in an evaluation using the Mental Health Matrix (Thornicroft & Tansella, 1999) as a conceptual framework. In addition the modules on *Quality Improvement for Mental Health, Information Systems* and *Research and Evaluation* provide more detailed guidance.

4.1 Step 1: Disseminate the policy

The formulated policy must be disseminated to health district offices and other partner agencies, and to individuals within those agencies.

The formulated policy must be disseminated to all involved governmental bodies at all appropriate levels, other stakeholders and key individuals. This needs to be an ongoing process over time and requires sustained efforts. Box 18 presents some ideas as to how such dissemination can take place.

Box 18. Ideas for the dissemination of a child and adolescent mental health policy or plan

- Hold meetings with health teams, consumers, families, advocacy groups and other stakeholders for analysis of the policy or plan.
- Involve as many sectors as possible in the dissemination process.
- Organize a public event with the media, where the minister for health, or another leader, officially announces the launch of the new policy, plan or programme.
- Organize national seminars to discuss the policy or plan.
- Print and distribute posters, leaflets and flyers highlighting the main ideas of the policy or plan.
- Print booklets about the policy, plan or programme for distribution to stakeholders.
- Recruit and support consumer, family and other advocacy groups to help with information dissemination about the policy or plan.

Stakeholders in the area of mental health of children and adolescents include the children and adolescents themselves, and their families. The success of the dissemination of a policy and plan will be maximized if children, adolescents and their families are reached at a variety of locations such as schools, streets, rural areas and workplaces.

Dissemination must also take into account the fact that large numbers of children, adolescents and their families are not able to read.

Dissemination must also take into account the fact that large numbers of children, adolescents and their families are either unable to read, or only able to read with difficulty. There are several reasons for this; for example, a child may be too young to read and an adult may be illiterate. Dissemination techniques also need to be culturally

appropriate. Examples of captivating and innovative dissemination techniques appropriate for children and adolescents and their families include dance, magic shows (Lustig, 1994), music (e.g. rap songs) (Remafedi, 1988), puppet shows (Skinner et al., 1991), theatre (Citizens Commission on AIDS for New York City and Northern New Jersey, 1991), story-telling and videos.

4.2 Step 2: Generate political support and funding

No policy or plan, no matter how well conceived and well researched, has a chance of success without political support and a level of funding commensurate with its objectives and strategies. Political support should be generated early in the process, with continued commitment and engagement to ensure that the policy, once formulated, is implemented. Because young people are often dependent on others to advocate on their behalf, advocates for child and adolescent mental health need to ensure the political and financial viability of a plan, often without the persistent advocacy of the service users themselves. Accurate estimates of cost should be provided to potential supporters to avoid underfunding of programmes or raising expectations for savings that may not be realized. Many advances in programming require initial investments before savings or efficiencies can be realized.

No policy or plan, no matter how well conceived and well researched, has a chance of success without political support and a level of funding commensurate with its objectives.

Advocates of a mental health policy within the ministry of health will need to find allies in other parts of the government, and in the community or country at large. They could organize meetings with their counterparts in other government departments. The goal of such meetings would be to demonstrate the importance of child and adolescent mental health and enlist broad support from within the government for implementation of the policy.

Generally, anyone with an interest in the well-being of young people can be encouraged to extend this interest to mental health issues. Table 7 lists some potential allies, along with examples of how improved child and adolescent mental health will have collateral benefits in their sphere of operation. Clearly, child and adolescent mental health advocates need to lobby officials in a range of relevant government departments.

Anyone with an interest in the well-being of young people can be encouraged to extend this interest to mental health issues.

Table 7. Potential allies when developing child and adolescent mental health services

Potential allies	Benefits within the sphere of interest of the ally for improved child and adolescent mental health
Civic organizations such as scouts, musical groups, AIDS prevention organizations	Increased enrolment Improved performance Fewer behavioural problems
Justice system officials	Fewer criminal acts Fewer court cases Fewer and milder sentences
Primary care clinics	Improved physical health Increased treatment adherence
Rate payers' or tenants' associations	More considerate neighbours Less crime
Religious organizations	Increased participation and attendance
School officials	Improved academic performance Lower truant and dropout rates Fewer behavioural problems

It is essential that people who are able to generate support for the policy at the highest

levels of government are involved in the development and implementation of the policy. Identifying and staying in constant contact with a sponsor or champion at the highest government level is one of the critical factors to initiate and sustain a policy. Community leaders can become important advocates for the policy, ensuring that strategies are actually implemented.

