WORLD MENTAL HEALTH DAY™
2003

EMOTIONAL & BEHAVIOURAL DISORDERS OF CHILDREN & ADOLESCENTS

A Global Mental Health Education Program of

The World Federation for Mental Health

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WORLD FEDERATION FOR MENTAL HEALTH

EMOTIONAL & BEHAVIOURAL DISORDERS OF CHILDREN & ADOLESCENTS

Dear Friends,

The theme for World Mental Health Day 2003, Emotional and Behavioural Disorders of Children and Adolescents, builds on last year's campaign, which focused worldwide attention on the effects of trauma and violence on the mental and emotional well-being of young people. This year's campaign is equally important and timely, as far too little attention and resources are currently allocated to understanding and effectively treating these problems experienced by children and adolescents.

The World Health Organization has stated that the absence of good mental health early in life may lead to mental disorders with long-term consequences, undermines compliance with good general health practices, and reduces the capacity of societies to be safe and productive. It is estimated that 20 percent of children and adolescents worldwide suffer from an impairing mental illness. It is critical that we all work together - mental health professionals, advocates, families, policy makers - to improve the care and treatment of our children and adolescents, to increase the knowledge base through research, and to establish enlightened public policies that can lead to a substantial reduction in the burden of disease caused by these disorders.

This year's World Mental Health Day global mental health education campaign packet offers you a wealth of information, resources, and suggested actions to address these important issues in your local communities and nationwide. I hope you will join other organizations in over 100 countries to commemorate World Mental Health Day 2003. Together we can raise public awareness about the needs of children and adolescents who experience emotional and behavioural disorders, encourage improved and readily accessible services, and promote positive action on the part of policy makers and national governments to improve the lives of all the world's young people.

We appreciate everyone's continuing efforts.

Sincerely,
Rosalynn Carter
Honorary Chair

World Federation for Mental Health

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Dear Friends and Supporters of World Mental Health Day:

I am particularly pleased to introduce the World Federation for Mental Health's 2003 ***WORLD MENTAL HEALTH DAY*** campaign packet addressing this year's theme -- *Emotional and Behavioural Disorders of Children and Adolescents*. I am grateful for your interest in World Mental Health Day, and look forward to hearing about the activities you will be undertaking to commemorate it in your community.

Advocacy on behalf of improved services for children and adolescents, and for enlightened public policy to raise the needs of our children to a high level of priority, has been a major part of my career working in the mental health field, both in volunteer and professional capacities. We have heard many times that "the future of our society depends on the health and well-being of our children." However, these lofty words are seldom backed up by public policy or the allocation of adequate resources to ensure that families and communities can nurture and support healthy mental, physical and social development of their young people. Certainly, we have much work to do in the mental health field if we are to assure the promotion, prevention, and treatment services and programs are to be available for every child who needs them in every community and country in the world.

Your World Mental Health Day 2003 public awareness, education and advocacy efforts are extremely important to reaching the goal of making mental health promotion, prevention, and treatment services and programs available for every child who needs them. I congratulate you for the important work that you are doing. I hope that you will find the materials included in this year's campaign planning packet useful in conducting your World Mental Health Day commemoration events. Please contact us at WFMH if we can be of assistance to you.

Sincerely,
L. Patt Franciosi
President
WFMH Board of Directors

A World of Thanks

Once again, it is time to prepare for the next World Mental Health Day global mental health education campaign. The World Federation for Mental Health is deeply appreciative of the many exciting activities and events that organizations, groups and individuals throughout the world planned and carried out in commemoration of the 2002 World Mental Health Day theme focusing on *The Effects of Trauma & Violence on Children & Adolescents*. We are impressed by the dedication and commitment so many of you have demonstrated in supporting World Mental Health Day during the past ten years, and we look forward to your continuing efforts in 2003.

The theme for World Mental Health Day 2003, *Emotional and Behavioural Disorders of Children & Adolescents*, was selected to focus worldwide attention and advocacy on the devastating effects of serious mental and emotional disorders on children and adolescents in all countries, and the pressing need to promote enlightened public policy, increase availability of treatment services, and develop and implement effective preventive strategies in order to reduce the suffering of children and their families.

The 2003 campaign packet includes some new resources for your use in making public awareness information on this important theme even more readily available for use by mental health educators, parents, teachers and advocates. WFMH is also launching a new website dedicated to World Mental Health Day, www.wmhday.net**,** that will contain regularly updated materials and information on issues related to the theme of the campaign.

WFMH extends its appreciation and gratitude to all those who have been involved in the preparation of the 2003 World Mental Health Day global mental health education campaign. The continued commitment of our Honorary Chair, Mrs. Rosalynn Carter, is gratefully acknowledged, and we welcome Professor John Copeland (UK) as the new Chair for the WFMH World Mental Health Day Committee, succeeding Dr. L. Patt Franciosi as she assumes the Presidency of WFMH.

We owe special thanks to the lead science writer for this year's packet, Ms. Robin Perth-Pierce, and to our contributors of materials on topics of the mental health consequences of war, trauma and violence and on the mental health needs of refugee children – Ellen R. Mercer, Thad Rydberg and Dennis Hunt. We also thank the colleague organizations that have graciously provided information and permission to use and adapt their excellent materials on the topics included in this year's theme – the Centre for Mental Health of the Health Department of New South Wales (AU), the American Academy of Child & Adolescent Psychiatry (US), the National Institute of Mental Health (US), the Australian Centre on Posttraumatic Mental Health (AU), the Federation of Families for Children's Mental Health, the Republic of South Africa's Department of Health and the Transcultural Mental Health Centre (SA). Each year, WMFH has been fortunate to gather a strong group of international advisors to lend support and guidance to the preparation of the campaign materials. We extend special thanks to Dr. Myron Belfer, Dr. Peter Jensen, Dr. Eve Moscicki, Dr. John Fayyad and Professor Brian Robertson for their assistance.

We also acknowledge the efforts of the WFMH staff, our translators and several members of the WFMH Board of Directors – Regina de Jesus (The Philippines), Dr. Chueh Chang (Taiwan), and Elizabeth Matare (Zimbabwe) – who reviewed early drafts of the materials for usefulness in their regions of the world. Our generous financial sponsors make the annual World Mental Health Day global mental health education campaign possible. Once again in 2003, *Janssen Cilag* has continued its investment as the project's major sponsor, and has been joined by *AstraZeneca, Eli Lilly and Company* and *Otsuka America* as supporters of this effort. We also thank the sponsors that contribute to national and local WMHDay commemoration activities everywhere.

In closing, WFMH would like to thank those organizations, governments and individuals that continue to be involved in World Mental Health Day year after year. The future of the project depends on you and all the wonderful events that take place around the world. You continue to put forth an incredible amount of effort and are the key to the growth of the World Mental Health Day project. We wish you continued success in your important work, and we look forward to hearing from you!

World Mental Health Day 2003

Section One: *Emotional & Behavioural Disorders of Children & Adolescents*

- Introduction: Childhood and Adolescent Mental Health: Serious Emotional and Behavioural Disorders
- Adolescent Substance Abuse
- Adolescent Suicide
- Anxiety in Children: What We Should Know as Parents
- Attention-Deficit/Hyperactivity Disorder (ADHD)
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- Advances in Research in Child and Adolescent Mental Health

INTRODUCTION

Childhood and Adolescent Mental Health: Serious Emotional and Behavioural Disorders

Children of the world face many threats; the image of the happy, laughing child with hopes for the future is but a dream for too many children and their families. The challenges are many, both physical and psychological. Having good physical and mental health can help children navigate the complex world they face. Good mental health has its foundations in early infancy, beginning with the attachments that infants make to parents or trusted caregivers, which form the basis for trust[1]. The societal and familial context for development provides an essential ingredient for continuing mental health. What we take for granted in Western countries, higher income countries, and more developed countries cannot be assumed to be present in developing countries, or in countries impacted by war, famine and disease. For many children around the globe with serious emotional and behavioural disorders, meeting the tasks of everyday life, having friendships, and being a meaningful part of society are supreme challenges. Too often children and adolescents with mental disorders are confronted with stigma and discrimination.

> *"Across the globe, good mental health of children and adolescents is important –for all cultures and races, from infancy to young adulthood and beyond. Recognizing and treating serious childhood and adolescent emotional and behavioural disorders must be a priority for all countries if all children, and the societies in which they live, are to reach their full potential."*
>
> L. Patt Franciosi, PhD
> President, WFMH Board of Directors

The Impact of Serious Child and Adolescent Emotional and Behavioural Disorders

Around the globe, up to 20% of children and adolescents suffer from a disabling mental illness, with 3-4% requiring treatment.[5] The mental health of children and adolescents is influenced by displacement through war and catastrophe, by stresses on families, by economic adversity, by the limitation on child rights affording access to education and health, and by the women in the society who must raise these children. For the many children who face uncertain futures...including those who are orphaned due to war or AIDS, and those traumatized by natural disasters... the burden of serious emotional and behavioural disorders afflicts their lives[4].

Globally, children and adolescents have many mental health needs. Suicide in youth is a pervasive world mental health problem; worldwide, suicide is the 3rd leading cause of death among adolescents. Substance abuse in adolescents is also a worldwide problem. Many children living amidst the rages of war or in the aftermath of natural disasters suffer from post-traumatic stress disorder.[3,7] Not only do these emotional and behavioural disorders affect a significant portion of the worldwide population, but their effects are pervasive, and costly. Evidence now documents the long-term consequences of childhood disorders and their continuity with adult psychiatric disorders.[3,11] The financial cost to society from the consequences of untreated disorders is now being documented.[12] Certain disorders, like eating disorders, are becoming more prevalent and observable across cultures.[8]

The burden of child and adolescent emotional disorders, most extensively felt by families and friends of those affected, also impacts many systems that support a society, including but not limited to health, education, welfare, and juvenile justice. There are untold associated costs of compromised mental health and mental disorders, including: lack of participation in educational systems, underachievement leading to dependency, involvement in criminal activity, the use of illicit drugs, the inability to benefit from rehabilitation, and co-morbid medical conditions.[12] These disorders, if untreated, leave indelible marks in their wake, eroding societies' abilities to be safe and productive[4].

Child and Adolescent Mental Disorders: Areas of Concern

This year, the World Federation for Mental Health (WFMH), as part of its celebration of World Mental Health Day 2003, would like to increase the public awareness, worldwide, of the serious emotional and behavioural disorders of children and adolescents. The WFMH is providing this packet of information to assist in your efforts to educate others about these disorders. Included in this packet are Fact Sheets on serious emotional and behavioural disorders of childhood and adolescence. Also included in the packet is information on creating a national child and adolescent mental health policy, outlined in detail in *The Citizen's Guide to Advocacy for Creating a Child and Adolescent Mental Health Policy*.

The Impact of HIV/AIDS on Children

In 26 African countries, the numbers of children orphaned for any reason will more than double by 2010, with more than half as a result of AIDS. By the year 2010, forty million children, in 23 developing countries, will lose one or both parents – this is equivalent to the entire U.S. population of children and adolescents[6].

The disorders marked with an asterisk have been identified by the World Health Organization (WHO) as priority areas of concern, based on their prevalence and/or potential for causing impairment, therapeutic possibilities for recovery, particularly at the primary health care level, and their long-term care consequences.[4]

- Asperger Syndrome
- Anxiety Disorders*
- Attention Deficit / Hyperactivity Disorders*
- Autism
- Bipolar Disorder
- Children Affected by HIV/AIDS
- Coping with Trauma, Violence, and War
- Depressive Disorders*
- Disruptive Behaviour Disorders
- Eating Disorders*
- Learning Disabilities*
- Substance Abuse*
- Tourette's Syndrome or Tics*
- Teen Suicide*

The Prevalence of Serious Emotional and Behavioural Disorders in Children and Adolescents Worldwide

In countries around the globe, the way in which mental disorders are diagnosed varies. Any diagnosis must of course account for the culture in which the children are raised, with attention paid to the migration of children to other countries. What may appear as a diagnosable disorder in one country or society may be deemed normal or simply adaptive behaviour in another[4]. While there is some good data on the incidence of serious emotional and behavioural disorders in non-Western countries, these data are not necessarily comparable with one another, largely due to the differences in how disorders are measured country to country. However, the data collected thus far shows the potential enormity of the problems worldwide, as demonstrated in Table 1[10]. Again, these data are not necessarily comparable with one another, but are provided to paint a picture of the potential magnitude of problems across countries.

For instance, the rate of psychiatric disorders of children (ages 4-12) in India has been reported to be between 7-20%. In Sudan, the Philippines and Colombia, data show that 12-29% of children (5-15) have mental disorders. In the Gaza Strip, 21% of school-aged children suffer from anxiety disorders, a rate comparable to that in Western societies. In the Western Pacific, 7% of children in China, 12% of children in Japan, and 19% of children in Korea are reported to have mental disorders. In the U.S, nearly 21% of children have a diagnosable mental or addictive disorder with at least minimal impairment. In Europe, the prevalence of mental disorders varies, as high as 15% in Finland (children ages 8-9), 17% in Sweden (ages 11-13), and 39% in Greece (ages 12-15). Overall, mental disorders affect roughly 10-20% of youth worldwide. Mental disorders account for 5 of the top 10 leading causes of disability in the world for children ages 5 and over.[10]

Table 1. Prevalence Rates*
Serious Emotional and Behavioural Disorders of Children and Adolescents, Selected Countries

Country	Prevalence
U.S.[9]	18-22%
New Zealand[9]	22%
Puerto Rico[9]	18%
Canada[9]	18%
Finland[10]	15%
Sweden[10]	17%
Greece[10]	39%
Japan[10]	12%
India[10]	7-20%
China[10]	7%
Gaza Strip (anxiety only)[10]	21%
Sudan, Philippines, and Colombia[10]	12-29%

*Note that the data are not necessarily comparable across countries; they are for different age groups, at different time periods, and the category "serious emotional and behavioural disorders" does not include the same disorders in each country.

Treating Serious Emotional and Behavioural Disorders

There is hope for the many families around the world whose children or adolescents have emotional and behavioural disorders. There is a need for continued dialogue and study about the most useful interventions to treat serious emotional and behavioural disorders in children. What can be learned from non-Western cultures? What treatments work in communities isolated from the mainstream? What role can be played by religious and faith-based programs? How early and how long should treatment be provided?

While the debate continues about using medication to treat young children, and few drugs have been approved specifically for use in children and adolescent by governing bodies, there is some scientific evidence of the benefit of medication for some disorders. For many disorders, a combination of medications and therapy can alleviate symptoms; Table 2 summarizes the various treatments for several mental disorders seen in children and adolescents. Certainly, some promising new treatments have been developed, but there remains work to be done to adapt these treatments to, or develop them in partnership with the communities in which they are truly needed.

In many developing countries, teachers and community workers play a significant role in identifying and in some cases, providing services to children and adolescents with mental disorders. Often, symptoms of anxiety and depression are interpreted as naughtiness, laziness, or attention seeking behaviours in communities where there is little information available. It is the hope of the World Federation for Mental Health (WFMH) that the information in this packet will further the understanding of the serious emotional and behavioural disorders of children, and provide resources for more information on the identification, prevention and treatment of these disorders.

TABLE 2. Therapeutic Interventions For Priority Mental Disorders Of Children And Adolescents[4]

	Psycho therapy	Cognitive behavioral therapy	Psycho-pharmacological therapy	Family therapy	School interventions	Counselling	Specialized interventions	Other
Learning Disorders					X	X		X
Hyperkinetic / ADHD			X*					
Tics		X	X	X				
Depression (and suicidal behaviours)	X	X	X*	X				
Psychoses			X		X		X	
Schizophrenia			X	X				

Overcoming Barriers to Care in Developed and Developing Countries

In spite of the existence of effective interventions for the care of children and adolescents with mental disorders, a huge proportion of those with these disorders do not have access to care. Barriers to care are evident in both the developed and developing world; economic decline in developed countries, and competition for financial resources in developing countries, almost universally impacts mental health services disproportionately[4]. In addition to the lack of resources targeted at mental health care, there exist several other barriers:

- Stigma (at the local, national and international level)
- Lack of transportation
- Lack of ability to communicate effectively in the patient's native language
- Lack of public knowledge about mental disorders in children and adolescents

Across the globe, work is being done to remove these barriers and improve treatment for children with serious emotional and behavioural disorders. From the creation of non-governmental organizations (NGOs) to care for those whose mental health needs are not being met by existing institutions (Cape Town), to the development of "mobile mental health teams" (Germany), there are many creative solutions being employed by nations around the globe.[4]

Snapshots of Creative Efforts to Overcome Barriers to Mental Health Care for Children and Adolescents

A Mobile Child Mental Health Service In Germany

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

- Follow-up of patients who had been previously hospitalized;
- New child psychiatric consultations on site; and
- Supervision of institutions for children.

Similar services have been developed in Thailand.

The Creation of an NGO for Children with Hyperkinetic Disorders in Lebanon

Local child mental health professionals helped parents of ADHD children come together to form a non-governmental organization (NGO), the Lebanese ADHD Association. In collaboration with child and adolescent psychiatrists and psychologists, this association has been raising public awareness about ADHD in schools and among NGOs that care for children. It also advocates for the right of children and adolescents with ADHD to have their special educational need recognized in schools, as well as at the national government level.

Adapting To Socioeconomic Transition In Bulgaria

During the so-called transitional period in Bulgaria, it was difficult to transfer new knowledge and experience from child mental health and child psychiatry into stable structures. The following steps had the most success:

1. The establishment of a model institution for child mental health with the help of the Medical University of Bulgaria. Funded by outside NGOs and with consultant help, a model facility and program were developed.
2. Creation of an organizational model adapted to local cultural and health backgrounds. During 1997-2000 the following program was developed:

- Evidence based medicine
- Evaluation of activities
- Separation of the diagnostic and therapeutic phases of work
- Mandated participation of the family
- Work with communities
- Creation of reciprocal bonds between schools and general practitioners.

3. Replication of the new model, outside Sofia, during the period 2001-2002.

An organizational workshop including representatives of the government, financial authorities, local authorities and visits from consultants facilitated the process. Other helpful measures included:

- Continuous education programs related to the new model;
- Cooperation with media outside Sofia;
- Encouragement by the professional association of child psychiatrists and allied professionals for the development of regional health centers; and
- Advocacy for the development of financial and local authority support for new specialized facilities.

Two modern institutions were created in distant areas of the country. This was done despite financial difficulties in Bulgaria. Advocacy for better standards has been helped by the new model.

A "Place of Healing" in South Africa

The Empilweni or "Place of Healing" project was established in 1994 in Khayelitsha, an informal settlement area of 500,000 in Cape Town, South Africa. Following a 1993 epidemiological study which found 64% of the children (age 6-16 years) had at least one psychosocial problem, the University of Cape Town created this new initiative. Because the primary health care clinics in the area are too overloaded to deal effectively with child psychosocial problems, this new initiative empowers the community to manage their mental health problems, with training and support from mental health professionals at the University. Essentially, the project is a walk-in mental health service staffed by community workers, local lay persons who are experientially trained using real cases. The workers perform case management, individual, group, parent and family counselling. Supervision is provided by a clinical psychologist on a weekly basis, and a qualified social worker is based at the centre. A child psychiatrist provides consultations, for some referrals. However, the majority of the problems are treated by the community workers themselves. Parents and community-based professionals are educated about child mental health problems by means of home, school and agency visits, workshops, and dissemination of information by hand or on community radio. The most common problems managed at the project are: sexual abuse, antisocial behaviour (conduct disorder), and the effects of HIV/AIDS. A 1997 evaluation found that this community centre provided cost-effective, accessible and appropriate alternatives to professional mental health systems, and that its goals had been largely achieved, resulting in renewed funding.

Improving the Future of our Children and Adolescents: What can be Done?
On a global level, work is being done to improve the identification and treatment of serious child and adolescent emotional and behavioural disorders. The World Health Organization (WHO) has focused attention on the following areas for the future advancement of the care of children with serious mental disorders.

- **Making Mental Health a Global Priority.** Due consideration of child and adolescent mental disorders should be incorporated into all initiatives relating to either overall health or specific mental health.
- **Establishing an Action Plan.** A global plan for child and adolescent mental health should support a *balanced approach to care,* utilizing *all appropriate means of treatment,* with priorities centred on helping mental health authorities with national plans, documenting the economic and personal effects of mental disorders, and identifying best practices and disseminating them.
- **Accumulating Expertise in a Registry.** Child and adolescent mental health specialists and centres of excellence with expertise in child and adolescent mental health should be identified on a country and regional basis.
- **Using the World Wide Web to Disseminate Information.** Interactive, high quality internet-based web-pages should serve as a world-wide focal point for the dissemination of information that could inform Ministers of Health and other interested parties of best practices, research findings, economic and epidemiological data, and consultative resources.

