A situational analysis of child and adolescent mental health services in Ghana, Uganda, South Africa and Zambia

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Abstract

Objective: Approximately one in five children and adolescents (CA) suffer from mental disorders. This paper reports on the findings of a situational analysis of CA mental health policy and services in Ghana, Uganda, South Africa and Zambia. The findings are part of a 5 year study, the Mental Health and Poverty Project, which aims to provide new knowledge regarding multi-sectoral approaches to breaking the cycle of poverty and mental ill-health in Africa. **Method:** The World Health Organization's Assessment Instrument for Mental Health Systems (WHO-AIMS) Version 2.2 was used to collect quantitative information on mental health resources. Mental health policies and legislation were analysed using the WHO Policy and Plan, and Legislation Checklists. Qualitative data were collected through focus groups and interviews. **Results:** Child and adolescent mental health (CAMH) - related legislation, policies, services, programmes and human resources are scarce. Stigma and low priority given to mental health contribute to low investment in CAMH. Lack of attention to the impoverishing impact of mental disorders on CA and their families contribute to the burden. **Conclusion:** Scaling up child and adolescent mental health services (CAMHS) needs to include anti-stigma initiatives, and a greater investment in CAMH. Clear policy directions, priorities and targets should be set in country-level CAMH policies and plans. CAMHS should be intersectoral and include consideration of the poverty- mental health link. The roles of available mental health specialists should be expanded to include training and support of practitioners in all sectors. Interventions at community level are needed to engage youth, parents and local organizations to promote CAMH.

Key words: Mental health; Policy; Legislation; Children and adolescents

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Introduction

In the year 2000, it was estimated that mental disorders contributed 12% of the global burden of disease, a figure predicted to rise to 15% by the year 2020.[1] Approximately one in five people suffer from a diagnosable mental disorder during the course of their lifetime. Amongst children and adolescents (CA), the prevalence of mental illness is estimated to be about the same as that in adults.[2-5] The burden associated with mental disorders in CA is made worse by stigma and discrimination of people with mental disorders.[4,5] A focus on CAMH is needed to improve the quality of life of affected young people, to prevent the onset of co-morbid conditions and to reduce the negative impact of mental ill-health on their ability to negotiate educational, occupational,

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social and interpersonal life tasks which accompany transition from childhood to adulthood. Approximately 75% of mental disorders in adulthood have their onset in youth, and persistent disorders in adulthood tend to be those with onset during the 12-24 year age group.[5] Promotion of mental wellbeing, strengthening of protective factors, reduction of preventable risk factors, early detection of disorders and provision of effective services for the treatment of mental disorders during childhood and adolescence should be a central concern on the public health agenda.

Despite evidence of the burden and impact of mental disorders, the prioritisation of policy and service development for mental health in general has remained low on the agendas of many governments.[2] Policies, plans and programmes for the promotion of mental health and reduction of the burden of mental disorders in CA has been given even less attention by policy-makers[2,4], and well developed CAMHS have been noted to be scarce, especially in developing countries.[4] A survey of policies focusing on CAMH conducted in 2002 found that only 35 of the 191 WHO member states (18%) had identifiable CAMH policies, and that this number included only 7 African countries.[6] Similarly, of 15 countries of the 46 African WHO member states who responded to a survey of key informants working in child mental health settings, only a third had a national CAMH policy.[7] Further, countries with mental health policies and programmes may still not have allocated human and material resources for the CAMHS, with most CA treated in adult facilities.[5]

The development of policies, plans and programmes for CAMH are key tools through which governments can articulate a commitment to the mental health and reduction of the impact of mental ill-health on its children and adolescents. This paper reports on the child and adolescent findings of a situational analysis to inform mental health policy development and implementation in Ghana, Uganda, South Africa and Zambia. It draws on the findings of the first phase of the "The Mental Health and Poverty Project (MHaPP): Mental health policy development and implementation in four African countries".[8] The first phase involved a situation analysis of mental health policy development and implementation in the four countries.[9-12] The MHaPP aims to provide new knowledge on multi-sectoral approaches to breaking the negative cycle of poverty and mental ill-health in the African context.

Methods

The study used quantitative methods to assess current mental health resources for CAMH, and qualitative methods to understand issues impacting on the development and implementation of mental health policy, legislation and services for CA. Findings were triangulated where possible, using two or more sources of data or research methods.

Quantitative methods

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) Version 2.2,2005 was used to collect information on available resources within the mental health systems of study countries.[13] Data on CAMHS are provided in domain 2 of the six interdependent domains:

- Domain 1 Policy and legislative framework
- Domain 2: Mental health services
- Domain 3: Mental health in primary care
- Domain 4: Human resources
- Domain 5: Public education and links with other sectors
- Domain 6: Monitoring and research

The WHO Mental Health Policy and Plan Checklist, 2005 was completed for the most recent mental health policy in each country. This included the 1994 Mental Health Policy in Ghana; the draft 2000 Mental Health Policy in Uganda; the 1997 National Mental Health Policy Guidelines for South Africa; and the 2005 National Mental Health Policy in Zambia.[14-18] The checklist assesses whether child expertise was involved in the drafting of policy and consideration given to CAMH priorities in policy content.