4.3 Step 3: Develop a supportive structure

The implementation of a child and adolescent mental health policy and plan requires contributions from individuals with a wide range of expertise.

The implementation of a child and adolescent mental health policy and plan requires contributions from individuals and organizations with a wide range of expertise in, for example, child and adolescent physical and mental health, public health, economics, management, epidemiology and research. As mentioned earlier, individuals with training or experience that is mainly applicable to adults may need to complement this with training applicable to children and adolescents.

It is necessary to involve all geographical and administrative levels of a country or health system in the implementation process. For example, at the national level, a multidisciplinary team may be charged with implementing the policy in the country. While the size and skills of the team will vary according to the country's needs, allocation of responsibility to a team will enhance implementation of the policy. At the local health service level, a community mental health worker may be given responsibility for implementing the policy.

4.4 Step 4: Set up pilot projects in demonstration areas

Pilot projects in demonstration areas, whereby policies and plans can be implemented relatively rapidly, can serve several useful functions: they can be evaluated more effectively and completely; they can provide empirical support for the initiative through demonstration of both feasibility and short- and long-term efficacy; they can produce advocates from the ranks of those participating in the pilot project; and they can educate colleagues from the health and other sectors on how to develop and implement policies and plans.

Care should be taken when establishing pilot projects with short-term funding. There are some risks when a project is commenced without sufficient ongoing funding or the capacity to expand the project later to other areas of the country. Consumers, families and the community may develop expectations of services that cannot be met in the long term with the available resources. It is also important to monitor the implementation of the pilot project in order to ensure that it is effective and that it is not being continued out of sheer inertia to change or due to the belief "that something is better than nothing", or because it is a source of income for the provider. This is another argument for project evaluation.

4.5 Step 5: Empower providers and maximize coordination

Service providers should be empowered as much as possible.

It is important to identify which individuals, teams or organizations in the health or other sectors will be responsible for implementing the plan. Accountability and monitoring are critical aspects of programme implementation. Central to steps 1 through 5 is the need for *monitoring* the implementation of the plan through the requirement for data on output activity or outcomes achieved. Providers need to submit this data in a form that can be used for further planning. A second essential need is for those implementing a plan to be held accountable. *Accountability* is important not only to ensure the integrity of programme implementation, but also to emphasize the importance and value attached to each activity.

Many countries rely on public mental health providers to deliver a large proportion of mental health interventions. While it is often easy to develop and implement a national policy through public providers, such systems can be rigid, inefficient, of low quality and unresponsive to the needs of the population (WHO, 2000). Incentives, such as decentralizing decision-making processes so that health facilities or teams have more control, can empower public providers. For example, the priority for one region may be a school-based mental health promotion programme, while for another region it may be the development of community-based treatment for children with mental retardation. Mental health providers will feel empowered and responsive if they have some control over the implementation of programmes within their region.

Private mental health practitioners are an important component of the mental health system, and are often more responsive to market conditions. While they are generally open to innovation and more flexible in responding to the needs of the population, they may be difficult to influence with a mental health policy. Strategies to empower private providers include establishing contractual arrangements, regulation and developing quality processes.

Private mental health practitioners are an important component of the mental health system, and are often more responsive to market conditions.

In child and adolescent mental health, there are likely to be a large number of providers who are outside the traditional health system. Chances for the successful implementation of an intervention will be enhanced if these providers are involved in the development and implementation of the policy and plan. Incentives can be developed to empower these workers. For example, teachers might be empowered to participate by the inclusion of mental health goals in contractual arrangements with schools.

Chances for the successful implementation of an intervention will be enhanced if providers outside the traditional health system are involved in the development and implementation of the policy and plan.

Other providers include traditional health workers, mutual aid groups, NGOs, voluntary organizations and mental health consumers and providers. These providers will respond to different incentives to implement the policy (see modules on *Mental Health Financing* and *Mental Health Policy, Plans and Programmes* for more detail).

In the course of just one day, children and adolescents move between several sectors, such as education, social services and housing. All sectors have a stake in both the present and future physical and mental well-being of young people. Table 8 provides some examples of child and adolescent mental health interventions that are delivered primarily through non-health sectors. Collaboration (including cost-sharing) around mental health initiatives produces good results, especially for young people.

All sectors have a stake in both the present and future physical and mental well-being of young people.