On the local level, your education and advocacy efforts are important. Enclosed in the packet is *The Citizen's Guide to Advocacy for Creating a Child and Adolescent Mental Health Policy,* which includes strategies to help promote a national child and adolescent health policy. Briefly, these strategies include:

Knowledge is Power

Know the mental health needs of your children and adolescents. A thorough knowledge is required of the mental health needs of children and adolescents in your country, how those needs are being addressed, the gaps that exist in the current mental health care system, the political and economic climate, and the potential allies within the government and non-governmental agencies and organizations in order to organize and conduct a successful advocacy initiative.

Creating Partnerships

Create a team and collaborate. Organizing a national public policy advocacy initiative is not a "one person" or "one organization" job. Creating a new national policy or improving existing policies requires a broad-based collaboration with many stakeholders – parents, professionals, public and private provider organizations, non-governmental organizations, and policymakers.

Proper Planning

Planning is at the heart of successful public policy advocacy initiatives. It encompasses the generation of knowledge, the creation of partnerships, and most importantly, planning includes gathering grassroots constituencies during crucial stages of the advocacy process, and bringing the collective voices of parents, professionals, and the concerned citizenry on the public officials in decision-making positions.

Persistence

Persistence pays off. Hard work and persistent efforts are required to build a new national mental health policy Effective advocates recognize that their issue may not always be the most important matter facing the legislative body, that economic, social, and political pressures may work against the objectives of the initiative, or that they have yet to establish a broad-based, grassroots constituency that is strong enough to raise their issue onto the agenda of policy makers to assure success. Persistence is the capacity to remain committed to

the goals of the initiative, to sustain and strengthen the coalition, and to continue the difficult work of educating and convincing key policy makers of the need and value of the initiative's goals and objectives.

The Future: Looking Ahead

The future of child mental health practice in developing countries is tied to economic growth, knowledge about mental child and adolescent mental health issues, and reduction of stigma. While there are few resources in many countries – for example, few child and adolescent psychiatrists - there are many other ways in which child and adolescent mental health services can be provided. The use of NGOs, the training of volunteers and peers, the use of primary care physicians in identifying and treating these disorders, and the involvement of families and communities in planning child and adolescent mental health programs should be the focus of future efforts. We thank you for your work in this area, and look forward to working with you in the future to make good mental health a priority for children and adolescents around the world.

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Adolescent Substance Abuse

Adolescent Substance Abuse

As young people enter adolescence, many of them will stretch their independence and take risks, and may experiment with drugs, alcohol, or cigarettes. For some teens, substance abuse is a way to "medicate" themselves. Perhaps they are depressed or anxious, living in a world in which they may be neglected, abused, cold and hungry, or reside with drug-dependent parents. Some may attempt to use alcohol, tobacco, or drugs in order to "fit in" with their peers.

Some Facts on Adolescent Substance Abuse[4]

Tobacco	Worldwide, of the 300 million young people who are smokers, 150 million will die of smoking related causes later in life.
Alcohol	The younger an adolescent starts drinking, the greater the chances of developing an alcohol problem as an adult.
Illicit Drugs	There is a trend of increased injection drug use among young people; worldwide, 5-10 percent of new HIV infections occur among needle users.
Inhalants	Adolescents tend to use substances that are affordable and readily available.

Substance abuse among teens is now recognized as a worldwide public health problem[2]. Over the past century, many social, economic, and political factors have contributed to the global spread of substance abuse[1]; with improvements in technology, transportation, and communication, there is now wider availability of illegal substances. And, in Western societies in particular, teens are bombarded by advertisements for alcohol and cigarettes. The use of tobacco, alcohol and other drugs impacts the lives of many adolescents across the globe. Substance abuse is a major contributing factor to accidents, suicides, violence, unwanted pregnancies and sexually transmitted diseases (including HIV/AIDS) among young people in many countries[4].

While drug use is a known worldwide problem, what is less well known are rates of use by young people globally, due to difficulties in collecting data. These difficulties include the fact that in some countries, substances are not recognized as substances of abuse (for example, inhalants), or perhaps there are no clear boundaries between use and abuse. There is also difficulty in comparing data across cultures, because patterns of use must be considered inside the cultural context where they

are taking place, and cannot necessarily be compared. The World Health Organization has recently updated guidelines to improve the collection of drug use data worldwide (http://www.who.int/substance_abuse/PDFfiles/EPI_GUIDE_A.pdf)

What Drugs Are Being Abused by Teens Today?

Beyond alcohol and cigarettes, there are many drugs which are being abused by teens today. The following data[2] present a snapshot of the types of drugs used worldwide:

- Inhalants are used primarily in poor economies; in Brazil, 25% of children and adolescents aged 9-18 use inhalants.
- Khat (induces a mild euphoria and excitement), if combined with other psychoactive substances, may lead to psychosis. Khat is used in East Africa and the Middle East from the age of 10.
- In Nigeria, heroin is now cheaply available and the pattern of use has shifted from use in affluent minority communities, to marginalized young and unemployed males.
- Among 16-29 year olds in the United Kingdom, rates of 14% for amphetamine and 6% for MDMA have been reported.
- In Lebanon, 9% of the high school and university students have tried an illegal substance (cannabis, heroin, cocaine, ecstasy). Moreover, about 12% were alcohol abusers[5].

Some of the Most Commonly Used Drugs

Amphetamines
Cocaine
Cough syrup mixtures
Crack (smokeable cocaine)
Hallucinogens
Heroin
Inhalants (glue, petrol)
Khat
LSD
Marijuana/hashish
MDMA (ecstasy)
Methamphetamine
PCP
Sleeping pills
Steroids
Tranquilizers

Treating Substance Abuse and Implementing Prevention Programs in Your Community

There are many different types of treatments for substance abuse available today. Treatments must be tailored to the specific substance being abused; space constraints prevent an in-depth discussion of each of these treatments here. However, treatment should include a combination of medication and psychotherapy as part of a comprehensive treatment program; research has shown that outcomes are dependent on adequate lengths of treatment.[3] Examples of effective treatments for adolescent substance abuse can be found at the Center for Substance Abuse Treatment (CSAT) web page (http://www.samhsa.gov/centers/csat2002/programs.html) or Drug Strategies, a non-profit research institute (http://www.drugstrategies.org/pubs.html#teen).

Understanding Addiction[6]

According to the National Institute on Drug Abuse (NIDA), addiction does begin with drug abuse when an individual makes a conscious choice to use drugs, but addiction is not just "a lot of drug use."

Recent scientific research provides overwhelming evidence that not only do drugs interfere with normal brain functioning creating powerful feelings of pleasure, but they also have long-term effects on brain metabolism and activity. At some point, changes occur in the brain that can turn drug abuse into addiction, a chronic, relapsing illness. Those addicted to drugs suffer from a compulsive drug craving and usage and cannot quit by themselves. Treatment is necessary to end this compulsive behaviour.

For communities, the costs of untreated teen substance abuse are enormous, and show up later in different parts of their human services systems (e.g. education, juvenile justice, and welfare). For more information on how your community can implement prevention programs, see "Preventing Drug Use among Children and Adolescents: A Research-Based Guide for the Community" or the Office of National Drug Control Policy campaign to develop drug prevention community coalitions (http://www.helpyourcommunity.org).

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For more information:

National Institute on Drug Abuse — INFOFAX
Phone: +1 888 NIH NIDA (644 6432) or +1 800 TTY NIDA (889 6432) (TTY/TDD)
http://www.drugabuse.gov/

National Clearinghouse for Alcohol and Drug Information (NCADI)
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http://www.health.org

Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration
Phone: +1 301 443 8956
http://www.samhsa.gov/centers/csat2002/programs.html

For local information, contact:

Adolescent Suicide

The Extent of the Problem

Suicide is a tragic and potentially preventable public health problem. Worldwide, suicide is the third leading cause of death among adolescents.[1]

Most adolescents who attempt suicide have mental health problems, especially depression. Depression and suicidal feelings are treatable mental disorders. Suicide is also often related to substance use; the major proportion of suicides in some countries of Central and Eastern Europe have been attributed to alcohol use.[1]

Suicide Worldwide

Globally each year, at least 4 million adolescents attempt suicide; at least 100,000 die by suicide.[8]

The rate of suicide varies from country to country. Researchers indicate that many factors could be responsible for this variation, including socioeconomic stability, ease of access to firearms and toxic substances, and alcohol consumption.[2] In Western nations, suicide is more likely to be associated with depression or other mental disorders; in non-Western countries, this connection is not as clear and suicide is attributed to other social, economic, religious, and political factors[1].

Suicide and the Mental Health of Adolescents

Many of the symptoms of suicidal feelings are similar to those of depression. Parents should be aware of the following signs of adolescents who may be in danger of harming themselves[3]:

- change in eating and sleeping habits
- withdrawal from friends, family, and regular activities
- violent actions, rebellious behaviour, or running away
- drug and alcohol use
- unusual neglect of personal appearance
- marked personality change
- persistent boredom, difficulty concentrating, or a decline in the quality of schoolwork
- frequent complaints about physical symptoms, often related to emotions, such as stomachaches, headaches, fatigue, etc.
- loss of interest in pleasurable activities
- not tolerating praise or rewards

A teenager who is planning to commit suicide may also[3]:

- complain of being a bad person or feeling "rotten inside"
- give verbal hints with statements such as: "I won't be a problem for you much longer," "Nothing matters," "It's no use," and "I won't see you again"
- put his or her affairs in order, for example, give away favorite possessions, clean his or her room, throw away important belongings, etc.
- become suddenly cheerful after a period of depression
- have signs of psychosis (hallucinations or bizarre thoughts)

Suicide Clusters

Though rare, suicide "clusters," or suicides that occur in close geographical proximity to one another, do occur. Approximately 5% (range 1-13%) of all suicides (in the U.S.) among young people occur as part of a cluster[4]. When these do occur, they often cause panic and fear, and are of great concern to parents and communities. Communities need to develop a plan to manage suicide clusters, should they occur.

Suicide and the Media

The way in which the media report suicide has an enormous impact on the general public. Idealistic or romantic portrayals of suicide can contribute to "copycat" suicides[7].

Efforts should be made to inform local media about teen suicide in your community. This includes educating reporters about the causes, warning signs, and prevention programs available.

Risk Factors for Suicide

There are several known risk factors for suicide. Low levels of serotonin, a chemical found in the brain, have been found in patients with depression, impulsive disorders, a history of violent suicide attempts, and also in postmortem brains of suicide victims[4]. Adverse life events in combination with other risk factors, such as depression, may lead to suicide. However, suicide and suicidal behaviour are not normal responses to stress. Many people have one or more risk factors and are not suicidal. Risk factors for attempted suicide in youth include depression, alcohol or other drug use disorder, physical or sexual abuse, and aggressive or disruptive behaviours.[4]

Prevention and Treatment

At the current time there is no definitive way to predict suicide or suicidal behaviour. Researchers have identified factors (above) that place individuals at higher risk for suicide, but very few persons with these risk factors will actually commit suicide. Suicide is a relatively rare event, and it is therefore difficult to predict which persons with these risk factors will ultimately commit suicide.

Early diagnosis and treatment of depression, accurate evaluation of suicidal thinking and limiting young people's access to lethal agents (e.g. firearm and toxic substances) are some steps that can be taken to prevent suicide.

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National Strategy for Suicide Prevention
www.mentalhealth.org/suicideprevention

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Anxiety in children
What we should know as parents

What is anxiety?

Anxiety is a word that health professionals use when a child is fearful or distressed and the distress keeps going on for a long time. In some children this fear or distress occurs in particular situations such as the playground or before going to sleep. Other children get anxious or worried that something bad might happen in any situation from starting school to being afraid of the dark. These can be normal reactions. As parents, we should be concerned when our children's fears or worries are bigger or stronger than we would expect for the situation.

Three things are necessary to work out how serious our children's worries are:

1. Do our children have the sort of worries that other children have?

It is normal for children under three to have strong reactions when separated from parents. During early school years many children develop fears of insects, strangers or ghosts. Teenage children can become shy and socially reserved. If our children's fears are too strong for what is happening or last too long they may be suffering from an anxiety problem. An anxiety disorder is not just a normal reaction but an illness. For example, if a teenager who always does well at school becomes fearful about failing in schoolwork, then the teenager may have developed an anxiety problem.

2. Can our children explain how they feel?

Children can't usually explain anxiety. They find it hard to talk about their fears or distress. As parents, it is our responsibility to be aware of changes in our children's habits and in the way they handle their feelings. For example, is our daughter withdrawing more? Is our son sleeping less? Is our pre-schooler clinging more? Is our primary school aged daughter missing a lot of school? Has our teenage son started worrying too much?

3. How long does it last?

Normal worries don't last long in childhood. They disappear quickly. However, if our children's fears or worries stay around for more than three weeks, we should begin to get worried. If they stay around for three months we need to ask for professional help.

How do we find out if there's a real problem with our children?

Our children mix with other children and adults in many situations every day. Some of these people may have noticed a change in our children's behaviour or they may be able to explain the cause of the behaviour. Sometimes when we know the cause we just have to be understanding and give our children time to adjust.

How can we tell the difference between normal worries and an anxiety that needs treatment?

Worries and fears are very common in both children and adults. We have to think carefully about whether we are making a problem bigger than it is or missing a very real problem, which could be blocking our children's progress. If we as parents treat every worry in our children's lives as a serious problem, it may do more harm than good. Our children may become worried that our world is a very dangerous place. Not all worries and fears need professional help. Some fears are normal for a child's age and may even show that they are maturing.

Apply the following rules to know whether our children are anxious:

1. It won't go away: Let us say that our children are bullied in the playground and that for some time after being bullied they were very anxious and frightened every time other children were around. A meeting with the school teacher leads to the bullying stopping. However, our children's fears go on. Even when they go to a friendly playground they continue to panic. If their attacks continue after the bullying stops, they should be seen by a professional to help them overcome their fears.

2. The worries have grown worse with time: We need to look into what is happening if the initial anxiety reaction has turned into new worries, especially if there are physical symptoms such as vomiting, stomach aches and headaches.

3. It shows in other parts of their life: If our children are not able to do the things they used to do before because of fear or anxiety, we should be concerned. If we are feeling that their reactions interfere with their normal lives and progress in growing up we should be asking for help.

What are the signs that our children are anxious?

- Anxious children will worry a lot about some danger or threat. For example, they worry about getting hurt, being laughed at, or someone close to them getting sick.
- When our children become anxious, their breathing becomes faster; there may be sweating, nausea, diarrhea, headaches and feeling miserable.
- When children get anxious they also get nervous. They may cry, cling, or fidget.
- Anxious children usually avoid the things that they fear; for example, not going to the playground for fear of meeting new children or refusing to go to parties for fear of separating from parents.

How can we help our children when they are anxious?

To help our children when their worries are interfering with daily life, we can begin by listening without trying to give answers or we can reassure them that their worries are not true. We try to encourage them gently but firmly not to avoid situations that frighten them. However, sometimes all of these things do not work and it is time to ask for help outside the family. This might be a wise and trusted friend or priest. But if the problem persists it is best to talk to professionals who can help anxious children. These professionals can be general practitioners, pediatricians, counsellors in school, psychologists, psychiatrists and therapists. They help children overcome their anxiety by using such helpful methods as relaxation, improving self-esteem and improving confidence. Sometimes, if none of these methods work well and the worries are severe, medication can also be used.

Are there different ways of getting worried in different cultures?

Yes. What is seen as anxiety in one culture, may be seen as normal behaviour by people from another culture. For example, talking softly, particularly by women and children, is normal in some cultures and is not considered a sign of fear or worry. As parents we try to do what is best for our children. If we are concerned about particular behaviours in our children it is important to look into it a little further. On the other hand, if we feel comfortable about the behaviours that others are concerned about in our children, so long as the behaviour does not create problems in their lives, it is unlikely to be serious. Remember that worries and fears are normal in children. But when our children show persistent worries and fears, good effective treatments are available and we should not let our children suffer unnecessarily.

What can we do when our children need help and we don't have the answers?

- Call your local mental health service for advice or to request an appointment with a professional.
- Talk to the children's school counsellor.
- Call the local community health centre.
- Talk to a general practitioner for advice about local professionals such as child psychologists or pediatricians.

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WFMH gratefully acknowledges the use of these materials.

For local information, contact:

Attention-Deficit/Hyperactivity Disorder (ADHD)

What is ADHD?

Children with ADHD—one of the most common of the psychiatric disorders that appear in childhood—have difficulty staying focused, fidget, act before thinking, and have problems completing schoolwork (e.g. inattention, hyperactivity and impulsivity). If untreated, the disorder can have long-term effects on a child's ability to make friends or do well at school or work. Over time, children with ADHD may develop depression, poor self-esteem, and other emotional problems (NIMH 2001). U.S. researchers have found that:

- ADHD affects an estimated 4.1 percent of youths ages 9 to 17 in a 6-month period[1]
- About 2 to 3 times more boys than girls are diagnosed with ADHD[2]
- Children with untreated ADHD have higher than normal rates of injury[3]
- ADHD often co-occurs with other problems, such as depressive and anxiety disorders, conduct disorder, drug abuse, or antisocial behaviour[4,5]
- Symptoms of ADHD usually become evident in preschool or early elementary years. The disorder frequently persists into adolescence and occasionally into adulthood[6]

ADHD: Studied and Documented Worldwide

Though often seen as a "Western" disorder, ADHD has been documented and studied all over the world, including France, Brazil, China, India, Nigeria, Lebanon and the United Arab Emirates. While some cultural variations in symptoms may occur, the core criteria of the disorder can be applied.[12]

In many countries around the world, non-governmental organizations have been created to promote awareness of ADHD. For instance, in Lebanon, the Lebanese ADHD Association was created to promote awareness of ADHD and to provide support and information for concerned families.

Diagnosing ADHD

Effective treatment depends on appropriate diagnosis of ADHD. ADHD can be reliably diagnosed when appropriate guidelines are used.[7,8] Ideally, a health care practitioner making a diagnosis should include input from both parents and teachers. But some health practitioners diagnose ADHD without all this information, and tend to either overdiagnose the disorder or underdiagnose it. Despite this, ADHD remains unrecognized, under-diagnosed and untreated in many countries, and regularly attracts public concern regarding its validity and impact.

Some Symptoms of Inattention[10]:

- Has difficulty sustaining attention during tasks or play activities
- Does not seem to listen when spoken to directly
- Has difficulty organizing tasks and activities
- Avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
- Loses items necessary for tasks or activities (such as toys, school assignments, pencils, books or tools)
- Is easily distracted by external stimuli
- Is forgetful in daily activities

Some Symptoms of Hyperactivity-Impulsivity[10]:

- Fidgets with hands or feet or squirms in seat
- Leaves seat in classroom or in other situations in which remaining seated is expected
- Runs around or climbs on objects in situations in which such behaviour is inappropriate
- Difficulty in quietly playing or engaging in leisure activities when required
- Is often "on the go" or acts as if "driven by a motor"
- Talks excessively
- Blurts out answers before questions have been completed
- Has difficulty awaiting his or her turn, often interrupting or intruding on others (for example, butting into conversations or games)

Is it ADHD?

Many conditions can either coexist (e.g. anxiety or depression) with ADHD or masquerade as ADHD.[11]

A comprehensive medical evaluation of the child must be conducted to establish a correct diagnosis of ADHD, and to rule out other potential causes of the symptoms.

What Can Look Like ADHD? [13]

- Underachievement at school due to a learning disability
- Attention lapses caused by petit mal seizures
- A middle ear infection that causes an intermittent hearing problem
- Disruptive or unresponsive behaviour due to anxiety or depression

Treating Children with ADHD

Diagnosing and treating ADHD early in a child's life is essential. Untreated ADHD is associated with likely higher rates of substance use, conduct problems and delinquency, school failure, and other adverse long-term outcomes, such as lower job status, vocational and marital problems.

According to the National Institute of Mental Health (NIMH), research has shown that behavioural therapies and certain medications, stimulants in most cases, can help children with ADHD control their activity level and impulsiveness, pay attention, and focus on tasks.[9] Like all medications, those used to treat ADHD do have side effects and need to be closely monitored.

Parents should be partners in the treatment process; they should obtain as much information as possible about ADHD and work with the child's doctor in developing a treatment plan. For more information about treating ADHD, see the new guidelines developed by the American Academy of Pediatrics (AAP) at www.aap.org

Treatment for ADHD: Medication or Therapy?

In December 1999, NIMH released the results of a study of nearly 600 elementary school children, ages 7 to 9, which evaluated the safety and relative effectiveness of the leading treatments for ADHD for a period up to 14 months. The results indicate that the use of stimulants alone is more effective than behavioural therapies in controlling the core symptoms of ADHD—inattention, hyperactivity/impulsiveness, and aggression. In other areas of functioning, such as anxiety symptoms, academic performance, and social skills, the combination of stimulant use with intensive behavioral therapies was consistently more effective. Of note, families and teachers reported somewhat higher levels of satisfaction for those treatments that included the behavioural therapy components.

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Sources: Reprinted in part from **"Attention Deficit Hyperactivity Disorder,"** Science on Our Minds Series (2001), The National Institute of Mental Health (NIMH), and "Backgrounder: Attention-Deficit/Hyperactivity Disorder" (2003), Janssen Pharmaceutica.