The WHO Mental Health Legislation Checklist, 2007 was used to review the most recent mental health legislation in each country. This included the 2006 draft Mental Health Bill in Ghana; the 1964 Mental Health Treatment Act in Uganda; the 2002 Mental Health Care Act in South Africa; and the Mental Health Disorders Act of 1951 in Zambia.[19-23] The checklist recommends inclusion of six provisions for protection of minors receiving mental health care, namely:

- Limitation of involuntary placement of minors in mental health facilities,
- Provision of separate living area from adults in mental health facilities,
- Age appropriate environment and developmentally appropriate services,
- Adult representation in all matters affecting the minor,
- Consideration of opinions of minors in all issues affecting them, depending on their age and maturity, and
- Banning of all irreversible treatments on children.

Qualitative methods

Semi-structured interviews (SSIs) and focus group discussions (FGDs) were conducted with purposefully selected respondents to understand issues impacting on the development and implementation of mental health policy and legislation. At national and regional level respondents included politicians, public sector policy makers and planners (from the Departments of Health, Education, Social Development, Housing, Labour, Justice and Constitutional Development, South African Police Services and Correctional Services), nongovernmental (NGO) programme managers, mental health care users, religious leaders development agencies, professional associations and unions, university and research institutions. At district level, service providers from these sectors were interviewed. Table I indicates the number of SSIs and FGDs conducted in each country. The interview schedule included questions about appropriateness of legislative, policy and service provisions for the prevention, care, treatment and rehabilitation of mental and behavioural problems in children and adolescents.

Table I: Number of interviews and focus groups per country

	Ghana	*South Africa*	*Uganda*	*Zambia*
SSIs	108	99	62	48
FGDs	14	12	13	9

Informed consent was obtained from all participants. Confidentiality of transcripts was assured by replacing participants' names with an interview code, and removing identifying material from interviews. A framework analysis approach was used to develop a generic coding frame (themes and sub-themes) for analysis of the transcripts.[24] The generic coding frame was modified at country level to reflect country specific mental health related themes. NVivo 7 qualitative data analysis software was used to multi-code transcripts on the basis of these themes, with additional themes added to the coding framework as determined by the data. Children and adolescents were included as a subcategory for each set of themes in the coding frame, and included coding items for contextual issues, policy content, and development and implementation issues for CAMH.

Permission to conduct the study was obtained from the relevant academic and departmental research ethics bodies within each country.[9-12]

Results

The current status of and contextual influences on policy, legislation and services for CAMH in the study countries, are presented below.

1. The policy and legislative framework for CAMH

National Mental Health Policy: The four countries all have a national mental health policy (Table II). The degree to which child and adolescent mental health was considered in these policies varied. With respect to the consultation process for the development of these policies, Uganda, Zambia and Ghana's policies were developed without a thorough needs assessment or extensive stakeholder consultation. While South Africa's policy was based on both an assessment of need and extensive consultation, child and adolescent experts were not specifically targeted during this consultation. In terms of policy content, however, the mental health needs of children and adolescents were specifically mentioned only in the mental health policies of South Africa (1997) and Uganda (draft, 2000). South Africa's mental health policy guidelines provides for the development of age-specific services for mental disorders, substance abuse and the sequela of trauma and violence, and highlights prevention programmes as the key strategy for this group. Interventions recommended include programmes for improving the quality of care given by caregivers, preventing delays in emotional and intellectual development, life skills education in schools, and the prevention of fetal alcohol syndrome. The policy further recommends state funded tenders to support appropriate child and adolescent mental health research. This policy guideline was developed as an overarching framework, with the intention of drafting more detailed policies for priority area. Stand alone national child and adolescent mental health policy guidelines have therefore also been developed.[25] (South Africa is included in the 2002 audit by Shatkin and Belfer (2004), but the document referred to in that article is the National Policy Guidelines for Mental Health (1997), not the stand alone policy published the year after the audit.)

This policy is closely aligned with the health promotion-focused directions and strategies embedded in the country's general child and youth health policy guidelines.[26] It recommends key settings for intervention (the home, family, community, schools and health facilities), and key strategies (a safe and supportive environment, information, skills-building, counseling and access to appropriate health services).

In Uganda, the draft mental health policy, 2000 proposes the development of a comprehensive child and adolescent mental health policy, a process which has not yet begun. The most recent recommendation in this respect is that child and adolescent mental health should be included as a focus area in a new national mental health policy.