Table 8. Examples of intersectoral child and adolescent mental health interventions

Issue	Intervention	Sector
Intellectual disability	Salt or water iodization	Commerce Water affairs
Promotion and prevention	Mother-infant home visiting School-based interventions	Social services Education
Psychopathological sequelae from		
> Inadequate housing	Improve housing, environment and supportive services	Housing Social services
> Community crime	Increase street patrols Community mobilization	Law enforcement Social services
Suicide	Gun control	Justice
	Restrict pesticide access	Media Local government
	Health education	Education
	Address inappropriate media reporting of suicides	Media
Truancy	Monitoring and home visits to truant students	Education Social services

Stakeholders should coordinate efforts with those working in the ministry of health who are responsible for the general health of children and adolescents, reminding them that implementing mental health promotion and prevention programmes is cost effective. They should work with educators who can help to de-stigmatize mental disorders by removing the source of blame from affected individuals. They also need to enlist the help of paediatricians who, even in developed countries, often need assistance in understanding abnormal behaviour that is not part of normal development. In collaboration with those financing the health system, they should demonstrate that simple educational and therapeutic materials are not necessarily expensive. Finally, they need to support efforts designed to boost physical health that have profound implications for the mental well-being of children and adolescents.

A number of barriers and solutions provided in the module entitled *Mental Health Policy, Plans and Programmes* are also applicable to child and adolescent mental health. In addition, there are several other barriers and solutions that are more specific to child and adolescent mental health. These are described below.

Barriers	Solutions
Insufficient resources are allocated specifically to child and adolescent mental health, out of the budgetary allocation for health or mental health in general.	> Refer to international treaty obligations, for example, the United Nations Convention on the Rights of the Child. > Support relevant advocates, for example, family groups and educators. > Use arguments that apply specifically to child and adolescent mental health, for example, the potential benefits in adulthood of attending to mental health in childhood and adolescence.
Resources that previously were allocated to child and adolescent mental health are now allocated to AIDS-related projects.	> Point out the relationship between HIV/AIDS and child and adolescent mental health. > Conduct mental health interventions using resources that were allocated to HIV/AIDS projects, drawing on the relationship mentioned above.
There is less evidence of the efficacy and effectiveness of mental health interventions among children and adolescents compared to adults.	> Highlight the evidence that does exist. > Ascertain what trials are in progress and advise people about the anticipated results.
There are relatively few professionals who are qualified and experienced in child and adolescent mental health work.	> Establish plans to train more staff to work in the field of child and adolescent mental health. > Provide in-service training to better equip “general” mental health workers to work with children and adolescents. > Modify the functions of child and adolescent mental health workers in recognition of the shortages, for example, by having them devote a larger proportion of their time to training, supervision and consultation.
There is misunderstanding about mental disorders, especially amongst young people.	Use the media, publicity and awareness campaigns in different settings to improve understanding of mental disorders.
Some children, adolescents and their families are unable to read.	Use innovative communication strategies such as dance, magic and puppet shows, theatre, storytelling and videos.

Glossary

Child
A person below the age of 10 years.

Child and adolescent mental health plan
A plan consists of a detailed scheme for implementing strategic actions that favour the promotion of mental health, the prevention of mental disorders and the treatment and rehabilitation of children and adolescents.

Child and adolescent mental health policy
An organized set of visions, values, principles, objectives and areas for action to improve the mental health of a child and adolescent population.

Adolescent
A person aged 10 to 19 years.

Efficacy
An intervention's ability to achieve a desired effect in a well defined population group.

Effectiveness
An intervention's ability to achieve a desired effect in a larger, non-experimental population.

Health district
A geographical or political division of a country that has responsibility for decentralized functions of the ministry of health.

Mental health intervention
A set of activities with the purpose of mental health promotion or mental disorder prevention, treatment or rehabilitation.

Mental health service provider
Professional, para-professsional, or community-based health or mental health team or institution, which delivers mental health interventions to a population.

Mental health stakeholders
People and organizations with some interest in improving the mental health of a population, including consumers, family members, professionals, policy-makers, and children and adolescents themselves.

Ministry of health
A country's government department in charge of the health of the population, headed by a minister or secretary of state.

Nongovernmental organization
An organization that is not part of the government system.

Policy objective
Outcomes that the policy hopes to achieve, and the manner in which the outcomes will be achieved.

Principle
Fundamental truth or doctrine, which implies rules of conduct. The core statements support or explain the vision and are underpinned by values.

Quality
A measure of whether services increase the probability of desired mental health outcomes and are consistent with current evidence-based practices.

Strategy
An orderly organization of activities for achieving an objective or goal.

Value
Cultural belief or the the moral/ethical standards concerning a desirable mode of behaviour or end-state that guides attitudes, judgments and comparison.

Vision for a child and adolescent mental health policy
Represents the positive expectations for the future, specifying what is desirable and what will be strived towards.

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