For local information, contact:

Autism and Other Pervasive Developmental Disorders*

*often called "Autism Spectrum Disorders"

What is Autism?

Most infants and young children are very social. They need and want contact with others to thrive and grow. They smile, cuddle, laugh, and respond eagerly to games like "peek-a-boo" or hide-and-seek (AACAP1999). Occasionally, however, a child does not interact in this expected manner. Instead, the child seems to exist in his or her own world, a place characterized by repetitive routines, odd and peculiar behaviours, problems in communication, and a lack of social awareness or interest in others. These are characteristics of a Pervasive Developmental Disorder (PDD) called Autism (APA 2000, WHO 1993). Although Autism is about 3 to 4 times more common in boys, girls with the disorder tend to have more severe symptoms (Fombonne 1998).

The Cause of Autism

No one knows for sure what causes Autism. It is a complex biological disorder, and no two people with Autism are the same. It is well-established that the cause is primarily genetic, but there are likely to be several genes involved. Studies are being conducted to determine whether other factors might interact with genes in some people, including infectious, neurological, metabolic, and environmental factors (NICHD 2001).

Diagnosing Autism and Pervasive Developmental Disorders in Children

Five early signs of Autism in young children are indicated by negative (or very limited) responses in the situations listed below (Kasari & Wong 2002):

- Does the baby respond to his or her name when called by the caregiver?
- Does the young child engage in "joint attention"? (e.g. join with caregivers in looking at same object or event or point at and show toys to others?)
- Does the child imitate others? (e.g. mimic facial expressions, stick out tongue?)
- Does the child respond emotionally to others? (e.g. smile when smiled at?)
- Does the toddler engage in pretend play?

Signs of Autism and other Pervasive Developmental Disorders (PDD) are often apparent before the child is three years of age, but may not be recognized until later. It is often discovered when parents become concerned that their child may be deaf, is not yet talking or gesturing, avoids interaction with others, or displays unusual repetitive behaviors and rigidity.

One reason PDD is not always recognized early is that the severity can vary from quite mild to very severe. Some children with PDD can function at a relatively high level, with speech and intelligence intact. Others have serious cognitive impairments and language delays, and some never speak. An infant with moderate to severe Autism may avoid eye contact, seem deaf, and abruptly stop developing language. Children with Autism may act as if unaware of the coming and going of others, or sometimes become physically aggressive. Children with Autism often remain fixated on a single item or activity, rock or flap their hands, seem insensitive to burns and bruises, and may even harm themselves. But none of these symptoms is apparent in all infants and toddlers with Autism and in the highest functioning children the symptoms might be relatively subtle.

Children with Autism and other forms of PDD often have co-occurring behavioural or emotional symptoms, including attention problems, disturbance of mood such as anxiety or depression, and seemingly obsessive or compulsive behaviour (Volkmar et al 1999). About one-third of children and adolescents with Autism develop seizures.

Asperger's Disorder is another Pervasive Developmental Disorder, and is the diagnosis used when the individual has social deficits and repetitive behaviours, but cognitive skills, self-help skills and early language development are normal, or above normal in some respects (APA 2000). Individuals with Asperger's Disorder have a better prognosis than those with other forms of Pervasive Developmental Disorders, with respect to outcomes such as gaining employment and living independently.

Treating Individuals with Pervasive Developmental Disorders

Although Autism and other forms of PDD are not curable, children and adults with PDD and their families can be helped with a variety of treatments for the core symptoms and co-occurring behavioural and emotional symptoms. These treatments include, but are not limited to (NICHD 2001):

- **Individualized Special Education Programs** are used to tailor education to meet the needs of children with PDD. Because the competencies of children with PDD are so variable, schools must plan according to the individual child's cognitive abilities and educational needs. Techniques for providing support to prevent problem behaviours typically related to PDD are a critical component of these plans (National Research Council 2001).

- **Comprehensive Treatment Programs** encompass a number of different theories and strategies for treating people with PDD. Several models based on empirically demonstrated strategies for treating specific problems have been developed, although they vary in their scope and the extent to which the models have been evaluated (National Research Council 2001; Siegel 1996; Cohen & Volkmar 1997). Comprehensive programs are intensive: 15-40 hours a week, often utilize behavioural techniques, begin at the youngest age possible, involve families, and utilize highly trained staff. The programs are individualized and carefully planned, and involve ongoing evaluation of the individual's progress. They focus on communication and other developmental skills, and use techniques to help the individual use the skills learned in the program within other settings such as the home and community.

- **Psychopharmacological treatments** (medication for behavioural or emotional symptoms) can also be effective in improving the behaviour or functioning of a person with Autism. In general, these medications are called "psychoactive" because the drugs affect the brain of a person with Autism. Medication is often used to deal with a specific behaviour, like reducing self-injurious behaviour or aggression, which may allow the person with Autism to focus on other things, like learning. Individuals with Autism often develop emotional symptoms such as anxiety or depression, and medication can be very helpful in alleviating these distressing symptoms and improving overall adaptive functioning (Posey & McDougle 2000).

When considering treatment options, it is important that children and adolescents with Autism be evaluated for co-morbid, potentially treatable conditions, such as seizures, allergies, gastrointestinal problems, or sleep disorders. Treatment of these co-morbid features may not cure Autism, but can lead to improvements in quality-of-life for both patients and their families.

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http://www.ninds.nih.gov/health_and_medical/disorders/asperger_doc.htm

Medline Plus Health Information: Autism
http://www.nlm.nih.gov/medlineplus/autism.html

National Center on Birth Defects and Developmental Disabilities:
Autism Information Center
http://www.cdc.gov/ncbddd/dd/ddautism.htm

Source: Information in this document reprinted in part from "Unraveling Autism," Science on Our Minds (2001), The National Institute of Mental Health, NIH Publication No. 01-4590.

For local information, contact:

Bipolar Disorder

What is Bipolar Disorder?

Bipolar disorder is a serious mental illness characterized by recurrent episodes of depression, mania, and/or a mix of both, that interfere significantly with normal, healthy functioning. Although rare in children and adolescents, bipolar disorder, also called manic-depressive illness, is difficult to recognize and diagnose in children and adolescents; this is because it does not fit the precise symptom criteria established for adults, and because its symptoms can resemble or co-occur with those of other common childhood-onset mental disorders. In addition, symptoms of bipolar disorder may be initially mistaken for the normal up and down moods of children and adolescents. But unlike normal mood changes, bipolar disorder significantly impairs functioning in school, with peers, and at home with family.

Who is Most Likely to be Affected and How?

Bipolar disorder is more likely to affect the children of parents who have the disorder. Twenty to 40 percent of adolescents with major depression develop bipolar disorder within 5 years after depression onset.[4] Existing evidence indicates that bipolar disorder beginning in childhood or early adolescence may be a different, possibly more severe form of the illness than older adolescent- and adult-onset bipolar disorder.[3] When the illness begins before or soon after puberty, it is often characterized by a continuous, rapid-cycling, irritable, and mixed-symptom state that may co-occur with disruptive behaviour disorders, particularly attention deficit hyperactivity disorder (ADHD) or conduct disorder (CD), or may have features of these disorders as initial symptoms. In contrast, later adolescent- or adult-onset bipolar disorder tends to begin suddenly, often with a classic manic episode, and to have a more episodic pattern, with relatively stable periods between episodes. There is also less co-occurring ADHD or CD among those with later-onset illness.

Identifying Bipolar Disorder in Children and Adolescents

Symptoms of bipolar disorder *may* include[5]:

- an expansive or irritable mood
- depression
- rapidly changing moods lasting a few hours to a few days
- explosive, lengthy, and often destructive rages

- separation anxiety
- defiance of authority
- hyperactivity, agitation, and distractibility
- sleeping little or, alternatively, sleeping too much
- bed wetting and night terrors
- strong and frequent cravings, often for carbohydrates and sweets
- excessive involvement in multiple projects and activities
- impaired judgment, impulsivity, racing thoughts, and pressure to keep talking
- dare devil behaviours
- inappropriate or precocious sexual behaviour
- delusions and hallucinations
- grandiose belief in own abilities that defy the laws of logic (ability to fly, for example)

Children with bipolar disorder usually have moods that continually switch between mania and depression.

Manic symptoms include:

- Severe changes in mood—either extremely irritable or overly silly and elated
- Overly-inflated self-esteem; grandiosity
- Increased energy
- Decreased need for sleep—ability to go with very little or no sleep for days without tiring
- Increased talking—talks too much, too fast; changes topics too quickly; cannot be interrupted
- Distractibility—attention moves constantly from one thing to the next
- Hypersexuality—increased sexual thoughts, feelings, or behaviours; use of explicit sexual language
- Increased goal-directed activity or physical agitation
- Disregard of risk—excessive involvement in risky behaviours or activities

Depressive symptoms include:

- Persistent sad or irritable mood
- Loss of interest in activities once enjoyed
- Significant change in appetite or body weight
- Difficulty sleeping or oversleeping
- Physical agitation or slowing
- Loss of energy
- Feelings of worthlessness or inappropriate guilt
- Difficulty concentrating
- Recurrent thoughts of death or suicide

Symptoms of mania and depression in children and adolescents may show up in different behaviours[1, 2]. When manic, children and adolescents are more likely to be irritable and prone to destructive outbursts, rather than elated or euphoric as in adults. When depressed, there may be many physical complaints, such as headaches, muscle aches, stomach aches or tiredness, frequent absences from school or poor performance in school, talk of or efforts to run away from home, irritability, complaining, unexplained crying, social isolation, poor communication, and extreme sensitivity to rejection or failure. Other expressions of manic and depressive states may include alcohol or substance abuse, and difficulty with relationships.

Treating Children and Adolescents with Bipolar Disorder

Treatments commonly used for child and adolescent bipolar disorder include the use of mood stabilizing medications (like lithium or valproate) and psychotherapy. The current treatments for children and adolescents are based mainly on the treatments delivered for adults with bipolar disorder; there is very limited data on the efficacy of mood stabilizing medications in youth.[4]

A Cautionary Note about the Use of Antidepressants to Treat Bipolar Disorder

Effective treatment depends on appropriate diagnosis of bipolar disorder in children and adolescents. There is some evidence that using antidepressant medication to treat depression in a person who has bipolar disorder may induce manic symptoms if it is taken without a mood stabilizer. In addition, using stimulant medications to treat attention deficit hyperactivity disorder (ADHD) or ADHD-like symptoms in a child with bipolar disorder may worsen manic symptoms.

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Children and Families Affected by HIV/AIDS

Meeting the Mental Health Needs of Children Affected by HIV/AIDS

When considering the basic needs of a child, one is inclined to think in terms of food, shelter, clothing, love and security — a combination of the material and psychological needs. Children infected and affected by HIV/AIDS have similar needs, except the fulfillment of these needs is potentially in jeopardy when a parent or caregiver becomes ill and eventually dies. Meeting these needs is important for the growth and ability of the child to succeed through life. And, according to the United Nations Convention on the Rights of the Child, meeting the psychological needs of children is not only a privilege, but a right of the child. Meeting children's psychological needs may help to bolster societies who face the destabilizing effects of poverty, armed conflict, famine, or other infectious diseases.

The Impact of HIV/AIDS

The HIV/AIDS epidemic has had an enormous impact on the world, especially in sub-Saharan Africa. Africa is home to 70% of the adults, and 80% of the children, living with HIV globally. Children are affected in countless ways – they have been born to HIV-infected mothers, contracted the disease from their mothers, quit school to assume care-taking or wage-earning roles, witnessed the devastating effect of HIV in their communities, or been orphaned by parents who die of AIDS-related diseases. The effects of HIV/AIDS on children's lives are many: economic, educational, social, and psychological.

HIV/AIDS and Children in Africa

- Of the 36 million people living with AIDS globally, 25.3 million reside in sub-Saharan Africa.
- 1.4 million children are living with AIDS globally.
- 95% of the world's orphans live in Africa.
- There are 13.2 million children under 15 whose mothers have died of HIV/AIDS since the beginning of the epidemic.
- In Zimbabwe, 25% of the adult population is HIV-positive (1999) and 900,000 children have lost at least one parent to an AIDS-related illness; 56,000 children are HIV-positive.

The Psychological Effects of HIV/AIDS on Children's Lives:

The psychological effects of HIV/AIDS, though less visible, are overwhelming for children and adolescents, and range from the loss of consistent nurturing, resulting in developmental problems, to assuming responsibility as the head of the household. The psychological effects of HIV/AIDS on children include:

- Emotional suffering, which appears in various forms (e.g. depression, aggression, failure to thrive).
- Children with sick parents worry about the future, where they will go and who will take care of them.
- Loss of consistent nurture, which can lead to developmental problems, and loss of guidance, which makes it more difficult for the child to reach maturity and to be integrated into society.
- Psychological disorders may manifest before, during or after parental loss.
- Children may not understand the situation and therefore cannot express their grief effectively. Even if they want to express their feelings, there is often no one to listen, particularly in societies in which it is taboo to discuss HIV and the devastation it brings.

Supporting Children and Families Affected by HIV/AIDS

In addition to the overwhelming loss of one or both parents, many children orphaned by HIV/AIDS will likely lose their home and source of financial support. These economic hardships can be devastating for children, leaving them without things such as food, shelter, clothing, medicine, or an education, forcing many to seek alternative sources of income (e.g. prostitution). The material needs of children orphaned or affected by HIV/AIDS are great, and are sometimes met by extended family or by the communities in which they live. In addition to basic needs, these children have many psychosocial needs, including the need for love, understanding and nurturing. The following lessons were learned from programmes in Zimbabwe and the United Republic of Tanzania on providing psychosocial support for children affected by HIV/AIDS.

- **Ensure the child's rights** (e.g. the right to protection against exploitation and discrimination).
- **Acknowledge the children's changing roles** (e.g. discussing the child's changing roles and preparing them by giving them skills, perhaps to be the head of the household).
- **Create an enabling environment** (e.g. educate the community about the needs of children affected by HIV/AIDS to help them respond positively; by reaching out and trying to understand a child's situation, a caregiver or teacher can provide love and guidance that the child desperately needs).
- **Allow kids to be kids** (e.g. giving children the chance to talk about their feelings and experiences with other children helps them realize they are not alone and builds self-confidence. Listening to what they say is a low-cost way of reinforcing the child's importance in an uncertain situation).

The psychosocial needs of parents with HIV/AIDS must also be considered. For parents with HIV/AIDS, the pain and anxiety of living with HIV/AIDS can be overwhelming, and is compounded by the grief they feel in leaving their children behind. Counseling should be provided to parents on disclosing their HIV/AIDS status to their children, and perhaps ways to talk about death or dying. These efforts must also include guidance for parents on finding safe and nurturing homes for their children in the future.

A similar, but more comprehensive list of multilevel strategies, can be found in the report, *Children on the Brink* (2002), which emphasizes further the need to support families and communities to care for these children (rather than rely on orphanages as first or second line defense), capitalize on communities' own (existing) capacity to support children affected by HIV/AIDS, ensure sufficient legal protections for youth – especially girls — from intra- and extra-familial exploitation and abuse, alter the opportunity cost of quitting school (voluntarily or otherwise) in order to earn money, and advocating societies' shared responsibility for action – especially in the amelioration of stigma and discrimination. The report, *Children on the Brink* (2002), can be found on the Internet at <http://www.dec.org/pdf_docs/PNACP860.pdf>, the website for the United States Agency for International Development (USAID).

Source:
This fact sheet is reprinted in part from "Investing in Our Future: Psychosocial Support for Children Affected by HIV AIDS. A Case Study in Zimbabwe and United Republic of Tanzania." (July 2001). The United Nations Programme on HIV/AIDS. For more information, see www.unaids.org

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Depression in children
What we should know as parents

There are a number of ways to work out how serious our children's feelings are:

1. Do our children have the signs that they are not just sad but are depressed?

Depression is more than feeling sad or being miserable. Depression can involve feelings of sadness, anger, hopelessness, resentment, guilt or low self-esteem. Growing up, particularly in the teenage years, can be a time of confusion, moodiness and over-sensitivity. It is often seen as a time of rebellion. As parents, it is our job to notice when our children's feelings of sadness, anger, resentment, guilt or low self-esteem are signs that they are feeling very sad. When our teenagers drink alcohol or take drugs to feel better, it may be a sign that they are feeling depressed.

2. Do our children's low feelings show in other parts of their lives?

Our children may have mixed with others, played with friends or enjoyed meeting with their peers. But now they may have lost friends and they may spend most of their time alone, withdrawn at home and in their own rooms. Activities and interests they once enjoyed may no longer be of interest to them. They may have been doing well with their schoolwork but the standard of their work may have dropped due to loss of concentration. Our children may not have as much energy as they used to have. They may have felt good about themselves but now they dislike themselves. They may take risks regularly. These changes can be gradual over a few weeks or even months. Depression may be developing.

3. Can our children explain how they feel?

Sometimes our children and teenagers who get into trouble at home or at school may actually be depressed but not know it. Because our children may not always seem sad, we as parents may not realise that the bad behaviour is a sign of depression. When asked directly, our children can sometimes say they are unhappy or sad. But our children and teenagers with depression may struggle to find the words to describe their emotions and moods. Often our children won't know they are depressed, so they don't ask for or get the right help. As parents it is up to us to notice changes in our children's day-to-day life and how they are coping with different feelings. When young people do not share how they are feeling, this is one sign that something is wrong.

4. Do our children have thoughts of suicide and death?

We as parents, are often worried when our depressed children and teenagers express feelings and thoughts that "life just isn't worth living", or that "life is so bad I feel like giving up". Hearing our children say they wish they were dead, or hearing them talk about suicide, is often overwhelming. Things said in an

emotional moment may not mean much but can be frightening to ourselves and our children. If these thoughts or feelings are more than temporary, they need to be taken seriously.

If our children are depressed, they may be thinking about suicide. Not talking about it will not make it go away. Gently, supportively and openly ask if they feel like going to sleep and not waking up – that is, have they thought of dying or wishing to die. If we ask our children about these fears, without panicking and without criticism, it often offers an opportunity to reduce their feelings of isolation. It does not "put thoughts of suicide into their mind". If our children are saying they want to die, we cannot ignore it. We may believe that our children do not really mean it when they talk about suicide. But it is important to allow our children to talk about their thoughts of harming themselves; and we should respond by taking their pain seriously, but without becoming too worried.

5. What do we do?

If our children think about hurting themselves or attempt to hurt themselves, we as parents need to make sure they are not alone. They need to be watched until they can be seen by a general practitioner, pediatrician or mental health professional. If our children are saying they feel like hurting themselves, we know that they will usually need help. If we feel we are unable to keep them safe we should take them to the family doctor or hospital.

6. How long does it last?

Normal feelings of being sad, "down" or "blue" usually do not last long. If our children's feelings of sadness and depression continue for more than two weeks we should begin to get concerned. If they continue for three months it is important to ask for help.

7. How do I know when to get help?

The most important sign of a depressive illness in children is persistent unhappiness and inability to do the normal things; being able to have control over feelings, keeping up with their usual results at school and holding onto friendships. Other signs might include being more worried than usual, feeling unwell physically, crying, being irritable, feeling hopeless, feeling helpless and feeling very guilty for things that they should not feel bad about.

There are signs that show us that we are dealing with ill children:

- **Sleep may become disturbed:** Poor sleep may include early morning waking, difficulty getting to sleep or waking up repeatedly. Watching television all night, because of being unable to sleep, may result in difficulty in getting up for school or sleeping during the day.
- **Weight and appetite changes:** Weight loss of greater than 3 kilograms due to loss of appetite and interest in eating, or weight gain of greater than 3 kilograms due to eating a lot to feel better.
- **Losing normal levels of energy and the ability to enjoy life:** This is a clear sign of depression. In its most extreme form, depression can cause a slowing of the way children move and think.
- **Difficulties with concentration and remembering:** These problems are often associated with being distracted and worried.

- **Bad times of the day:** When our children tell us that they feel worse at a particular time of the day (for example, when alone at night) and the feelings are not related to a specific daily stress, then depression may be the problem.
- **When bad thoughts keep coming:** When thoughts of death, harming themselves, or harming others keep pushing themselves into children's minds, then depression is likely.

What should we be aware of as parents?

As parents, it may be difficult living with children who are lonely, miserable, depressed or angry. During this time we may experience many feelings, including feeling scared for our children, feeling helpless, hopeless and overwhelmed when our children are hurting. Because of these feelings it will be important to find ways to manage our own anger, sadness, frustration and reactions to our children.

What can we do?

1. Be available to listen and offer help: When our children are feeling sad and down, it is important to let them know that we will listen, spend time with them, and find professional help for them when needed.

2. Find out what we don't know: We should get to know how most children grow and mature. We can ask for information from health professionals and our children's school teacher or school counsellor. For example "what's happening with my child to make them behave like this?" We may not come up with the answers but at least we can begin to think about what we need to know.

