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Acknowledgements

The talk is based on a presentation given by the following at the launch of the Lancet Series on Global Mental Health at Cape Town, October 2011

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CHILD AND ADOLESCENT MENTAL HEALTH GLOBALLY
AN OVERVIEW

Kieling, Baker-Henningham, Belfer, Conti, Ertem, Omigbodun, Ulkuer, Rohde, Srinath, Rahman
• Mental disorders are a leading cause of health-related burden in first three decades of life

• Given that mental illnesses are conceptualized as “chronic disorders of young people”, addressing mental health problems in early developmental stages in LMIC is a priority for the global health agenda

• Besides the arguments of how societal costs can be reduced by early intervention, there is also an ethical responsibility to the most vulnerable young people, who can have their full developmental potential thwarted
Studies on the global prevalence of child and adolescent mental disorders in LMIC

Kieling et al, 2011
• The co-occurrence of risk and protective factors restricts the identification of the elements responsible for the onset and continuity of MH problems.

• Early distal factors work together with proximal causes through a probabilistic chain that is conditioned by issues such as dosage, context, and timing.

• The lifecycle approach provides a model that maps relevant risk factors in a chronological order.

Ertem, adapted in Kieling et al, 2011
# EPIDEMIOLOGY

## KEY MESSAGES

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<tr>
<th>AVAILABLE EVIDENCE</th>
<th>FUTURE DIRECTIONS</th>
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<tr>
<td>• Mental disorders affect 10% to 20% of children and adolescents worldwide</td>
<td>• Prevalence studies should ideally be connected with and serve as basis for services planning</td>
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<td>• Heterogeneity among prevalence studies prevents direct comparisons between countries or meta-analytic approaches</td>
<td>• Nationally representative studies from LMIC are still lacking</td>
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<td>• Risk factors for mental disorders identified in LMIC are similar to those found in HIC; research on resilience is still scarce in LMIC</td>
<td>• Assessing risk and protective factors using a developmental approach facilitates the connection with intervention models</td>
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INTERVENTION

A. PREVENTION

• Incorporating preventive strategies to reduce the effect of mental health problems requires the adoption of a framework that goes beyond the traditional disease model.

• Major challenge of selective and indicated interventions: the characterisation of individuals at whom the interventions should be targeted.

Panel 2: Design and adaptation of effective interventions to prevent child and adolescent mental health problems in low-income and middle-income countries

- Establish the extent of the problem and the perceived need for an intervention within the community.
- Choose or design an intervention that targets risk factors and protective factors for child and adolescent mental health in that setting.
- Promote ownership of the intervention by the community; for example, by inclusion of key stakeholders in the design or choice of the intervention.
- Promote buy-in to the intervention by all stakeholders before implementation (eg, a study reported difficulties with a school dropout intervention due to poor teacher support).
- Use evidence-based interventions with inbuilt cultural flexibility. For example, use interventions that build on existing practices and strengths.
- Assess the feasibility and acceptability of the intervention for staff within the setting before implementation (eg, are sufficient resources and time available?).
- Ensure the intervention is acceptable and is perceived as relevant by participants to promote engagement. For example, assess the extent to which the intervention fits in with prevailing attitudes, beliefs, and current practices.
- Pilot and assess the intervention in the new setting, with quantitative and qualitative methods, and use the data to inform any modifications to the intervention before wider implementation.
- Integrate interventions into existing services and use existing staff to promote sustainability (eg, integrate interventions into school settings, health-care services, social services, and community services).
- Provide intervention staff with systematic training and provide ongoing monitoring and support for staff.
INTERVENTION

B. TREATMENT

Kieling et al, 2011
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<tr>
<td>• An increasing number of preventative strategies has been successfully tested in many LMIC</td>
<td>• Culturally appropriate and scalable interventions still need to be further developed and tested in order to close the 10/90 gap</td>
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<td>• Whereas 90% of the children and adolescents live in LMIC, only 10% of the mental health randomized trials come from these countries</td>
<td>• Additional RCTs on psychosocial treatments are required</td>
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<tr>
<td>• Packages and manuals (such as the mhGAP guide) are available for management of childhood mental disorders in LMIC</td>
<td>• Future intervention studies should also collect data for cost-effectiveness analyses</td>
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• Economic research has documented the long-term consequences of childhood mental health problems in HIC, both in terms of achievement scores and education.

• Investments made in the womb have a higher return than those made at later ages; the returns from earlier investments can be reaped over long periods.

• Since capabilities (cognition, and physical and mental health) show both self-productivity and cross-productivity, an early investment has many positive effects.

Heckman, 2007
SERVICES AND POLICY

• Recognition that mental and physical health are indivisible is crucial — infectious diseases, malnutrition, and poor obstetric practices all have an effect on a child’s mental health.

• Although collaboration between agencies presents opportunities for joint work, such an approach raises important challenges.

• As well as political will, the key to the development of CAMH policy is the education of the population about the need for such services in order to improve the quality of life for individuals, families, and communities.
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<td>• Less than a third of the countries has an entity in charge of mental health</td>
<td>• Early interventions and rehabilitative/curative interventions need to develop</td>
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<td>programmes for children and adolescents</td>
<td>side-by-side, which can be made more efficient by task-shifting</td>
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<td>• Initial experience suggests that integration with existing, community-based</td>
<td>• Partnership with physical health programmes and agencies outside the health</td>
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<td>systems is feasible</td>
<td>sector (education, social care, criminal justice) is advised</td>
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<tr>
<td>• Investments in children and adolescents yields high returns – in terms of</td>
<td>• Awareness programmes and mobilization of potential stakeholders should be</td>
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<td>developmental potential realized, adult disorder prevented or less severe, and</td>
<td>considered part of any child and adolescent mental health service development</td>
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<tr>
<td>ultimately in terms of economic advantage of healthy individuals</td>
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The promotion of child and adolescent mental health is a worldwide challenge, but a potentially rewarding one.

Accumulating evidence suggests that early interventions can provide long-term health and socioeconomic benefits by prevention of the onset of mental health problems and their development into chronic disorders.

These issues are even more relevant in LMIC, where the proportion of children and adolescents in the population is high and the resources are scarce.

The situation in LMIC also presents a window of opportunity, because many LMIC are currently going through a demographic transition, and intervention today is likely to result in a decreased burden in the future.