3. Ask for help from others but trust ourselves to do the best for our children: Attempting to sort out a problem within our families can give our children the message that we are taking care of them and shows our love and support for them. Sharing ideas, feelings and sorting out problems as a family will make it easier for our children to talk to us when they are feeling sad. Showing encouragement and appreciation and not criticising can also help.

4. Encourage our children to:

- Talk and express their feelings
- Spend time with supportive friends
- Share feelings with others they trust
- Join in activities they enjoy
- Do exercise that is non-competitive
- Learn new ways to relax such as seeing a movie or going for a walk

Ways we can deal with hard times:

1. We can start to sort out practical problems: We can offer to make an appointment to see a professional to support our children and also to be someone who can begin to help to sort things out.

2. We can do special things that make us and our children feel good: An example would be actively planning some future event together.

3. We can put effort into feeling good: Children need to know that we care for them and that we have confidence that things will get better.

4. We can actively prepare for setbacks and disappointments: We can accept that for things to get better, it will take time, lots of effort and energy.

Depression is usually a temporary condition in children, if recognised and helped. Even when it is a bigger problem it will almost always respond to professional treatment. The most important part of recognising depression is to realise that depression can happen to our children and to keep talking to our children.

What can we do when our children need help and we don't have the answers?

- Call your local mental health service for advice or to request an appointment with a professional.
- Talk to the children's school counsellor.
- Call the local community health centre.
- Talk to a general practitioner for advice about local professionals such as child psychologists or pediatricians.

For local information, contact:

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Disruptive Behaviour Disorders

What are Disruptive Behaviour Disorders?

Disruptive behavior disorders (DBDs) are characterized by a repetitive pattern (lasting more than six months) of anti-social behaviour that causes significant impairment in the ability to function at school, work, or in social situations – typically involving the violation of rules and rights of others. DBDs are one of the most common forms of mental health problems in children and adolescents and affect up to an estimated 6 percent of all children and adolescents worldwide. Oppositional defiant disorder, one type of DBD, is at the milder end of the spectrum. Conduct disorder, another type of DBD, is at the more extreme end of the spectrum.

Symptoms of Oppositional Defiant and Conduct Disorder

Oppositional Symptoms (at least 4)	Conduct Symptoms (at least 3)
Temper tantrums	Lying
Frequent arguments with adults	Initiates fights
Defiant	Cruel to animals
Annoying	Cruel to people (including bullying threats of harm)
Blames others	Destructive (committing arson and/or vandalism)
Touchy	Steals
Spiteful/vindictive	Forces sexual activity or exhibits other inappropriate sexual behavior
Angry/resentful	Commits crimes (such as robbery, burglary)

What are Conduct and Oppositional Defiant Disorder?

Oppositional defiant disorder is characterized by a persistent pattern of negative, hostile, defiant and disobedient behaviour. If untreated, it can evolve into a more severe type of DBD, conduct disorder.

Conduct disorder is characterized by impulsive aggression (without premeditation) against animals or people, destruction of property, deceitfulness, or violation of laws. Children may exhibit some symptoms of both disorders, resulting in a diagnosis of Disruptive Behaviour Disorder, not otherwise specified.

Treating Disruptive Behaviour Disorders

Children who exhibit these behaviours should receive a comprehensive evaluation because many of these children may have coexisting conditions, such as mood disorders, anxiety, PTSD, substance abuse, ADHD, or learning disorders. Evaluation is critical as these disorders often require specific treatment strategies. Early intervention is critical in treating disruptive behaviour disorders since up to half of children with severe disruptive behaviour will go on to develop personality disorders in adult life. While some "oppositional" behaviour is a normal part of child development, a diagnosis of DBD is made when it goes beyond what is developmentally appropriate and is impairing function and social relationships at home and school.

The best treatment for serious, persistent disruptive behaviours is a multi-disciplinary approach. The first step after diagnosis often is one or more types of social and psychological intervention, such as parent effectiveness training (in which parents are taught to set clear goals and limits for the child, apply rewards and negative consequences, etc.). If this is insufficient, medication may be added. Specific medications selected are based on the type of symptoms that are present, their duration, and their severity in terms of impact on function.

For more serious symptoms such as those associated with conduct disorder, a number of medications have been tried — including psychostimulants, conventional antipsychotics, antidepressants, and beta blockers. However, the use of these drugs for severe disruptive behaviour often is limited by side effects, and results have been inconsistent. Recently, risperidone has been licensed in some countries to treat disruptive behavioural symptoms such as impulsive aggression, cruelty to animals and people, and defiant rule-breaking.

For local information, contact:

Please see the attached fact sheet on disruptive disorders developed especially for parents, "Disruptive Disorders in Children: What We Should Know as Parents?" This material was produced by the Department of Psychological Medicine, Children's Hospital at Westmead, and the New South Wales Transcultural Mental Health Centre as part of a collaborative project called "Children of Culturally & Linguistically Diverse Backgrounds: Mental Health Project." It is also available at http://www.tmhc.nsw.gov.au/translations/transinfo.htm

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Disruptive Disorders in Children
What we should know as parents

What are Disruptive Disorders?

Disruptive Disorders are what health professionals call the problems our children are having when they have difficulty in following the rules that most other children accept.

Some examples of these problems are:

- Not doing as we tell them. Most children disobey sometimes, but children with disruptive disorders disobey almost all the time, even when they know they may be punished.
- Having tantrums that are much more frequent and severe than the average child their age.
- Becoming aggressive and carrying out destructive behaviour. This may involve damage to people's property, or stealing, or threatening or dangerous behaviour.
- Always disagreeing, arguing and making small situations seem bigger than they really are. Children with disruptive disorder often want to have the last word.
- Refusing to do everyday tasks such as homework and attending to personal cleanliness. Most children are likely to have untidy rooms and to be hesitant to help with the housework. However, constant refusal to do anything to help and a disregard for basic cleanliness and hygiene is less common.
- All children lie, especially if they are frightened of getting into trouble or want something desperately. However, some children with a disruptive disorder lie repetitively, even when they do not need to.
- Children with a disruptive disorder often show other antisocial behaviours such as excessive anger and swearing, offensive behaviour such as spitting at people, and repeatedly disregarding the rights and feelings of others.

Some names given to the extreme form of these behaviours:

- **Oppositional Defiant Disorder** is a term used to describe children who become angry quickly and argue a lot. Oppositional defiant disorder is more common in younger children who frequently defy their parents and teachers. These children are not usually cruel, bullying, deceitful or antisocial; but they may develop these behaviours if their problems are not dealt with.
- **Conduct Disorder** is a term used to describe children who have the problem of constantly breaking reasonable rules set by parents or teachers.

- **Attention Deficit Hyperactivity Disorder (ADHD)** is a term used to describe our children if they are more overactive, excitable, distractible and impulsive than most other children, most of the time. ADHD problems may also be associated with attention, concentration and other learning problems.

All children and young people can be difficult sometimes. In some children, it can be a reaction to the stress of what is happening to them. If we, as parents, are going through a divorce, or our children are leaving primary school to go to high school, then our children may become very stressed and be hard to live with. But the sort of problems we are discussing here – disruptive disorders in children – last longer and are more difficult. Children with a disruptive disorder do not always respond to our care and concern, and often push away those who want to help.

When our children have these problems it is useful to think about things that will make the problem worse:

1. Family problems

- When we have so many other problems that it is hard to concentrate on our children's problems
- When we as parents disagree about how to help them with their problems
- When parents argue or fight with each other in front of the children
- When we involve them in our fights
- When they are worried about our safety and happiness

2. Drug and alcohol use

- When our children use alcohol and drugs that bring out the worst in them
- When we use alcohol and drugs that bring out the worst in us
- When we use alcohol and drugs instead of getting proper help

3. Peer pressures

- When other young people put pressure on our children to drink and take drugs
- When we expect our children to behave differently than their friends expect them to behave
- When there is pressure on our children to do the wrong thing

4. School pressures

- When each teacher expects a lot of them without realising what other teachers expect
- When we expect too much of our children and make them more anxious
- When we expect too much of ourselves and our children follow our examples
- When our children are being teased or are going through tough times with other children

5. The children's own pressures

- When our children are sensitive we need to teach them to protect themselves in ways that do not get them into trouble. Some very sensitive children try to act tough to protect themselves

and may even be bullies. Sometimes children who are depressed become irritable and aggressive. Sometimes when our children have these problems it is too hard for us to deal with. We may want to do the best for our children but cannot work out how to do it.

Here are some ways to manage disruptive children while waiting for help:

1. Acknowledge our children's strengths and overlook their weaknesses.
2. Praise our children when they get it right instead of only punishing them when they do the wrong thing.
3. Try to do the things that THEY like doing rather than what WE want them to do.
4. Listen to our children. If we want our children to listen to us we need to learn how to listen to them.
5. Be open and fair. If we think the best of children, but also acknowledge when they have done the wrong thing at school or with the law, we show our children support and honesty.
6. Show our children that we do not blame everyone else when we do the wrong thing or when things go wrong through bad luck.
7. Show our children how to focus on finding solutions instead of finding someone to blame.
8. Try to encourage our children to do the right thing by setting a good example, rather than force them to do the right thing by threat or punishment.
9. Let our upset feelings settle before we try to talk with our children about what they have done wrong.
10. Not fighting our partner in a way that upsets the whole family and worries the children.
11. Let the children talk when they are upset without getting upset ourselves. This helps them know that being upset is safe and can be talked about in a helpful way.
12. Set fair and consistent rules for our children.

When do we need to seek professional help?

- When the family is finding it difficult to cope and we as parents have lost confidence in what to do next.
- When the disruptive behaviour disrupts our children's education, leads to them or someone else being hurt, or if they are in trouble with the police.

What can we do when our children need help and we don't have the answers?

- Call your local mental health service for advice or to request an appointment with a professional.
- Talk to the children's school counsellor.
- Call the local community health centre.
- Talk with a general practitioner for advice about local professionals such as child psychologists or pediatricians.

For local information, contact:

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Eating Disorders

What are Eating Disorders?

Eating disorders involve serious disturbances in eating behaviour. Children and adolescents with eating disorders will either drastically reduce their food intake to the point of near starvation; this is known as anorexia. Or, they will overeat and purge; this is known as bulimia. Children and adolescents with eating disorders are extremely concerned about their weight and body shape, and have an intense fear of gaining weight. They see themselves as overweight, even if they are dangerously thin. Eating disorders are not due to a failure of will or behaviour; they are real, treatable medical illnesses in which over- or under-eating patterns develop and take on a life of their own[2].

Identifying Eating Disorders: What are the Signs[3]?

Parents frequently ask how they can know if their child has an eating disorder. Unfortunately, many teenagers successfully hide these serious and sometimes fatal disorders from their families for many months or years. Parents should be on the lookout for the symptoms and warning signs of anorexia nervosa and bulimia, outlined below:

- Those affected will believe they are fat no matter how thin they become.
- They may avoid eating with the family.
- They may eat large amounts of food without gaining weight (e.g. vomiting).
- They may appear excessively preoccupied with food and dieting.
- They may exercise excessively to lose weight.
- They may eat compulsively, hide food or eat in secret.
- They may wear loose clothes that hide their body.
- They may feel they have a sense of control when they say no to food.

Eating Disorders On the Rise Across the Globe

Eating disorders are now seen in both developing and developed countries, and may even manifest themselves in the face of apparent starvation. It is believed that one factor linked to the rise in eating disorders is the exposure to Western media and its influence on desirable body characteristics.[1]

Treatment[2]

Eating disorders can be treated and a healthy weight restored. The sooner these disorders are diagnosed and treated, the better the outcomes are likely to be. Because of their complexity, eating disorders require a comprehensive treatment plan involving both medications and counseling, with frequent follow-up. Adolescents with eating disorders often do not recognize or admit that they have a problem. As a result,

they may not want to get treatment, and as such, need the support of family members to insure that medical treatment is obtained.

The primary goals when treating of anorexia include: (1) restoring weight lost to severe dieting and purging; (2) treating psychological disturbances such as distortion of body image, low self-esteem, and interpersonal conflicts; and (3) achieving long-term remission and rehabilitation, or full recovery. Use of medications in children or adolescents with anorexia should be considered *only* after weight gain has been established. Certain selective serotonin reuptake inhibitors (SSRIs) have been shown to be helpful for weight maintenance and for resolving mood and anxiety symptoms associated with anorexia.

The primary goal of treatment for bulimia is to reduce or eliminate binge eating and purging behaviour. To this end, both counseling and medication are often used. Establishment of a pattern of regular, non-binge meals, improvement of attitudes related to the eating disorder, encouragement of healthy but not excessive exercise, and resolution of co-occurring conditions such as mood or anxiety disorders are among the specific aims of these strategies. Medications, primarily antidepressants such as the selective serotonin reuptake inhibitors (SSRIs), have been found helpful for people with bulimia, particularly those with significant symptoms of depression or anxiety, or those who have not responded adequately to psychosocial treatment alone. These medications also may help prevent relapse.

For local information, contact:

References:
[1]The World Health Organization (WHO), Department of Mental Health and Substance Dependence. *Caring for Children and Adolescents with Mental Disorders: Setting WHO Directions*. Geneva, 2003.
[2]Eating Disorders: Facts about Eating Disorders and the Search for Solutions." (2001). The National Institute of Mental Health.
[3]The Mental Health Association of New South Wales. "Body Image and Eating Problems." New South Wales, 2003.

For more information
Mental Health Association of New South Wales
Phone: +61 2 9816 5688
www.mentalhealth.asn.au

National Eating Disorders Association
Phone: +1 206 382 3587
www.nationaleatingdisorders.org

Learning Disabilities

Parents are often worried when their child has learning problems in school. There are many reasons for school failure, but a common one is a specific learning disability. Children with learning disabilities usually have a normal range of intelligence. They try very hard to follow instructions, concentrate, and "be good" at home and in school. Yet, despite this effort, he or she is not mastering school tasks and falls behind. Learning disabilities affect at least 1 in 10 schoolchildren.

It is believed that learning disabilities are caused by a difficulty with the nervous system that affects receiving, processing, or communicating information. They may also run in families. Some children with learning disabilities are also hyperactive; unable to sit still, easily distracted, and have a short attention span.

Child and adolescent psychiatrists point out that learning disabilities are treatable. If not detected and treated early, however, they can have a tragic "snowballing" effect. For instance, a child who does not learn addition in elementary school cannot understand algebra in high school. The child, trying very hard to learn, becomes more and more frustrated, and develops emotional problems such as low self-esteem in the face of repeated failure. Some learning disabled children misbehave in school because they would rather be seen as "bad" than "stupid."

Parents should be aware of the most frequent signals of learning disabilities, when a child:

- has difficulty understanding and following instructions.
- has trouble remembering what someone just told him or her.
- fails to master reading, spelling, writing, and/or math skills, and thus fails schoolwork.
- has difficulty distinguishing right from left; difficulty identifying words or a tendency to reverse letters, words, or numbers; (for example, confusing 25 with 52, "b" with "d," or "on" with "no").
- lacks coordination in walking, sports, or small activities such as holding a pencil or tying a shoelace.
- easily loses or misplaces homework, schoolbooks, or other items.
- cannot understand the concept of time; is confused by "yesterday," "today," "tomorrow."

Such problems deserve a comprehensive evaluation by an expert who can assess all of the different issues affecting the child. A child and adolescent psychiatrist can help coordinate the evaluation, and work with school professionals and others to have the evaluation and educational testing done to clarify if a learning disability exists. This includes talking with the child and family, evaluating their situation, reviewing the educational testing, and consulting with the school. The child and adolescent psychiatrist will then make recommendations on appropriate school placement, the need for special help such as special educational services or speech-language therapy and help parents assist their child in maximizing his or her learning potential.

Sometimes individual or family psychotherapy will be recommended. Medication may be prescribed for hyperactivity or distractibility. It is important to strengthen the child's self-confidence, so vital for healthy development, and also help parents and other family members better understand and cope with the realities of living with a child with learning disabilities.

For local information, contact:

For more information:
National Center for Learning Disabilities (NCLD)
http://www.ncld.org/

The National Information Center for
Children and Youth with Disabilities
Phone: +1 800 695 0285
http://www.nichcy.org

The American Academy of Child and Adolescent Psychiatry
Phone: +1 800 333 7636
www.aacap.org

The National Institute of Mental Health
Phone: +1 301 443 4513
www.nimh.nih.gov

Schizophrenia

What is Schizophrenia?

Schizophrenia is a medical illness that causes strange thinking, strange feelings, and unusual behaviour. It is an uncommon psychiatric illness in children and is hard to recognize in its early phases, but often begins in adolescence.

Identifying Schizophrenia in Children and Adolescents

Psychiatrists look for several of the following early warning signs in children and adolescents with schizophrenia:

- seeing things and hearing voices which are not real (hallucinations)
- odd and eccentric behaviour, and/or speech
- unusual or bizarre thoughts and ideas
- confusing television and dreams with reality
- confused thinking
- extreme moodiness
- ideas that people are "out to get them," or talking about them
- behaving like a younger child
- severe anxiety and fearfulness
- difficulty in relating to peers, and keeping friends
- withdrawn and increased isolation
- decline in personal hygiene

The behaviour of children with schizophrenia may change slowly over time. For example, children who used to enjoy relationships with others may start to become more shy or withdrawn and seem to be in their own world. Sometimes youngsters will begin talking about strange fears and ideas. They may start to cling to parents or say things which do not make much sense. These early problems may first be noticed by the child's school teachers. Studies of childhood-onset schizophrenia indicate that there is a pattern of progressive abnormal brain development[1].

Treating Schizophrenia

Children with the problems and symptoms listed above must have a complete evaluation. Usually these children need comprehensive treatment plans involving other professionals. A combination

of medication and individual therapy, family therapy, and specialized programs (school, activities, etc.) is often necessary. Medication can be helpful for many of the symptoms and problems identified. These medications require careful monitoring by a child and adolescent psychiatrist. Parents should ask their family physician or pediatrician to refer them to a child and adolescent psychiatrist who is specifically trained and skilled at evaluating, diagnosing, and treating children with schizophrenia.

For local information, contact:

For more Information:

The National Alliance for Research on Schizophrenia and Depression (NARSAD)
Phone: +1 800 829 8289
www.narsad.org

The National Institute of Clinical Excellence
(Guidelines for treating schizophrenia are available from the National Institute for Clinical Excellence, United Kingdom, at http://www.nice.org.uk/pdf/media_briefing_FINAL.pdf).
Phone: +44 (0) 20 7067 5800
www.nice.org.uk/

The National Institute of Mental Health
Phone: +1 301 443 4513
www.nimh.nih.gov

The American Academy of Child and Adolescent Psychiatry
Phone: +1 202 966 7300 or +1 800 333 7636
www.aacap.org

Sleep Deprivation in Children and Adolescents

For many parents of infants and young toddlers, sleep and its related issues can be a struggle. While some babies and toddlers fall off to sleep easily, and perhaps sleep for a full night, for other young children, sleep is unwanted and seemingly elusive, much to the chagrin of parents who know the value of a good night's sleep. Ten years later, the same parents are trying to pull sleepy adolescents out of bed to get ready for school. While anecdotally many parents report that the lack of sleep or poor sleep patterns affect their child's behaviour, relatively few scientific studies have established the consequences of inadequate sleep on mood, behaviour, and school performance.

Sleep and Early Brain Development

Research has shown that in adults, sleep may play an important role in the functioning of the brain, particularly in learning and memory. Because young infants spend far more time sleeping than adults, there is great interest in understanding why there are such increased requirements for sleep during this period, and what effects sleep may have on the developing brain during infancy. From the few studies that have been conducted in both normal and sleep-deprived children, the evidence indicates that:

- The prevalence and extent of disturbed and restricted sleep in children and adolescents is far greater than previously believed.
- Inadequate or disturbed sleep leads to significant daytime sleepiness; most studies suggest a strong link between sleep disturbances and behavioural problems.
- Sleep disturbance is consistently associated with decreased positive mood.
- Preliminary research[1] shows that sleep and sleep loss may alter genes that appear to control the development of brain "circuitry" or wiring.

Sleep and Attention Deficit/Hyperactivity Disorder (ADHD)

ADHD is one of the most common disorders of childhood. Sleep disturbances have been associated with ADHD, though the relationship between the two is not well understood.

Mounting evidence suggests that the same part of the brain that controls sleep also controls attention and arousal. While there are no consistent findings that show that children with ADHD have different sleep patterns than other children, parental report studies indicate that children with ADHD have trouble falling asleep, restless sleep, and nighttime waking (Owens et al 2000). More rigorous studies need to be conducted to better understand the relationship between ADHD and sleep disorders.

Sleep During Adolescence

There is new evidence that hormonal changes during puberty affect the sleep and wake cycles of adolescents. Indeed, the dynamic biological changes that occur during puberty result in later sleep — and later wake times — for adolescents. For many, this means that they do not get the optimal 9 hours of sleep they need, as many go to bed late and rise early for school. This persistent lack of sleep has implications for functioning at home and in school. Research shows that chronic sleep restriction results in a decline in alertness levels - including a negative impact on mood, vigilance and reaction time, attention, memory, and behavioural control. These changes in behaviour may subsequently be associated with poorer school performance, increased risk-taking behaviours, and injuries (Dahl 1999; Fallone et al 2002).

For local information, contact:

Source: Information in this document is based on *The 2003 National Sleep Disorders Research Plan*." The NIH Trans-NIH Sleep Research Coordinating Committee, The National Center on Sleep Disorders Research and the National Heart, Lung and Blood Institute, The National Institutes of Health, U.S. Department of Health and Human Services. Rockville, M.D.

For more information:
The National Heart, Lung, and Blood Institute,
The National Center for Sleep Disorders
Phone: +1 301 592 8573 or +1 240 629 3255 (TTY)
www.nhlbi.nih.gov/about/ncsdr/index.htm

References:

Dahl, R.E. The consequences of insufficient sleep for adolescents: Links between sleep and emotional regulation. *Phi Delta Kappan*, 80: 354-359.

Fallone G, Owens JA, Deane J. (2002). Sleepiness in children and adolescents: clinical implications. *Sleep Med Rev*, Aug;6(4):287-306.

Owens JA, Maxim R, Nobile C, McGuinn M, Msall M. (2000). Parental and self-report of sleep in children with attention-deficit/hyperactivity disorder. *Archives of Pediatric Adolescent Medicine*, 154(6):549-55.

Footnotes

[1] In animal models.

Tics and Tourette's Disorder

What are tics?

A tic is a problem in which a part of the body moves repeatedly, quickly, suddenly and uncontrollably. Tics can occur in any body part, such as the face, shoulders, hands or legs. They can be stopped voluntarily for brief periods. Sounds that are made involuntarily (such as throat clearing) are called vocal tics. Most tics are mild and hardly noticeable. However, in some cases they are frequent and severe, and can affect many areas of a child's life.

Identifying Tics or Tourette's Disorder

The most common tic disorder is called "transient tic disorder," which may affect up to 10 percent of children during the early school years. Teachers or others may notice the tics and wonder if the child is under stress or "nervous." Transient tics go away by themselves. Some may get worse with anxiety, tiredness, and some medications. Some tics do not go away. Tics which last one year or more are called "chronic tics." Chronic tics affect less than one percent of children and may be related to a special, more unusual tic disorder, called Tourette's Disorder.

Children with Tourette's Disorder have both body and vocal tics. Some tics disappear by early adulthood, and some continue. Children with Tourette's Disorder may have problems with attention, concentration, and may have learning disabilities as well. They may act impulsively, or develop obsessions and compulsions.

Sometimes people with Tourette's Disorder may blurt out obscene words, insult others, or make obscene gestures or movements. They often cannot control these sounds and movements and should not be blamed for them. Punishment by parents, teasing by classmates, and scolding by teachers will not help the child to control the tics but will hurt the child's self-esteem. A comprehensive medical evaluation, often involving pediatric and/or neurologic consultation, can determine whether a youngster has Tourette's Disorder or another tic disorder.

Treatment for Tics and Tourette's Disorder

Treatment for the child with a tic disorder may include medication to help control the symptoms. The child and adolescent psychiatrist can also advise the family about how to provide emotional support and the appropriate educational environment for the youngster.

For local information, contact:

Source: Reprinted from "Tic Disorders" (2000). The American Academy of Child and Adolescent Psychiatry; taken from www.aacap.org

For more information:
The American Academy of Child and Adolescent Psychiatry
Phone: +1 202 966 7300 or +1 800 333 7636
www.aacap.org

The Tourette Syndrome Association, Inc.
Phone: +1 718 224 2999
http://www.tsa-usa.org

The Tourette Syndrome Association (UK)
Phone:+44 (0) 8 45 45 81 252
http://www.cwgsy.net/community/tosy/information.htm

Association Française du Syndrôme Gilles de La Tourette
Phone: +33 1 39 50 10 00
http://www.afsgt-tourette-france.org/main.html

Advances in Child and Adolescent Mental Health Research

The hope for all children across the globe is for good physical and mental health. Good mental health in the early years, built on the strong attachments infants make with parents or other primary caregivers, is essential to children's health and development. This good start allows children and adolescents to better meet expected cognitive, social and emotional developmental milestones, develop satisfying social relationships, and cope effectively with daily life (USDHHS 1999). But some children in the world are at risk for serious emotional and behavioural disorders because their economic and social environments hinder healthy mental (and physical) development, diminishing their potential. These conditions include poverty, poor sanitation, infectious disease and little or no access to primary health care.

Children's early experiences, including their environments and the relationships they establish with those around them, play a large role in their development, as has been documented in a recent seminal report, *From Neurons to Neighborhoods*. The report summarizes the science of early childhood development – what we now know to be true about their early years of children's development — and in so doing, provides a comprehensive guide to all nations in their efforts to build systems that nurture, protect, and ensure children's well-being (The National Research Council and Institute of Medicine, 2000)(see below "Research on Children's Development: Ten Core Concepts"). But early experiences, including nurturing environments rich in stability and consistency, are not all that matters for children's early development. Genetics also play a part. We now know that each child's genes, the blueprint that controls their own development, interact inseparably with their environments to either protect against, or promote, the chances of developing a serious emotional or behavioural disorder. A genetically- or biologically-vulnerable child is less likely to develop a disorder in a protective environment; conversely, a debilitating environment may lead to disorder even in a child who is not genetically or biologically vulnerable.

Regardless of cultural or political boundaries, serious emotional and behavioural disorders plague up to 20% of all children worldwide today (WHO 2001). But there is hope, because much more is now known about the developing brain, and the interactions between the mind, brain and environment leading to disorder. Over the last several decades, many children, adolescents and their families have benefited from ground-breaking research advances – advances in the identification, prevention, and treatment of serious emotional and behavioural disorders. These research findings, and their subsequent translation to practice settings, are critical to the health and development of all countries. Successful prevention and treatment intervention strategies allow children and adolescents with mental health problems to develop to their full potential and contribute fully to the societies in which they live.

In concert with these revolutionary research advances of the last decade is the increased global interest in protecting children's rights and improving their health, and in particular, their mental health. In 1989, the international community, embracing the notion that the well-being of all children must be protected, ratified the United Nations Convention on the Rights of the Child (UN 1989). In addition, the World Health

Organization (WHO), as part of its year-long focus on mental health, issued a comprehensive report on meeting children's mental health needs, and implemented an anti-stigma campaign. The WHO report recognized that children's early environments, and the traumas they face, like war, famine and displacement, have a profound impact on their mental health (WHO 2001). In addition, the first-ever world conference on the promotion of mental health and prevention of behavioural disorders was held in the United States in 2000, with 27 countries participating; a follow-on conference was held in 2002 (WFMH 2000). Finally, in parallel with these dynamic research discoveries and increased global interest, there has been unprecedented involvement of family members in the identification, prevention, and treatment of their children and adolescents with mental health problems.

The Science of Early Childhood Development:
Ten Core Concepts

1. Human development is shaped by a dynamic and continuous interaction between biology and experience.
2. Culture influences every aspect of human development and is reflected in child-rearing beliefs and practices designed to promote healthy adaptation.
3. The growth of self-regulation is a cornerstone of early childhood development that cuts across all domains of behaviour.
4. Children are active participants in their own development, reflecting the intrinsic human drive to explore and master one's environment.
5. Human relationships, and the effects of relationships on relationships, are the building blocks of healthy development.
6. The broad range of individual differences among young children often makes it difficult to distinguish normal variations and maturational delays from transient disorders and persistent impairments.
7. The development of children unfolds along individual pathways whose trajectories are characterized by continuities and discontinuities, as well as by a series of significant transitions.
8. Human development is shaped by the ongoing interplay among sources of vulnerability and sources of resilience.
9. The timing of early experiences can matter, but, more often than not, the developing child remains vulnerable to risks and open to protective influences throughout the early years of life and into adulthood.
10. The course of development can be altered in early childhood by effective interventions that change the balance between risk and protection, thereby shifting the odds in favor of more adaptive outcomes.

Source: National Research Council and Institute of Medicine, 2002.

The Identification of Serious Emotional and Behavioural Disorders in Children and Adolescents

The recognition that mental disorders can affect children and adolescents is a relatively new phenomenon. Thirty years ago, the first schemes to classify childhood mental disorders (International Classification of Diseases (ICD)) were created, and diagnostic criteria developed to categorize childhood mental disorders (Diagnostic and Statistical Manual of Mental Disorders (DSM)). The ICD provides all countries a framework to assess and understand the mental health of children; many developed countries are utilizing the ICD, while others are working toward integrating their own rating scales with the ICD.

The Importance of Maintaining a Developmental Perspective in Identifying and Treating Child and Adolescent Mental Disorders

Identifying mental health problems in children and adolescents is tricky because of the rapid rate at which they grow and develop during the first 20 years of their life. It may therefore be difficult to tell whether something is part of normal development, or abnormal. For instance, separation anxiety in a preschooler is expected, but is not normal if it occurs in a 13-year old. The identification, prevention and treatment of serious emotional and behavioural disorders in children and adolescents must be done within a developmental framework. This means that interventions that are developed must be appropriate to one's age and developmental stage, and in addition, must be culturally competent (Davis 2002).

Various new diagnostic and assessment tools have also been developed for both research and epidemiologic use during the last decade (e.g. the Diagnostic Interview Schedule for Children 2.3, the Reporting Questionnaire for Children (RQC)). The combination of these diagnostic and assessment tools provide much-needed information on children and adolescents at both the individual and population levels, allowing clinicians and policy-makers alike to assess the mental health of youth. As a result, in developed countries there is now a better awareness of major mental disorders in youth, including Attention Deficit Hyperactivity Disorder (ADHD) and depression.

Though progress has been made, even in developed countries, as many as 80% of children with identified need are not in treatment (Kataoka et al 2002). Though the range and rates of psychiatric symptoms in children in developing countries are similar to those in the developed world, in most developing countries, there is little information available on the identification and treatment of the serious emotional and behavioural disorders of children (Fayyad, Jahshan & Karam 2001). The collection of data on child mental health in developing countries is not only needed in order to understand the extent of mental illness in this population, but is also essential for understanding culture-specific risk factors for developing mental disorders and the burden that serious emotional and behavioural disorders bestow on each nation. Overall, in developing countries, current mental health services are inadequate and general health personnel are insufficiently trained (Giel et al cited in Fayyad et al 2001), though efforts are underway in many developing nations to better identify (as well as treat) those in need (Belfer 2003).

The Prevention of Serious Emotional and Behavioural Disorders

Many child and adolescent mental health problems are preventable. Mental health problems, as defined by Australia's New South Wales Health Department, are a "disruption in the interactions between the individual, group, and the environment, producing a diminished state of positive mental health" (Scanlon 1997 et al cited in Davis 2002). The prevention of mental health problems and the promotion of good mental health are closely linked; that is, efforts to promote positive mental health will also impact upon the prevention of mental disorders.

Significant research has been conducted on the prevention of mental health problems. Researchers have studied normal and abnormal development (psychopathology) at all levels — the molecular and the individual levels, as well as the large-scale programmatic levels (community, state and national). Many insights have been gained, including the identification of sensitive periods, risk and protective factors, and genetic and environmental vulnerabilities for mental disorders (NAMHC 2001). There is now scientific evidence demonstrating the cost-effectiveness of timely preventive and treatment interventions (Dorfman 1999 cited in Davis 2002). Examples of some effective prevention programs include:

- **Infancy/early childhood**. A nurse-home visitation program, aimed at improving the outcomes of infants in high-risk families in the U.S., has shown early and long-term positive outcomes (Olds et al 1999, cited in NAMHC 2001).

- **Middle childhood/elementary school**. Pro-social programs, such as the anti-bullying program by Olweus in Norway (Olweus 1994 cited in Davis 2002), and the P.A.T.H.S. curriculum to prevent depression in children of depressed parents (Greenberg et al 1998) have proven to be effective. The Parent Management Training program (PMT), developed and used in Norway and aimed at preventing severe behavioural problems from developing in children (ages 5-12), shows promise (Askeland, cited in WFMH 2000).

- **Early adolescence/middle school.** Anti-bullying programs (Olweus 1994 cited in Davis 2002), a life skills training program (Botvin et al 1998), and a depression prevention program for children of depressed parents (Beardslee et al in press; Beardslee 2002; Beardslee et al 1996) show promise.

While many effective prevention programs now exist, there remain questions about how developed countries employing these preventive approaches can assist developing countries in deploying similar prevention programs. Some of these issues include disparities in technology and infrastructure, wealth, unemployment and poverty, and differences in research methods (including assessment tools). Many of these issues are the focus of ongoing work in prevention research. Research opportunities in the prevention research area include: 1) identifying risk in early development 2) improving nosology (classification of diseases), 3) aligning epidemiology, basic processes, and intervention development and 4) encouraging the leap from research to application.

General Principles Underlying the Need for Prevention and Promotion Programs in Child and Adolescent Mental Health

- There is no health without mental health; mental health is an integral part of overall health and quality of life.
- Mental and behavioural disorders have grown to epidemic proportions and create a large social and economic burden to society.
- To address the epidemic of mental and behavioural disorders, prevention and promotion must be recognized as essential components of a public health approach alongside treatment and maintenance.
- Because of their positive effects in multiple sectors - education, economic, and legal, the promotion of mental health and prevention of mental and behavioural disorders are in the shared interest of diverse groups of stakeholders. An opportunity exists to develop powerful intersectoral coalitions for promotion and prevention at global, regional, national, and local levels.
- Discrimination and stigma regarding mental and behavioural disorders continue to impede the development and delivery of prevention, treatment, maintenance, and rehabilitation services.
- Effective evidence-based programs and policies are available to promote mental health, enhance resilience, reduce risk factors, increase protective factors, and prevent mental and behavioural disorders.
- Growing evidence demonstrates that these practices can be cost-effective.
- Strengthening mental health and resilience not only reduces the risk of mental and behavioural disorders, but also contributes to better physical health, well-being, productive life, social capital, safer environments, and economic benefits.

Source: The World Federation for Mental Health, 2000.

The availability of prevention and early intervention programs is fueled not only by rigorous research findings, but also by the policies that guide each nation. Only 18% of countries today have child and adolescent mental health policies (Shatkin & Belfer, in press). This leaves the majority of nations without adequate policies – and consequently, likely without adequate resources — for the provision of prevention and intervention programs. Even in developed countries with recognized child and adolescent mental health policies, resources are scarce, and more often than not compete with other critical social issues of the day. "A Citizen's Guide to Advocacy," included in the WFMH's 2003 World Mental Health Day campaign packet, explains in more detail why such policies are the foundation for the development of mental health service systems, and provides strategies to all nations for developing such policies. In addition, The World Health Organization (WHO) will soon be issuing guidelines on child and adolescent mental health policy development (Shatkin & Belfer, in press).

Treatment and Service Systems

Untreated mental health problems during childhood and adolescence can have life-long impact. For the many families around the world whose children or adolescents have serious emotional and behavioural disorders, new treatments, both behavioural and medication, or a combination of both, are effective for a variety of mental illnesses. Some of these treatments include:

- **ADHD.** The results of a large U.S. multi-site study provide an improved understanding of quality treatments for ADHD; the findings indicate that medication management and combined treatment are superior to behavioural treatment alone, and to routine community care, in targeting core ADHD symptoms for up to 14 months. The study also found that combined treatment is necessary to produce results consistently superior to routine community care for addressing non-ADHD symptoms and functional outcomes (NAMHC 2001). These results have led to the development of new practice guidelines for pediatricians and others.

Top Child and Adolescent Mental Health Research Advances

1. The past decade has witnessed enormous advances in prevention science, and in the development and application of preventive intervention strategies focused on reducing the risk for mental disorders.

   For the first time, interventions to prevent the onset of adverse mental health outcomes have been successfully tested using rigorous, randomized, controlled trials methodologies in community settings. These trials have demonstrated that mental disorders, such as depression and conduct disorder, can be prevented, and developmental trajectories significantly modified to produce long-term individual and societal (including economic) benefits.

2. Research on understanding and intervening in the development of externalizing behaviour, including aggression and violence, has moved from descriptive, to risk factor identification, to intervention development, testing, and deployment. There are now effective interventions for prevention and treatment of serious antisocial behaviour and youth violence; there is also new information about strategies that do not work.

3. Large multi-center randomized controlled trials have established the efficacy of selective serotonin reuptake inhibitors (SSRIs) as new medications for the treatment of depression and anxiety, and have pointed the way for further studies in this area.

4. The scientific knowledge base on the treatment of Attention Deficit Hyperactivity Disorder (ADHD) has grown tremendously. The Multimodal Treatment Study of Children with ADHD (MTA), a landmark multi-site clinical trial conducted in the U.S., has demonstrated that long-term combination treatments as well as medication-management alone, are both significantly superior to intensive behavioural treatments and routine community treatments in reducing ADHD symptoms. The study also demonstrated that the quality and intensity of the medication management treatment was very important in achieving benefits for children and families.

5. The body of work on childhood onset of obsessive-compulsive disorder, its diagnosis, epidemiology, and treatment has helped relieve the suffering of many children and their families.

- **Depression and Anxiety.** New medications, called selective serotonin reuptake inhibitors (SSRIs), are now available to treat depression and anxiety in youth. SSRI's are highly effective in treating anxiety in children, moderately effective for treating depression in children, and much safer than older medications (Ryan 2003; Pine 2002). New psychotherapies, like cognitive behaviour therapy

(CBT) have been developed for anxiety and depression in youth, and have been proven effective (Brent et al 1997; Leveni et al 2002).

- **Aggression.** New medications, atypical neuroleptics, decrease aggression, lowering use of restraints and seclusions, preventing out-of-home and out-of-state placements (Snyder et al 2002). New therapy treatments have been developed for severely disturbed aggressive children, including Therapeutic Foster Care (Chamberlain & Reid 1991, cited in NAMHC 2001), and Multisystemic Therapy (Henggeler et al 1999, cited in NAMHC 2001). These new treatments appear to be much better than common practices in assisting these children.

The debate continues about using medication to treat young children with mental disorders. Some drugs prescribed to children, including those for schizophrenia, bipolar and anxiety disorder, have not been tested in young children and/or approved for use in this age group by appropriate authorities. Research must continue to document the effectiveness of many "off label" medications for treating the mental disorders of childhood and adolescence; in the U.S., there are now at least 30 pediatric psychopharmacology trials underway at the National Institute of Mental Health. In most developing countries, treatment for child and adolescent mental health disorders remains scarce; there are few resources (both dollars and trained child mental health specialists) dedicated to child and adolescent mental health. During the last decade, the use of primary care practitioners (who have been provided training in child and adolescent mental health), has proven useful to identify and treat children in need (Murthy 1998). In addition, in developing countries, many non-governmental organizations (NGO's) have been created to both educate people about childhood and adolescent mental disorders and promote positive mental health.

Child and Adolescent Mental Health Research and Services in Developing Countries

In developing countries like India, few if any research studies have been done in the field of child and adolescent psychiatry. Those that exist focus on epidemiology or use of assessment tools. (Shah & Sheth 1998).

Beyond the issues of the availability of treatment, there still remain, in both developed and developing countries, barriers to care, including stigma, lack of resources, and lack of knowledge about mental disorders. The ongoing work focused on understanding barriers to treatment must continue, particularly in overcoming the stigma of mental illness. Though treatment has improved and represents a vast change from the days of the institutionalization of children and adolescents with serious emotional and behavioural disorders, more dialogue is needed on the most useful interventions for those in need, particularly in developing countries. There are many research opportunities in this area, and there is much to learn from non-Western cultures. This includes the development of alternative intervention strategies, determining treatments that work in communities isolated from the mainstream, and looking at the role that can be played by religious and faith-based programs. Other research opportunities in the treatment area include:

- How early and how long should treatment be provided, and what is the long-term impact?

- What is the efficacy/effectiveness and safety of the most commonly used treatment and preventive interventions?
- How can current interventions be improved and novel interventions be developed?
- How do we address treatment non-response; which interventions work for which children?
- What is the impact of comorbidity, and what are the service needs and delivery of services to youth with co-morbidities of various types?
- What are the patterns of mental health service use among children and families?
- What do we know about the quality, organization, and financing of services for children and their families?
- What services are available in different sectors and settings, e.g., schools, primary care, child welfare, juvenile justice, and mental health?
- What can we learn from clinical and economic evaluation of innovative service models?

Certainly, some promising new treatments have been developed, but there remains work to be done to adapt these treatments to, or wherever possible, develop them in partnership with, the communities in which they are truly needed.

Looking Forward

In the last several decades the international child mental health research community has made great strides toward identifying, preventing, and treating serious emotional and behavioural disorders in child and adolescents. Much more work remains to be done in developing and successfully deploying effective treatments for populations worldwide, particularly in developing countries. While there are now effective treatments available that treat the symptoms of some of the major mental disorders of childhood and adolescence, there is no cure for these disorders. Efforts should be redoubled to develop preventive interventions to spare many children, adolescents, and their families the burden of mental illness, where prevention is possible. In many developed countries, governments are examining and/or reforming their mental health care systems, and some are applying a public health approach in their efforts to reduce the burden of child and adolescent mental disorders. In other places, work is underway in better identifying children and adolescents with mental health needs. For all countries, whether they are in early stages of assessing the mental health needs of their youth, or in the midst of dramatically altering the way in which mental health services are provided, the dynamic discoveries of the last decade provide a firm foundation upon which to build. Employing a comprehensive public health approach — which includes the promotion of positive mental health, the identification (through epidemiologic surveillance) and prevention of mental disorders, and access to treatment — will further all nations' efforts to give children and adolescents with mental disorders a chance to live full and productive lives.

"Only when a comprehensive strategy for mental health which incorporates both prevention and care elements is adopted will we see substantial and sustainable progress."
Dr. Gro Harlem Brundtland, Director-General, World Health Organization

Source; The World Federation for Mental Health, 2000.

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World Mental Health Day 2003

Section Two: Taking Action/What You Can Do

- A Guide for Those Who Care for and Teach Young Children
- A Citizen's Guide to Advocacy for Creating a National Child & Adolescent Mental Health Policy
- Publicizing Your Event
- Sample World Mental Health Day 2003 Proclamation
- WFMH Membership Application
- World Mental Health Day 2003 Report Form

A Guide for Those Who Care for and Teach Young Children

What We Know About Early Child Development

Parents of young children often marvel at how quickly their young children grow and develop. Those who care for infants and young children know this well, and are witnesses to the many milestones of infancy and toddler hood: first steps at independence and first friendships formed. For the many children today who are placed in out-of-home care while their parents are at work, there is new research about the importance of the first years in a young child's life to his/her growth and development.

Off to a Good Start

During the early years, caregivers need to develop warm, nurturing relationships with the infants in their care. An infant's social and emotional competence is rooted in these relationships.

Never before have we known so much about how young children learn, think, and act. Researchers have learned that the newborn brain develops at an astonishing speed during the first few years of life. It is during these first few years that caregivers play an essential role in child development.

The First Years

The healthy, early development of a child depends in part on the nurturing and dependable relationships he/she has established with a parent(s) or caregiver. For a caregiver, a nurturing and dependable relationship with an infant includes frequent eye contact, a gentle "touch," and plenty of cuddles and responsive cooing, which teaches infants about love, trust, and comfort.

It is during this first year infants achieve a major social and emotional milestone: the development of a secure attachment to their mother, father, or primary caregiver. Infants who do not have these attachments more often than not develop difficulties in later social and emotional, as well as cognitive, development (FAN 2000). Social and emotional competence is rooted in the relationships that infants and toddlers experience early in life.

The Preschool Years: Getting Ready for School

Social and emotional skills are as important to early academic success as cognitive skills, such as knowing the ABCs and 1-2-3s. In other words, it is just as important for children to be able to form good relationships with their peers and teachers as it is to decode spelling words and master the use of a crayon or pencil (FAN 2000). Key social and emotional skills children need as they enter school include (U.S. Department of Health and Human Services 2003):

- Confidence
- Capacity to develop good relationships with peers
- Concentration and persistence on challenging tasks
- Ability to effectively communicate emotions (e.g anger, joy and frustration)

- Ability to listen to instructions and be attentive

Children who enter school without these basic social and emotional competencies are not ready to learn, are less likely to be successful in the early years of school, and may face a cascade of behavioural, emotional and academic problems through out their young lives (FAN 2000).

Tips and training modules on how caregivers can promote the social and emotional competence of young children in their care can be found at the Center on the Social and Emotional Foundations of Early Learning, http://csefel.uiuc.edu/modules.html.

The Importance of Children's Mental Health: A Guide for Elementary Teachers

Millions of children across the globe attend school each day. Each child that steps off the bus is different and unique. But each of their lives is shaped and guided by their parents, cultures, and societies in which they live – and also by the teachers they encounter during their years of schooling. Some children arrive at school healthy, happy, and ready for school; but others, up to 20% worldwide, have serious emotional and behavioural disorders. Teachers, as one of the central adults in many children's lives — and for some the only adult with whom they may have a trusting relationship— are in a key position to identify these mental health problems. These disorders must be identified and treated early in order to allow children to learn effectively.

Children's Mental Health

- Every child's mental health is important.
- Many children have mental health problems.
- These problems are real, painful, and can be severe.
- Mental health problems can be recognized and successfully treated.
- By working together, caring families and communities can help.

Source: SAMSHA 2001.

Identifying mental health problems in children and adolescents is tricky because of the rapid rate at which children grow and develop the first 20 years of their life. The National Association of School Psychologists (NASP) has outlined key strategies for both the identification of mental disorders, and the promotion of good mental health in its guide for teachers, "The ABC's of Children's Mental Health." According to the guide, teachers should be on the lookout for key symptoms of mental health problems, which include:

- Changes in habits
- Withdrawal
- Decreased social and academic functioning
- Erratic or changed behaviour
- Increased physical complaints

When Should Teachers Seek Help from Mental Health Professionals?

Teachers should contact their school psychologist or other available community mental health professional if the symptoms outlined above:

- are new or changed in intensity, frequency or presentation
- continue for a significant period of time
- do not improve with combined parental and classroom interventions
- interfere with a student's social and academic function
- routinely disrupt the classroom
- are beyond the student's control; or
- present a danger to the student or others

Mind Matters: A Model School Mental Health Program in Australia

MindMatters is a mental health promotion program for secondary schools in Australia. MindMatters emphasizes a whole school approach to mental health promotion and suicide prevention, and aims to enhance the development of school environments where young people feel safe, valued, engaged and purpose. All education systems in the states and territories have agreed to support the program. Around 50 per cent of schools have requested a copy of the resource, professional development has been conducted in all states and territories, and an Indigenous strategy is being developed, including the publication *Community Matters*.

Source: Mind Matters Evaluation Consortium (2000).

Promoting Good Mental Health

Beyond the identification of mental illness and subsequent referral for services, school is also an excellent place to promote good mental health. In the school setting, mental health should not only be thought of as the absence of mental illness, but the possession of skills and abilities that allow students to cope with everyday challenges (The National Association of School Psychologists (NASP), 2002). To assist children and adolescents in developing their social and emotional capacities, NASP recommends that schools develop policies that promote protective factors, including:

A Sense of Belonging. A sense of belonging is essential to all of us. It is the basis for children's positive adjustment, self-identification, and sense of trust in both the system and themselves. In fact, studies have shown that school connectedness in elementary school decreases incidents of risky behaviour into young adulthood. Young children's strongest bond is to their parents, and a primary objective in early elementary school is to extend that sense of connection to school. A close bond with the classroom teacher or other significant adult is crucial. This develops through personal interaction. It is also important to establish a positive relationship with parents. Children take cues from their parents when it comes to affiliation and a sense of trust between teacher and parent will transfer to the child. Principals can make an effort to meet new students and their parents at beginning of the year, hold monthly parent chats or coffees, include a personal message in the weekly newsletter, encourage parents to volunteer, and keep their office door open. We also can promote connectedness through the environment. Welcoming children when they arrive, greeting them by name in the hallways, and putting up a "Did You Know?" bulletin board in

the hall for students to share important events (e.g., a picture of Amy's new puppy) reinforces that students are valued members of the school community.

Adapting to Change. Routine is important to young children. We introduce the concept in kindergarten and first grade with habits, such as coming in quietly, putting belongings in a cubby, checking in, ordering lunch, etc. Such regular activities lend structure to the child's environment and help establish their sense of competence and belonging. Equally important, though, is the ability to adapt to change. This is a critical capacity throughout life that begins to develop at a young age. Some children react negatively to change, particularly if they are experiencing emotional stress, and may need help adjusting to small changes at school (substitute teacher, new seating arrangement) or at home (new sibling, different bed). Principals and teachers should encourage parents to inform them of any unsettling changes at home. We can minimize anxiety associated with change by giving students advance warning and allowing them to take part in the change, such as discussing the possibilities for rearranging the classroom. It is also important to help children develop coping strategies. Identifying the things that have not changed and focusing on their competencies (switching tasks independently during center time) can help children maintain a sense of control and stability.

Recognition. All children need recognition. Positive feedback validates behaviours or accomplishments that are valued by others. We recognize academic achievement through grades, sharing a child's work in class, and awards. We can also use recognition to help children develop mentally healthy behaviours, such as praising a child who exhibits self-control when angry, raises their hand instead of calling out, or shows compassion for a peer. The key is to focus on positive behaviours, even as a way of stopping negative ones. For instance, if a child is misbehaving, try to acknowledge at least three children doing something right before attending to the child who is not. In some cases, it may be necessary to devise situations where a child can do the right thing, such as completing a task (collecting the pencils), and ask the student for help.

Principals often have students in their offices when children are at their lowest point. Try to start the interaction with something positive about the child before addressing the problem behaviour. Acknowledge the validity of the feelings that may be underlying the actions. Help children identify something they do well, and if possible, link that skill to an appropriate, achievable task that they can do in the office or other supervised setting until they are ready to return to class. Be prepared. Establish with your school psychologist or counselor in advance activities that are effective in various situations.

Making a Difference. Children need to know that they can make a difference. We see this in their eagerness to do classroom chores or read the morning announcements. Such pro-social behaviours build self-esteem, foster connectedness, reinforce personal responsibility, and present opportunities for positive recognition. It is important to create a variety of developmentally appropriate opportunities to contribute, such as putting homework in the take-home folders, helping create a bulletin board, and being a "4th Grade Buddy." Children can contribute outside of school

through activities like the "Gran Club," a group of students who visit residents at a local nursing home once a week. Activities like this reinforce being part of the community and also give children who do not easily step forward in school the chance to make a difference in the larger context of neighborhood.

Resiliency and Accomplishment. Resiliency is an essential ingredient to success. It refers to the ability to bounce back from defeat by resetting one's compass, redefining goals, and continuing on course. Research shows that children with similar risk factors may have different outcomes based on their resiliency. This comes not from blind determination but in a renewed sense of determination. Educators can help children develop resiliency by taking on the role of the "Encourager," someone who acknowledges the significance of the defeat but does not allow it to result in a sense of personal failure. The key is to help children see the big picture and help them refocus on trying again or, if necessary, find alternative means to accomplish their goal. This process allows children to accept the responsibility for their effort, but also be reassured of their own worth. They also need to believe that accomplishment comes through their own actions. This is often referred to as self-efficacy or self-determination. Children who lack this ability may be less resilient, overly dependent, or tend not to accept responsibility for their actions because they do not believe they are in control. The skill is relevant to academics (e.g., learning to read) and social functioning (e.g., conflict resolution). We can help children learn to define a goal, identify useful strategies and personal resources, assess progress toward the goal, determine a realistic time period for success, and judge when they need help. It is appropriate for children to seek help once they have exhausted their own capacity or recognize that the situation is beyond the scope of their competency.

Source: Reprinted in part with permission from the National Association of School Psychologists, "The ABC's of Children's Mental Health," www.nasponline.org/advocacy/SPAN/span_sep02_abc.html

For more information:

Australia's Department of Health and Aged Care
Phone: +1 800 624 065 (Mental Health Funding Programme)
www.health.gov.au/hsdd/mentalhe/index.htm
(for information on Mind Matters, see http://online.curriculum.edu.au/mindmatters/index.htm)

National Association of School Psychologists
Success in School/Skills for Life (www.naspcenter.org/resourcekit/index.html, an online resource kit of information on mental health topics) and exemplary school mental health programs (www.naspcenter.org/model.html).
Phone: +1 301 657 0270

The Substance Abuse and Mental Health Services Administration (SAMHSA)
Caring for Every Child's Mental Health Campaign (materials for teachers)
Phone: +1 800 7892647
http://www.mentalhealth.org/child/default.asp

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The following documents are for teachers to distribute to parents. They are meant to encourage dialogue about children's mental health between parents and teachers. More information is available for teachers at http://www.mentalhealth.org/child/default.asp

Your Child's Mental Health

When your child has a high fever, you get medical advice. Most likely, your child soon will be back to his or her playful and rambunctious self.

Mental health problems can be more difficult to recognize. Worldwide, up to 20% of children have a diagnosable mental, emotional, or behaviour problem that can lead to school failure, family discord, violence, or suicide. Help is available. However, many children with mental health problems are not getting the help they need.

Mental health is how we think, feel, and act. It's common for children to feel sad or to behave badly from time to time. If you see troubling behaviours that seem persistent and severe, it's time to take action. These questions can help you:

- Does your child seem angry most of the time? Cry a lot? Overreact to things?
- Does your child avoid friends or family? Want to be alone all the time? Seem to have lost interest in things usually enjoyed?
- Does your child destroy property, break the law, or do things that are life threatening? Often hurt animals or other people? Seem not to care when you explain that this behaviour is harmful? Use alcohol or other drugs?
- Is your child extremely fearful? Having unexplained fears or worrying more than other young people?
- Is your child limited by poor concentration? Suddenly having trouble making decisions? Grades showing a marked decline?
- Is your child obsessed about how he/she looks? Experiencing unexplained changes in sleeping or eating habits? Often complaining about headaches, stomachaches, or other physical problems?
- Does your child feel that life is too hard to handle or talk about suicide?

If you answer "yes" to any of these questions, talk to your family doctor or pediatrician about your child's feelings and behaviour. Discuss how your child may have been affected by recent major changes in your family or community. Together, you may decide that your child and family need help from someone with more mental health training. Parents, teachers, and other care providers can work together to build on your family's strengths. All families have strengths.

Maybe your family strengths are shared during a community function that you attend regularly. A family activity like cooking together may provide a time to experience both good communication and good food. Bonds may be strengthened and skills developed in the ways you encourage your child's interest in activities like baseball, science, or being a helpful neighbor. Building on your family's strengths can provide the support your child and family need to succeed.

Source: Reprinted from "Your Child's Mental Health: What's up Doc?" Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
Rockville, MD. May 2002.

Caring for Your Child

There is no one right way to raise a child. Parenting styles vary. But it is important that all caregivers communicate clear and consistent expectations for each child.

In today's world, some parents are so busy and stressed that nurturing children may sometimes take a back seat to problems that seem more important. However, here are a few suggestions that can help parents provide for children's physical safety and emotional well-being.

- Do your best to provide a safe home and community for your child, as well as nutritious meals, regular health check-ups, immunizations, and exercise.
- Be aware of stages in child development so you don't expect too much or too little from your child.
- Encourage your child to express his or her feelings; respect those feelings. Let your child know that everyone experiences pain, fear, anger, and anxiety. Try to learn the source of these feelings. Help your child express anger positively, without resorting to violence.
- Promote mutual respect and trust. Keep your voice level down even when you don't agree. Keep communication channels open.
- Listen to your child. Use words and examples your child can understand. Encourage questions. Express your willingness to talk about any subject.
- Provide comfort and assurance. Be honest. Focus on the positives.
- Look at your own problem-solving and coping skills. Are you setting a good example? Seek help if you are overwhelmed by your child's feelings or behaviors or if you are unable to control your own frustration or anger.
- Encourage your child's talents and accept limitations. Set goals based on the child's abilities and interests, not someone else's expectations. Celebrate accomplishments.
- Don't compare your child's abilities to those of other children; appreciate the uniqueness of your child.
- Spend time regularly with your child.
- Foster your child's independence and self-worth. Help your child deal with life's ups and downs. Show confidence in your child's ability to handle problems and tackle new experiences.
- Discipline constructively, fairly, and consistently. (Discipline is a form of teaching, not physical punishment.) All children and families are different; learn what is effective for your child. Show approval for positive behaviours. Help your child learn from his or her mistakes.
- Love unconditionally. Teach the value of apologies, cooperation, patience, forgiveness, and consideration for others.
- Do not expect to be perfect; parenting is a difficult job.

Source: Reprinted from "Caring for your Child." Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. Rockville, MD. 1998

A Citizen's Guide to Advocacy for Creating A National Child & Adolescent Mental Health Policy

1. Introduction

Effective and informed advocacy is a key tool in the promotion of health policies and for increasing resources to help build healthier communities. Advocating for enlightened policies to promote improved mental health services for children and adolescents will take a variety of forms in different countries depending on such factors as

- The structure of the national government's executive and legislative branches,
- Accepted procedures for informing elected and administrative officials about the needs of the citizenry, and
- The availability of non-governmental organizations that have the capacity to organize and support sustained public policy campaigns on specific issues.

Summary

The task of planning and promoting the development and implementation of a national child and adolescent mental health policy is a difficult and complex one. Effective citizen advocacy can play a major and positive role in creating the social and political climate that supports enlightened policy development. Citizen advocacy coalitions that are established for the purpose of promoting child and adolescent mental health policy development must prepare their members to cultivate positive and collaborative relationships with elected and administrative governmental leaders. Few policy coalitions succeed in their objectives without sustained supportive relationships with the officials they are attempting to influence. It is also critically important for citizens who want to change governmental policy to have a clear understanding of their country's policies relating to advocacy to influence legislative and administrative reform.

The draft document created by the World Health Organization, *Mental Health Policy and Service Guidance Package; Child and Adolescent Mental Health*[6], outlines a series of steps that can be taken to develop a child and adolescent mental health policy. These steps can serve as a useful roadmap for citizen coalitions with such a goal in mind:

Step 1: Access the population's needs.
Step 2: Gather evidence for effective policy.
Step 3: Consultation and negotiation.
Step 4: Exchange with other countries.
Step 5: Determine the vision, principles and objectives of the policy.
Step 6: Determine the areas for action.
Step 7: Identify the major roles and responsibilities of different stakeholders and sectors.
Step 8: Undertake pilot projects.

Making the decision to organize and coordinate a coalition with the goal of promoting creation and implementation of a national child and adolescent mental health policy is a momentous one for a citizen's mental health organization. However, such an initiative has the potential of greatly improving the availability, accessibility and affordability of care and treatment services to assist children and adolescents who experience mental, emotional and behavioural disorders. The success of effective advocacy can have a lasting effect on the nation and its citizens.

In some countries, advocacy to improve national policies and services for children and adolescents with unmet mental health needs may have to begin with the organization and presentation of patient and family education programs at the community level. Such programs emphasize informing and teaching parents and family members about the emotional and behavioural disorders their children are experiencing, including how to recognize symptoms, how to respond to them, and what the available treatments are and how to find them. This strategy helps both the affected children and their family members develop techniques and strategies for managing and coping with the disorder and its effects.

> Through patient and family education strategies, community-based organizations can accomplish two objectives:
>
> 1) Help families better understand and support their children who are experiencing emotional and behavioural disorders; and
>
> 2) Begin building a well-informed and motivated constituency of citizens that both understands the unmet child and adolescent mental health services needs in its community and country and has a vested interest in supporting efforts to see change and reform happen.

Patient education can be as simple as distributing easy to understand materials about child and adolescent emotional disorders, such as the fact sheets in the World Federation for Mental Health's ***World Mental Health Day*** campaign packet[2] or from a number of internet sites. It can also include organizing and presenting community workshops or supporting the development of regular meetings of parents that have children or adolescents with emotional problems.

Mental health policy advocacy may take quite different forms in other countries, especially in those where citizen participation in the development and influencing of national laws and policies is the norm. In such countries, formally organized advocacy campaigns are often characterized by intense efforts to make changes or bring about reform in the manner in which government addresses the needs of the country's citizens. This "*Citizens Guide to Advocacy for Creating a National Child and Adolescent Mental Health Policy*" attempts to provide both an understanding of why national policy is critical to improving the quality and quantity of effective and accessible mental health services for children and adolescents, and to offer some strategies to generate community-based citizen support for the establishment of those policies in your own country.

2. Why a National Child and Adolescent Mental Health Policy Matters

The absence of national policy to support mental health services for children and adolescents with emotional and behavioural disorders in countries around the world is a major barrier to improving services to treat young people who are in need. The failure of national governments to adopt and implement national mental health policies imposes a heavy burden on program and financial resources that could be lessened with the establishment of an effective policy.

As the World Health Organization points out, there are increased health and social service expenditures, societal disruptions, and lost productivity where there is a failure to provide the full range of mental health services. Where the availability of appropriate, affordable and accessible services don't exist, children and adolescents with mental disorders may

- Over-utilize costly and ineffective institutional care,
- Receive only partial treatment for disorders that then persist,
- Continue to drain financial and human resources, or
- End up entangled in the juvenile or criminal justice system.

Additional benefits of an effective child and adolescent mental health policy are the opportunities to promote the mental and emotional well-being of youth, and facilitate stewardship of services to a population that may exceed 50% of the overall population (under age 15) in developing countries[1]

One of the major objectives guiding the selection of the theme for the ***2003 World Mental Health Day*** campaign is to encourage mental health and child advocacy organizations to promote the establishment of comprehensive national child and adolescent mental health policies by the governments in their countries.

A comprehensive child and adolescent mental health policy, as part of an overall national mental health policy or as part of a child health policy, can foster the needed structure for services, training and efficient resource allocation that can benefit national health care delivery systems[1]. The adoption of such a policy can, as stated in the Executive Summary of the Government of South Africa's *Policy Guidelines for Child and Adolescent Mental Health*[3], "serve as a framework for establishing mental health services for children and adolescents at national, provincial and local levels of health care…" As outlined in the Executive Summary (page 4), South Africa's policy focuses on:

1. Optimal development as a foundation for the mental health of the child;
2. The inter-relationship between the various areas of development and competency;
3. Critical periods of opportunity and risk – there is a continuum in one's life, and the extent to which a developmental stage is negotiated is partially dependent on the successful accomplishment of the tasks associated with the previous developmental stages;
4. Socio-cultural factors which shape and influence one's cognition, attitude, affect and behavior, and which in turn determine mental health status and guide intervention strategies;
5. Certain groups of children and adolescents being more compromised and vulnerable to mental health problems than others (for example, children from poor backgrounds, who are HIV positive or have genetic or chromosomal abnormalities);
6. The centrality of gender considerations – for example, gender influences vulnerability through discrimination[3].

3. Rationale for Creating a National Child and Adolescent Mental Health Policy

The WHO Mental Health Policy Project provides the following rationale for establishing and implementing a national policy for child and adolescent mental health:

- There is a virtual worldwide absence of identifiable national child and adolescent mental health policies.
- Current epidemiological data identify a worldwide prevalence of approximately 20% of children and adolescents under the age of 18 with a diagnosable mental disorder. Three to four percent of them have a serious mental disorder requiring specialized treatment.
- There is a considerably larger number of children with developmental problems that have a collateral, but not diagnosable mental disorder.
- A [comprehensive] national child and adolescent mental health policy can facilitate the ability to gather more precise epidemiological data essential for treatment and prevention program development tailored to country needs.

"Without policy guidance for child and adolescent mental health, there is a very real danger that fragmented, ineffective systems of care will emerge or be sustained. In this case, competing constituencies and agencies inevitably provide a less than adequate product for a cost that exceeds expectations. Whereas, a good collaborative planning and policy development can have cost efficiencies and provide a continuum of care that benefits the recipient…child, adolescent, family and community"[1].

Benefits of a National Child and Adolescent Mental Health Policy

An identifiable child and adolescent mental health policy will facilitate:

- More efficient resource utilization for child and mental health services by promoting more effective use of scarce resources, increasing the focus on developing a continuum of care in the least restrictive settings, and reducing inappropriate and wasteful treatment.
- Enhanced ability to provide effective stewardship through better use of personnel, more effective facility utilization, increased accountability for financial expenditures, and a reduction in services duplication.
- Establishment of a focal point for the discussion of issues related to appropriate treatment of children with broader implications for the health care system.
- Increase input from parents and communities regarding child and adolescent mental health[1].

4. Some Guiding Principles for Elements of a National Child and Adolescent Mental Health Policy

Financing

"As for all mental health services, sustained financing is a critical factor. For child and adolescent mental health the extended timeframe for some interventions makes sustained funding even more critical."[1]

- All funding sources for children and adolescents must recognize the longer-term commitment to see positive outcomes.
- Budgeting for child and adolescent mental health services needs to provide incentives for collaborative efforts among potentially competing systems.
- Funding needs to foster the development of a continuum of care.[1]

United Nations Convention on the Rights of Children

Implementing the principles and provisions of the United Nations Convention on the Rights of Children can have an important impact on many elements of child and adolescent health services; among the most important are:

- *Provision for the maintenance of confidentiality.*
- *Providing strict controls over involuntary commitment.*
- *Ensuring access to family members.*
- *Eliminating coercive treatments, such as electro-convulsive therapy, unwarranted restraint, and over or inappropriate medication.*
- *Restoring rights when there is no evidence of mental disorder.*
- *Protecting persons with mental illnesses from abusive treatment.*

For information on the United Nations Convention on the Rights of Children, visit the UNICEF website at www.unicef.org/crc.htm

Legislation and Human Rights
"Child and adolescent mental health policy is most effective when it encompasses a framework that relates child development and an understanding of the rights of the child. Such an approach presents challenges, but can facilitate the formation of policies that fit with communities, cultures and the expected trajectory for healthy development. This framework emphasized the health promotion side of mental health initiatives and supports the development of linkages to other parts of the health system, which can result in the reduction of stigma so often associated with mental and emotional disorders."[1]

Advocacy
"Child and adolescent mental health advocacy by parents, professionals and adolescents themselves has brought a new awareness to legislative bodies in developed countries of the need for child and adolescent mental health policy and services. Advocacy should not be equated with adversarial positions, but rather can facilitate the understanding of issues, generate support in new initiatives and convey to the larger public the rationale for decisions made by governmental bodies."[1]

- Parent advocacy groups form as a result of international attention to specific disorders such as autism. It is helpful to be supportive of these groups as allies in the development of national policy.
- Adolescents as advocates for their own interests and concerns need to be recognized with respect and given voice in policy deliberations.

Quality Improvement
"Evidence provides a strong incentive to institute and maintain quality child and adolescent mental health services. To do otherwise, is to risk the expenditure of large sums of money on programs that may not be accountable, may utilize outmoded or inappropriate services, or fail to support the desired continuum of care."[1]

- The provision of quality services for children and adolescents is cost effective.
- The quality of services may be monitored with a variety of indicators and through the establishment of various administrative mechanisms.
- Any agency monitoring quality would be well advised to incorporate parent involvement in the development and oversight of quality guidelines.

Organization of Services
"The development of adequate child and adolescent services is a challenge even for the most developed and wealthiest countries. However, the development of effective services is not dependent on the wealth or development of a country, but rather on the will and creativity to enhance local strengths, to pool resources and emphasize a commitment to the mainstreaming of persons with mental disorders in community settings."[1]

- Isolated inpatient, outpatient, school or social service treatment services are not effective.
- Establish a continuum of care.
- Service components for a continuum of care include:
  Community-based
  1) Outpatient services (public and private).
  2) Partial care services.
  3) Home visiting services.
  4) Care homes.
  5) Drop-in centers.
  6) Youth centers.
  7) School-based services.
  8) Consultative services.

9) Active case management.

Institutional
1) Psychiatric beds in:
    a. General hospitals.
    b. Pediatric hospitals.
    c. Psychiatric hospitals.

- Provide for transparency in budgeting.
- Involve parents and communities in planning.
- Integrate the services of non-governmental organizations (NGOs) into a comprehensive plan.
- Include planning for specific service delivery components that address special demographic and population characteristics and concerns.

Planning and budgeting for service delivery

"The rational planning for child and adolescent mental health services requires adequate information on the local and national needs for services, the current allocation of funds across relevant sectors of the economy and in relevant branches of government and the private sector, and basic epidemiological and demographic data on children and adolescents."[1]

Planning and budgeting for effective service delivery must address the following elements:

- Needs assessment to ensure that national plans are responsive to country specific needs.
- Human resources and training, taking into account the worldwide shortage of child and adolescents mental health clinicians and the need to increase training of nurses, social workers and others to have the necessary skills to work independently or under supervision.
- Research and evaluation focusing on culturally specific problems of priority to the country and its people.

5. Advocacy Strategies for Promoting National Child and Adolescent Mental Health Policy Development

Effective public policy advocacy requires **Knowledge, Collaboration, Planning** and **Persistence.**

- In order to organize and conduct a successful advocacy initiative, thorough **Knowledge** is required of the mental health needs of children and adolescents in the country, how those needs are being addressed, the gaps that exist in the current mental health care system, the political and economic climate of the country, and the potential allies within the government and non-governmental agencies and organizations.
- Organizing a national public policy advocacy initiative is not a "one person" or "one organization" job. Successful advocacy to create new national policy, or to improve currently existing policy, requires a broad-based **Collaboration** by a diverse grassroots constituency representing a range of stakeholders – parents, professionals, public and private provider organizations, non-governmental organizations, and policymakers. It is important to recognize that many of the members of the

> *"When starting any sort of advocacy campaign, always be sure of your facts and try to anticipate the types of questions you will face. Emphasising your organisation's values and accomplishments to the community in a positive way will help move your initiative along and prevent petty or wasteful arguments from sidelining your efforts."* [4]

coalition will have competing interests and differing objectives that must be recognized, respected and managed if success is to be achieved.

- **Planning** is at the heart of successful public policy advocacy initiatives. Planning includes conducting needs assessments to gain the knowledge on which to establish goals, objectives and strategies for the initiative. It involves the enlistment of the key partners and collaborators willing to join forces around the issue, the identification of well-placed legislators and parliamentarians that can serve as "inside advocates" for the goals of the initiative, and the development and execution of a well-constructed plan of action. Planning also includes the marshalling of grassroots constituencies during crucial stages of the advocacy process, and bringing the collective voices of parents, professionals, and the concerned citizenry to bear on the public officials in decision-making positions.

- It is extremely rare for a public policy advocacy initiative, especially one with the goal of establishing a new national policy direction of the significance represented by a national child and adolescent mental health policy, to succeed on the first attempt. Successful advocates recognize that accomplishing major advances in national public policy requires a large amount of patience and **Persistence.** Effective advocates recognize that

    - Their issue may not always be the most important matter facing the legislative body,
    - Economic, social, and political pressures may work against the objectives of the initiative, or
    - They have yet to establish a broad-based, grassroots constituency strong enough to raise their issue onto the agenda of policy makers to assure success.

> *"Persistence will be needed to overcome old attitudes people may have toward health and community problems, and possible resistance to change. Building healthy communities sometimes calls for compromise with groups whose goals may not be identical to your own."* [4]

Persistence refers to the capacity to remain committed to the goals of the initiative, to sustain and strengthen the coalition, and to continue the difficult work of educating and convincing key policy makers of the need and value of the initiative's goals and objectives.

6. Getting Started on an Action Plan

When an organization such as a national mental health association makes the decision to take a leadership and convening role in creating an advocacy coalition with the goal of promoting the development of a national child and adolescent mental health policy, what are some of the strategic steps it needs to put into place? The following list offers some suggestions for getting started.

- The governing board of the organization should adopt the goal of creating a national child and adolescent mental health policy, and convene and sustain an advocacy coalition to achieve the goal, as the major public policy priority for the organization. A formal commitment should be made to support the coalition for the period of time necessary to achieve its objective.

- The sponsoring organization should identify and recruit the leadership core of the coalition, including its chairperson, and assign staff to support the coalition's work.

> *"Advocates must be clear on their goals and then identify their supporters, any opposition, and key decision makers that need to be influenced."*[4]

- The core leadership should identify and recruit representatives of key stakeholder organizations and interests to join the coalition. Once the membership has been recruited, the process of establishing the structure, funding, operations, and management should be determined and agreed on the members.
- Once the coalition has established its structure and procedures, it should develop an action plan and set of strategies through which it will work to achieve its goal.

7. Building an Advocacy Strategy for Promoting a National Child and Adolescent Mental Health Policy by Involving Families

Organizations and groups working on mental health issues are made up of individuals who are expected to speak with authority and make recommendations based on their experience and knowledge. Whether these are consumer groups, mental health associations, or organizations representing professionals delivering mental health services, their members bring a special perspective forged through personal involvement and understanding.

When family members of children and adolescents with emotional and behavioural disorders become involved in advocacy coalitions formed to promote enlightened public mental health policy, they contribute reality-based, culturally relevant information from a perspective that no one else has. Yet, recruiting family members who are willing to make such a commitment and sustain their involvement over time can be a difficult task.

How can organizations such as national mental health associations successfully recruit, enlist, and sustain family members as integral members of a coalition developed to promote and advocate for a national child and adolescent mental health policy for their country? Here are some practical suggestions and steps from the Federation of Families for Children's Mental Health [5]:

- Contact and recruit family members through both indirect and direct methods. Indirect methods for reaching family members include contacting state and local agencies that work with children and adolescents who have emotional and behavioural problems, family service organizations, mental health service providers, and schools to identify parents who participate on advisory councils or are known as effective advocates. More direct methods include sponsoring or attending conferences, meetings or public discussions concerning children's mental health, or by hosting public forums or other events that create awareness of the coalition's purpose and achievements. Using the media to publicize the coalition's development, goals, and strategies is another method to reach parents of children and adolescents with mental health problems.
- Once family members have been contacted, and their interest established, a representative of the coalition should meet with them to:
    - Explore common hopes and concerns.
    - Explain the importance of creating a national child and adolescent mental health policy – especially for them and their children.
    - Explain the purpose of the policy group.
    - Discuss their interest in being involved – their expectations and support needs.
    - Help them to understand the structure of the coalition, how decisions are made, and how activities are conducted.
    - Describe the composition of the coalition (member organizations, key leadership, major constituencies involved).
    - Provide information on the various levels of participation and involvement in the coalition's work (letter-writing and telephoning policy makers, making public presentations, attending legislative meetings and hearings, etc.).
    - Establish links between the coalition and family groups and other organizations in which family members are already active.

- In addition to establishing relationships with the coalition, it is vital for family organizations to know the realities of the environment in which the coalition works. Internal and external factors (such as personal or organization agendas, competitive issues between coalition members, the political climate and how it will affect the coalition's efforts) can have impact on how the coalition chooses its priorities and makes decisions.
- Coalitions and policy groups that have access to flexible, tangible and practical resources are better prepared to meet the individual needs of their family members. Training for family representatives is essential for them to effectively participate in policy advocacy activities.
- Families of children and youth with mental health problems have demanding schedules. Coalitions should be flexible and creative in scheduling meeting times and locations that accommodate family scheduling needs. Many policy coalitions are relying more heavily on communicating with their members through the Internet by e-mail.
- Advocacy coalitions working on a national issue such as creating a child and adolescent mental health policy should avoid any implication of "tokenism" by limiting the representation of family members or family organizations. When national issues are being addressed, it is of particular importance to have family member representation from all regions of the country – rural as well as urban areas, from cultural sub-groups, and from groups reflecting different types of emotional and behavioural disorders of children and adolescents (autism, ADHD, depression).
- Many families cannot afford the extra expenses of active participation in a national advocacy coalition. Stipends and reimbursement for dependent care, transportation, lodging and meals for travel to coalition meetings or to testify at legislative committees can make a critical difference for family members, and lends credence to the importance of their involvement in the coalition.
- Share information.
- Provide validation and appreciation.
- Sustaining family member involvement.

Resources and References

The following sources and references were utilized, quoted and adapted in the preparation of this advocacy guide

[1]***WHO Mental Health Policy Project: Child and Adolescent Mental Health: Outline for Guidance Module***, ©2001, World Health Organization, Department of Mental Health and Substance Dependence, Geneva, Switzerland*) (Cited with permission. This document is in draft form and the content of the final version may differ from the extracts used in this publication.)*

[2]***World Mental Health Day 2003 Global Mental Health Education Campaign,*** World Federation for Mental Health, Alexandria, Virginia, USA (www.wmhday.net)

[3]***Policy Guidelines for Child and Adolescent Mental Health,*** Directorate of Mental Health and Substance Abuse, Department of Health, Republic of South Africa, January 2001

[4]***Promoting Mental Health and Wellbeing, "Advocacy: Some Hints",*** VicHealth, New South Wales Health Department, NSW, Australia (www.togetherwedobetter.vic.gov.au)

[5]***Involving Families in Policy Group Work,*** Tip Sheet prepared by The Federation of Families for Children's Mental Health, Alexandria, Virginia USA, September 2001 (www.ffcmh.org).

[6]***Mental Health Policy and Service Guidance Package: Child and Adolescent Mental Health,*** ©2002, World Health Organization, Department of Mental Health and Substance Dependence, Geneva, Switzerland: *(Cited with permission. This document is in draft form and the content of the final version may differ from the extracts used in this publication.)*

[7]***Project ATLAS:*** *A Project of the Department of Mental Health and Substance Dependence, World Health Organization, Geneva, Switzerland ©2002 WHO*

[8]***Influencing Your State Legislature, Advocacy Primer,*** National Mental Health Association (US), Washington, DC

An Action Plan for a Policy Advocacy Coalition

An action plan for the coalition might include, among others, the following steps and strategies:

- Prepare a case statement that outlines the goals and objectives of the coalition, presents the rationale for creating and implementing a national child and adolescent mental health policy, summarizes the current status of child and adolescent mental health (incidence, burden of disease, current service availability, gaps in service, unmet needs) for the nation, and describes the benefits of such a policy for the citizens of the nation.
- Schedule and hold a media conference to announce the creation of the coalition and release the coalition's case statement to explain the rationale for advocating for a national policy, and describe the potential benefit to the citizens of the nation for adoption and implementation of such a policy.
- Schedule and hold meetings with selected national elected and administrative government officials to explain the goals of the coalition, present the case statement, establish positive working relationships, and cultivate support for the objectives of adopting a national child and adolescent mental health policy.
- Advocate for the establishment of an Ad Hoc Advisory Committee to the Minister of Health or legislative body to shape a responsive, appropriate and economically sound child and adolescent mental health policy.
- Advocate for funding to support the Ad Hoc Advisory Committee and to commission a report on the status of child and adolescent mental health and the need to formulate a national child and adolescent mental health policy.
- Plan, schedule and conduct a "Child & Adolescent Mental Health Advocacy Day" information forum in the Capital in commemoration of World Mental Health Day. Invite legislators to attend the forum and/or have forum participants schedule personal visits with their representatives to share the coalition's case statement and encourage support for its goals and objectives.
- Promote the establishment in the Ministry of Health of a child and adolescent mental health bureau or equivalent in the Division of Mental Health or other appropriate national government agency.
- Urge the leadership of appropriate legislative or parliamentary committees to hold public hearings on proposals to develop and adopt a national child and adolescent mental health policy.
- Work in concert with the Ad Hoc Advisory Committee in the Department of Health to draft specific proposals for legislation to establish a national child and adolescent mental health policy.
- Provide examples of current policies that have been adopted and implemented by other countries (particularly those of similar size and demographics). The WHO *ATLAS* can serve as a useful resource for this strategy.
- Promote sponsorship and passage or adoption of the proposed policy developed by the Ad Hoc Advisory Committee.
- Organize letter writing (and/or e-mail message) campaigns among coalition organization members, family members, professionals, and citizen advocates urging support for passage of the legislation or administrative action required for adoption of the proposed policy.

South Africa's Policy Guidelines for Child and Adolescent Mental Health: A Blueprint for Action

The Republic of South Africa's *"Policy Guidelines for Child and Adolescent Mental Health"* (Department of Health, Republic of South Africa, January 2001), offers a number of guiding principles, strategies and recommendations intended to guide provincial departments of health to develop policy to address the mental health service needs of children and adolescents. The guidelines serve as an example of the elements that should be included in a national policy proposal.

Guiding Concepts

South Africa's policy guidelines are based on the following guiding concepts:

- Optimal development lays the foundation for child and adolescent mental health.
- Problems are interrelated.
- Critical periods of opportunity and risk exist.
- Socio-cultural factors shape and influence behaviour and mental health.
- Not all children and adolescents are equally vulnerable.
- Gender considerations are important.

Current Legislation and Policy Framework

The guidelines for child and adolescent mental health services were influenced by a number of exciting policies, treaties and legislation, which directly or indirectly impact on mental health of children and adolescents, including:

- The Constitution of the Republic of South Africa, 1996 (Section 28 defines specific rights of the nation's children).
- The Reconstruction and Development Program of South Africa (which contains a series of national goals for children).
- The United Nations Convention on the Rights of the Child (ratified by South Africa in 1995, which committed the government to enhance the survival, protection and development of the nation's children).
- The White Paper for the Transformation of the Health System in South Africa (which charges the Directorate: Mental Health and Substance Abuse to improve and promote psychosocial wellbeing of the population).
- The Child Care Act 74 of 1983 as Amended (the country's foremost statute for the protection of children).
- The National Health Policy Guidelines for Improved Mental Health in South Africa.
- The Mental Health Care Bill, 2000.

Vision and Mission for the Child and Adolescent Mental Health Services

The guidelines spell out a clear vision supported by a set of mission statements that address the desired direction and outcomes for the nation's child and adolescent mental health programs.

General Intervention Strategies

The guidelines outline general strategies that cover the areas of:

- Promoting a culturally sensitive, safe and supportive environment.
- Counseling.
- Providing information.
- Building skills.
- Access to health care services.

General Intervention Settings

The guidelines identify the home/family, school, and health facilities as the primary intervention settings to be addressed by services and intervention strategies.

Priority Areas

The final section of the plan discusses three priority areas that have been selected for emphasis: alcohol and other substances, child abuse, and intellectual disability. Examples are presented on how the principles and strategies described above can be applied to each of the priority areas for children in difficult circumstances.

(3) Policy Guidelines for Child and Adolescent Mental Health, Department of Health, Republic of South Africa, January 2001.

PUBLICIZING YOUR EVENT

The following material will help you prepare information for the media on World Mental Health Day 2003. We are providing you with sample letters and tips on how to understand and work with the mass media. By establishing and maintaining good working relationships with your local media, you will ensure that mental health issues are covered with accuracy and sensitivity.

I. Understanding the News Media

The three most important elements in a good story are action, people and substance. Match the media's needs with your message and ensure that the information is provided to them in a timely manner. In order to develop appropriate media activities and messages, ask yourself:

- What goal(s) do you want to accomplish in your WMHDAY event?
- Who is your target population?
- What messages must be developed and conveyed to influence your target audience to make the desired changes?
- What role do you want the community at large to have?
- What types of media outreach would be efficient and cost effective for accomplishing the above?

II. Tips for Success

- Look for ways to tie your local event in with a national observance or campaign.
- Remember to provide information in a way that the general public will understand. Avoid using professional terms that may be confusing to your audience.
- Know facts about WMHDAY and the year's theme and have them readily available to discuss and FAX to the reporter or other interested parties.
- Consider having a radio or TV station co-sponsor your event, which would highlight the station's commitment to the community and generate free publicity for your event.
- Use the WMHDAY Theme to attract both media and public attention. Use it on all publicity related material, from invitations to fax sheets, letterhead, media kits and banners.
- Keep in touch with your media contacts even after the event is over. Thank them for covering your story. Keep them informed of new issues and new information. Remember, you are trying to build long-term relationships with the media, making their job easier by keeping them up-to-date.

SAMPLE NEWS RELEASE

FOR IMMEDIATE RELEASE

For Information Contact:

WORLD MENTAL HEALTH DAY 2003 FOCUSES ON CHILDREN AND ADOLESCENTS

_____ announces plans to commemorate World Mental Health Day 2003 on 10 October (***describe your planned activities here)***

The theme for ***World Mental Health Day 2003***, *Emotional and Behavioural Disorders of Children and Adolescents,* focuses worldwide attention and concern on the identification, treatment, and prevention of emotional and behavioural disorders in children and adolescents. World Mental Health Day is a global mental health education project of the World Federation for Mental Health and is commemorated in over 100 countries each year on 10 October.

The selection of this theme reflects the need to increase the awareness of the public concerning the devastating effects of mental and emotional disorders on children and adolescents. One of the goals of this year's World Mental Health Day campaign is to encourage advocacy efforts that will promote enlightened public policy, increase availability of treatment services, and develop and implement effective preventive strategies in order to reduce the suffering of children and their families.

Certainly, the need is great. According to the World Health Organization, worldwide up to 20% of children and adolescents suffer from an impairing mental illness, but only one in five receive the help they need. The programs and activities planned by the _____ to commemorate World Mental Health Day in _____ will help the citizens of our community better understand the needs of children and adolescents who experience emotional and behavioural problems, encourage parents to seek assistance from health care professionals to help their children, and encourage governmental officials to plan and fund services necessary to effectively treat and prevent emotional health problems in young people.

According to _____, _____ of the _____, "World Mental Health Day is an important event in our community because it helps all of our fellow citizens learn more about mental health issues and encourages them to support improved services and policies on behalf of children and families. We urge everyone to participate in this year's World Mental Health Day events."

More information about _____ and its World Mental Health Day commemorative activities can be obtained by contacting _____ at _____.

#######

SAMPLE LETTER TO THE EDITOR

FOR IMMEDIATE RELEASE

For Information Contact:

EMOTIONAL HEALTH OF YOUNG PEOPLE NEEDS OUR SUPPORT

The _____ has announced its plans to commemorate World Mental Health Day 2003 on 10 October. This year's theme focuses on the emotional and behavioural disorders of children and adolescents, and will present information on a subject that all of us – parents, teachers, health professionals, and government officials – need to pay attention to.

Mental health problems can affect all families. About one in five children and adolescents will experience an emotional health problem or disorder. For adolescents, mental health problems are already as common as physical health problems, such as asthma. Emotional problems which effect children, adolescents, and young people include depression and anxiety disorders, grief, challenging and disruptive behaviours such as conduct disorders and attention deficit hyperactivity, post-traumatic stress, psychosis, eating disorders and suicide.

Families, friends and teachers are often the first to notice changes in young people that may signal an emotional or behavioural problem, but they may be reluctant to talk about them. Families may also be embarrassed about seeking help or may decide to wait, hoping that problems will sort themselves out. For most emotional health problems, early help gives the best results. Effective help for children and adolescents during the early stages of an emotional or behavioural problem, just as with a physical illness, generally involves short-term counseling or treatment. Treatment is usually based in the local community with as little disruption to school and family life as possible.

Our children and adolescents are our community's most precious resource, and we all have a responsibility to promote and protect their physical, social, educational, and emotional well-being. That includes understanding the toll that emotional and behavioural problems and disorders have young people and their families, supporting families when children suffer from these disorders, and encouraging our governmental leaders to plan, fund and provide adequate and appropriate services for children and their families.

The citizens of _____ are urged to join with the _____ in commemorating World Mental Health Day 2003, and to work throughout the year to support improved services for the children and adolescents in our community who experience emotional and behavioural disorders.

World Mental Health Day is a global mental health education program of the World Federation for Mental Health, and is commemorated in over 100 countries throughout the world on 10 October.

For more information about World Mental Health Day activities in _____, contact _____ at _____.

SOME TIPS ON CELEBRATING WORLD MENTAL HEALTH DAY

- Assemble your planning group immediately to allow maximum time for planning an event.
- Review the contents of this global education packet; begin outlining your World Mental Health Day program.
- Note that these pages are set up for ease in their removal. They can be copied and distributed as is, in order to reduce your time and effort.
- The proclamation page provides suggested wording for your community's commitment to mental health advocacy. Before it is given to your president, prime minister, governor or mayor for signing, it should be carefully reviewed by local administrators to determine how appropriately it reflects the needs of your citizens. You are free to modify the words to suit your situation.
- You may wish to have your proclamation printed on fine quality paper for the official signature. A local attorney can help you produce an attractive formal document.
- Companies that have provided funding for World Mental Health Day are listed in the packet. Identify and communicate with your local representatives of these companies. Let them know that event planning is in progress. Ask if there are ways in which they would like to participate, such as hosting a reception, paying for the printing of your material, or sponsoring workshops, or an exhibit, or whatever your ideas are.
- Carefully consider any time-sensitive activities involving data gathering and/or compiling material for reports. Coordinate your deadlines so that publicity announcements can be released and published in time for World Mental Health Day.
- Begin organizing public events early enough to secure the location and the people you want for your program.
- To help publicize WMHD, put a link on your Website to www.wmhday.net so others may find out about WMHD and its activities. Find other ways to 'spread the word'.
- After October 10, please complete and return the Report Form along with newspaper clippings, photos and other materials produced in connection with your World Mental Health Day activity.
- After October 10, call your planning group together to review what was successful, what could have been improved, and what will be beneficial to do next year.

PROCLAMATION

Whereas the World Federation for Mental Health has designated "Emotional and Behavioural Disorders of Children and Adolescents" as the primary focus of WORLD MENTAL HEALTH DAY 2003; and

Whereas the World Health Organization has reported that worldwide up to 20 percent of children and adolescents suffer from an impairing mental illness, yet only one in five receive the treatment they need; and

Whereas the current world-wide situation in both developed and developing countries reflects a virtual absence of policies for caring for children and adolescents with emotional and behavioural disorders;

Now, Therefore, in support of World Mental Health Day 2003, I urge all citizens of _____ *to*

- *Participate in efforts to increase public awareness and understanding of the physical, mental and emotional health needs of all children and adolescents*
- *Advocate for improved quality of access to mental health services for children and adolescents and for the increased availability of effective mental health services that are culturally, age and gender appropriate, and that meet local needs*
- *Support advocacy efforts to encourage governmental leaders to adopt and implement a national child and adolescent mental health policy to provide guidelines for developing a responsive, appropriate and economically sound continuum of mental health care for children and adolescents.*

In recognition of the pressing needs to increase public awareness of the importance of the emotional well being of our nation's young people, the need to reduce stigma and discrimination that prevents many parents from seeking help for their children who experience emotional and behavioural problems, and the need to improve the availability and quality of child and adolescent mental health services,

I, _____,
(Name)

_____,
(Title)

Hereby proclaim 10 OCTOBER 2003 to be

WORLD MENTAL HEALTH DAY
in

_____
(Country)

And urge all my fellow citizens to take part in the activities designed for the observance of this day.

_____
Signature *(SEAL)*

_____
Date

MEMBERSHIP APPLICATION

If you and/or your organization are not yet a member of the World Federation for Mental Health, why not join now and become a part of the worldwide mental health movement to help improve the mental and emotional well-being of people around the world!

TYPES OF MEMBERSHIP

- Individual membership, for any individual who would like to join WFMH.
- Affiliate membership, for organizations that would like to be affiliated with WFMH.
- Voting membership, for national or international organizations that would like to help with the matters related to WFMH, both internally and externally. Applications are available upon request.

MEMBERSHIP BENEFITS

- Opportunities for networking and collaboration with colleagues in other parts of the world with common interests and concerns
- Quarterly newsletters - bringing you timely information on global mental health issues
- Annual reports of WFMH's activities
- Reduced rates at WFMH events including regional seminars and conferences as well as the Biennial World Congresses

MEMBERSHIP FEES

Individual membership

Regular member (developed countries)	$35
Developing country member (designated by OECD)	$15
Lifetime member	$500

Affiliate membership

Libraries (publications only)	$40
Annual budget below $100,000	$50
Annual budget of $100,000-$999,999	$150
Annual budget of over $1 million	$300

Application on other side

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WORLD FEDERATION FOR MENTAL HEALTH
P.O. Box 16810
Alexandria, VA 22302-0810
USA

REPORT FORM

How Did You Celebrate The Day?

Here is your chance to let us know about your World Mental Health Day events and help us improve future education packets. The strength of this project lies in the effect it has in the field - therefore we urge you to send in a report of your 2003 activities. We hope everyone will join in, not only doing something to 'spread the word' but by letting the rest of the world know what you are doing by writing back to us! Every event - no matter how large or small - is important to us. And all pictures, news articles, and promotional materials are welcome. Most of the prominent activities, if received by January 15, 2004, will be in the World Mental Health Day Summary Report which is compiled, published and distributed each year to friends of WFMH around the world. We look forward to hearing from all of you!

(PLEASE PRINT ALL INFORMATION)

NAME: _____

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1. Overall, how satisfied were you with the World Mental Health Day Educational Material?
   (circle one)

   Very Satisfied Satisfied Neutral Dissatisfied Very Dissatisfied

2. Do you have any helpful suggestions on information that could be useful for future planning material?

3. Please circle the materials within the planning kit that you feel are useful for World Mental Health Day.

Introduction	Fact Sheets
Advances in Research	Publicizing Your Event section
Proclamation	Resources
A Citizen's Guide to Advocacy	Sample Letters, Media Releases
A Guide for Those Who Care for and Teach Young Children	

4. What Special Events did you hold to observe World Mental Health Day?

5. If you were to choose the one outcome that you are most proud of accomplishing through your World Mental Health Day Event, this year, what would it be? (Use additional pages, if needed)

Do you know of anyone who would be interested in obtaining a copy of future World Mental Health Day Educational Material? Please **PRINT** their name and address below:

Name: _____

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World Mental Health Day 2003

Section Three: Reference Information

- The World Federation for Mental Health: A Profile
- WFMH Board of Directors
- World Mental Health Day 2003 International Panel of Science Advisors
- World Mental Health Day 2003 Endorsers
- A List of Valuable Resources for Additional Information on Child and Adolescent Mental Health

WORLD FEDERATION FOR MENTAL HEALTH

The WFMH was founded in 1948 to advance, among all peoples and nations, the prevention of mental and emotional disorders, the proper treatment and care of those with such disorders, and the promotion of mental health.

The Federation, with members and contacts in 112 countries on six continents, has responded to the international mental health crisis through its role as the only worldwide grassroots advocacy and public education organization in the mental health field. The Federation's organizational and individual membership includes mental health workers of all disciplines, consumers/users of mental health services, family members and concerned citizens. The organization's broad and diverse membership makes possible collaboration among governments and non-governmental organizations.

Throughout its history, the Federation has been active in advancing the concerns of the mentally ill before international forums, both private and governmental, and in supporting the efforts of its member organizations at the national and regional level.

The Federation is accredited as a consultant to the United Nations and its specialized agencies, working closely with the World Health Organization, UNESCO, the UN High Commissioner for Refugees, the UN Commission on Human Rights, the International Labour Organization and others.

MISSION

The mission of the World Federation for Mental Health is to promote, among all people and nations, the highest possible level of mental health in its broadest biological, medical, educational, and social aspects.

VISION

The World Federation envisions a world in which mental health is a priority for all people. Public policies and programs reflect the crucial importance of mental health in the lives of individuals, families and communities, and in the political and economic stability of the world. The interdependence of mental and physical health within the social environment is fully recognized. Serious and effective programs are focused on research, training and services for promotion of mental health and optimal functioning, prevention of disorders, and care and treatment of those with mental health problems throughout the life cycle. Those who experience mental, neurological and psychological disorders are understood and accepted, and treated equitably in all aspects of community life.

GOALS

- *To heighten public awareness about the importance of mental health, and to gain understanding and improve attitudes about mental disorders.*
- *To promote mental health and optimal functioning.*
- *To prevent mental, neurological, and psychosocial disorders.*
- *To improve the care and treatment of those with mental, neurological and psychosocial disorders.*

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To obtain individual information for the people listed above,
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WORLD MENTAL HEALTH DAY ADVISORY COMMITTEE

A panel of expert advisors has been formed to provide assistance with this year's World Mental Health Day topic
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To obtain contact information on an individual endorser in your country or geographic region, contact the WFMH Secretariat by email info@wfmh.com

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Zambia
Zimbabwe

as of press time

RESOURCES

About Our Kids
New York University Child Study Center
555 First Avenue
New York NY 10016 USA
Website: www.aboutourkids.org

African Child Association
International Secretariat
5 Westminster Bridge Road
London SE1 7XW ENGLAND
Website: www.acaint.org

American Academy of Child & Adolescent Psychiatry
3615 Wisconsin Avenue, NW
Washington, DC 20016-3007 USA
+1 202 966 7300
Website: www.aacap.org

American Academy of Pediatrics
141 Northwest Point Boulevard
Elk Grove, IL 60007-1098 USA
+1 847 434 4000
Website: www.aap.org

American Psychiatric Association
1000 Wilson Boulevard, Suite 1825
Arlington VA 22209-3901 USA
+1 703 907 7300
Website: www.psych.org

Australian Clearinghouse for Youth Studies
GPO Box 252-64
Hobart Tasmania 7001 AUSTRALIA
Website: www.acys.utas.edu.au

Australian Centre for Posttraumatic MH
Locked Bag 1
West Heidelberg VIC 3081 AUSTRALIA
+61 3 9214 7888
Website: www.ncptsd.unimelb.edu.au

Australian Network for Promotion, Prevention and Early Intervention AUSINET
C/-CMHS – Southern
Flinders Medical Centre
Bedford Park SA 5042 AUSTRALIA
Website: www.ausinet.flinders.edu.au

The Carter Center
Mental Health Program
One Copenhill
Atlanta GA 30307 USA
+1 404 420 5165
Website: www.cartercenter.org

Centre for Health Education & Promotion
Nat'l Health Prgm for Children & Adolescents
Ruutli 24, Tallinn ESTONIA
+372 627 9283
Website: www.tervis.ee

Centre for Mental Health
New South Wales Health Department
LMB 961
North Sydney NSW 2059 AUSTRALIA
Website: www.health.nsw.gov.au

Child Abuse & Neglect in Eastern Europe
Website: http://www.canee.net

Children's Mental Health Alliance
52 East 72nd Street
New York NY USA
Website: www.cmhalliance.org

Center for Mental Health Services
SA & MH Services Administration, USDHHS
5600 Fishers Lane
Rockville MD 20857 USA
Website: www.samhsa.gov/cmhs

European Academy for Child & Adolescent Psychiatry (ESCAP)
Website: www.escap-net.org

Federation of Families for Children's MH
1101 King Street, Suite 420
Alexandria VA 22314 USA
+1 703 684 7710
Website: www.ffcmh.org

Geneva Initiative on Psychiatry
P. O. Box 1282
Hilversum 1200BG THE NETHERLANDS
Website: www.geneva-initiative.org

Global Childnet
#113-990 Beach Avenue
Vancouver, British Columbia V6E 4MZ CANADA
Website: www.gcnet.org/gcnet

Health Canada
Division of Childhood and Adolescence
Tunney's Pasture, Address Locator: 1909C2
Ottawa ON K1A 1B4 CANADA
Website: www.hc-sc.gc.ca/dca-dea/

Immigration and Refugee Svcs of America
National Alliance for Multicultural Mental Health
1717 Massachusetts Avenue, NW, Suite 200
Washington DC 20036
Website: www.refugeeusa.org

Institute for Development Research and Applied Care (IDRAC)
www.idrac.org.lb

International Academy for Child & Adolescent Psychiatry and Allied Professions
Website: www.iacapap.org

International Save the Children Alliance
275-281 King Street
London W6 9LZ UNITED KINGDOM
+44 208 748 2554
Website: www.savethechildren.net

International School Psychology Association
Hans Knudsens Plads 1A 1st Floor
2100 Copenhagen DENMARK
Website: www.ispaweb.org

Int'l Union for Health Promotion &Education
2 rue Auguste Comte
92170 Canves FRANCE
+33 01 46 45 00 59
Website: www.iuhpe.org

National Institute of Mental Health
Child and Adolescent Research Branch
6001 Executive Boulevard
Bethesda MD 20892 USA
Website: www.nimh.nih.gov

National Mental Health Association
2001 North Boulevard Street, 12rh Floor
Alexandria VA 22311 USA
+1 703 684 7722
Website: www.nmha.org

Transcultural Mental Health Centre
Locked Bag 7118
Parramatta BC NSW 2150 AUSTRALIA
Website: www.tmhc.nsw.gov.au

Trust for the Study of Adolescence
23 New Road
Brighton, East Sussex BN1 1WZ UNITED KINGDOM
+44 127 369 3311
Website: www.tsa.uk.com

United Nation's Children Fund
Division of Communication
3 United Nations Plaza
New York NY 10017 USA
+1 212 326 7467
E-mail: pubdec@unicef.org

UN High Commissioner for Human Rights
Committee on the Rights of the Child
D 214, Palais des Nations
1211 Geneve 10 SWITZERLAND
Website: www.unchr.ch

UN High Commissioner for Refugees
Case Postale 2500
1211 Geneve 2 Depot SWITZERLAND
+41 22 739 8111
Website: www.unchr.ch

UNICEF Headquarters
UNICEF House
3 United Nations Plaza
New York NY 10017 USA
Website: www.unicef.org

VicHealth
Victoria Health Promotion Foundation
Post Office Box 154
Carlton South, VIC 3053 AUSTRALIA
Website: www.vichealth.vic.gov.au

WFMH Collaborating Centre on Psychiatry in Africa
University of Cape Town
Groote Schuur Hospital
Observatory, Cape Town 7925 SOUTH AFRICA
+27 21 447 5450

World Health Organization
Division of Mental Health and Substance Dependence
Geneva CH-1211 SWITZERLAND
Website: www.who.int

World Psychiatric Association
WPA Secretariat
Elmhurst Hospital/Mt. Sinai School of Medicine
79-01 Broadway, Room D-10-20
Elmhurst NY 11373 USA
+1 718 334 3459
Website: www.wpanet.org

Young Minds
The National Association for Child & Family MH
102-108 Clerkenwell Road
London EC1M 5SA UNITED KINGDOM
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Website: www.youngminds.org.uk

These materials were created with the assistance of educational grants
from the following organizations:

The World Federation for Mental Health would like to thank the following Sponsors of this year's World Mental Health Day project. Their assistance has been instrumental in the production and distribution of this publication. If you found this document helpful, we encourage you to send a brief thank you note to the Sponsors through the following contacts:

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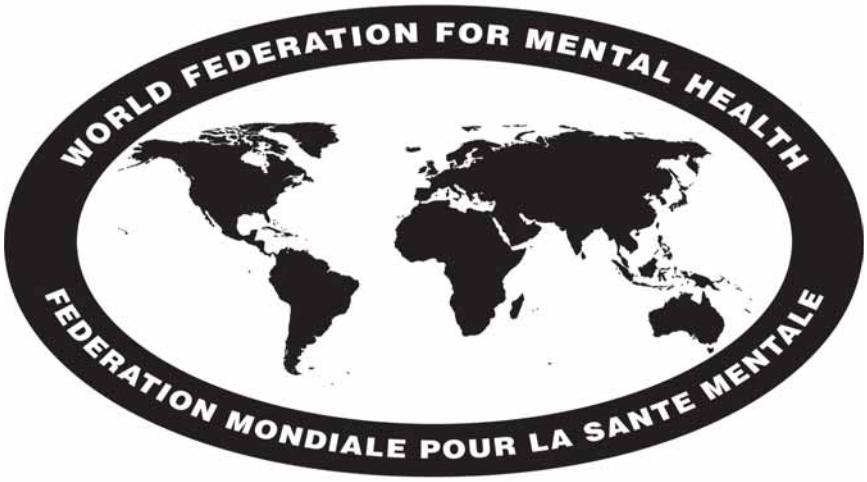

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