National Mental Health Plans: Uganda has included mental health in its Health Sector Strategic Plan II, 2005, and South Africa has prioritized the implementation of the Mental Health Care Act in its Strategic Plan 2004-2009.[27-28] Other than provision in the Ugandan Plan for psychological rehabilitation for children living in conflict and post-conflict situations, there are no specific provisions for CAMH, with children and adolescents considered as a target group for priority attention across all programmes. None of the countries had a recent stand alone national mental health plan to support the implementation of current mental health policies, and any provisions for children and adolescents in these policies. In South Africa, supportive provincial implementation plans recommended as a next step for the stand alone CA policy have not yet been drafted, and two barriers to provincial level planning for the provisions of the policy were identified. Firstly, the lack of formal acceptance of the overarching South African mental health policy guidelines:

Table II: Policy and Legislative Framework for CAMH

	Ghana	*South Africa*	*Uganda*	*Zambia*
Mental Health Policy	1994	1997 (draft, 2006)	(draft, 2000)	2005
National MH Plan	1976	NO.	In Health Sector Strategic Plan, 2005	NO
National CAMH Policy	NO	2002	NO	NO
MH legislation	1972 (draft, 2006)	2002	1964	1951 (draft, 2006)
Provides for protection of minors[1]	1/6	1/6	NO	NO

[1]Refers to the 6 provisions for protection of the rights of minors in the WHO Legislation Checklist

> *R I think a national policy should be in place and then…policies that are specific will follow(…) we do not even have the services that are necessary for severe mental health disorders, overnight and then you find we are having a child and adolescent mental health unit elsewhere. I: So another constraint to developing an implementation plan for child and adolescent is because the bigger picture is not well articulated and accepted as a national policy? R Yes*
> (Respondent 43, provincial mental health programme manage, South Africa)

Secondly, the lack of capacity at provincial level to develop these plans was highlighted by respondents:

> *R it's very broad to say, provinces, see how you can translate it into a, you know. meaningful policy, and for it to translate into services and service delivery. I would say, much as provinces should be doing, you know, independently doing certain things – at this point in time, provinces actually…some of the provinces need a lot of direction. And they would need a lot of detail.*
> (Provincial mental health programme manager, South Africa)

Legislation: As reflected in Table II, with the exception of South Africa which adopted the Mental Health Care Act, no 17 of 2002 in 2004, mental health legislation in the remaining three study countries are not in line with contemporary issues in mental health care.[22] Draft legislation is in process in two of the countries at the present time: In Ghana, the 1972 Mental Health Degree is to be replaced by the draft Mental Health Bill, 2006; in Zambia, the Mental Health Disorders Act of 1951 will be replaced by the Mental Health Services Bill, 2006.[29-30] In Uganda, a key recommendation of the situational analysis is the revision of the outdated Mental Health Treatment Act of 1964. Child and adolescent mental health issues are not included in existing outdated legislation in the four study countries, and current draft or newly adopted legislation either address none or few of the six provisions recommended for the protection of minors by the WHO legislation checklist: Zambia and Uganda provide no recommendations, Ghana provides recommendations for separate facilities from adults, and South Africa provides recommendations for age appropriate services.

2. Service provision for child and adolescent mental health

Table III summarises the WHO AIMS data on the limited availability of current services for child and adolescent mental health in each of the study countries. The proportion of available inpatient beds for CAMH care in general and psychiatric hospitals was low in all countries. There were no residential services for CA with mental disorders in the study countries, and no specialist day and outpatient health facility services for CA in Uganda, Ghana and Zambia. Specialist day and outpatient services in South Africa are provided by the few tertiary level CAMH inpatient units located in metropolitan regions of the country. There were few psychiatrists working in the public health sector, and only South Africa reported psychiatrists specialising in child and adolescent mental health, although the numbers available are unknown. Similarly only South Africa reported mental health professionals

Table III: Services for CAMH

Service Type	*Examples of Services*[1]	*Ghana*	*South Africa*	*Uganda*	*Zambia*
No of all outpatient facilities -Percentage for CA only	Community mental health centres; mental health outpatient departments in general hospitals; specialized NGO clinics providing mental health outpatient care.	70 0	3460 1.4	28 0	10 0
Gen hosp psych. Inpat. units -Beds per 100 000 population -Percentage of beds for CA	Short-term management of acute problems in children and adolescents within a general hospital.	5 0.33 0	41 2.8 3.8	27 1.4 15	0 0 0
No of mental hospitals -Beds per 100000 population -Percentage of beds for CA	Specialized hospital-based inpatient care and long-stay residential services for children and adolescents with mental disorders.	3 7.04 4	23 18 1	1 1.83 0	1 1.75 11
No of day treatment facilities -Percentage for CA only	Day centres; day care centres; club houses; drop-in centres employment/rehabilitation workshops and social firms.	0 0	81 1	1 0	0 0
No of residential facilities -Beds per 100 000 -Percentage for CA	Supervised housing; group homes with some residential or visiting staff; hostels with day, day and night staff; or 24-hour nursing staff; halfway houses and therapeutic communities.	1 0 0	63 3.6 Unknown	0 0 0	0 0 0
Psychiatrists per 100000	Psychiatrists, specialist CA psychiatrists	0.05	0.28	0.08	0.02
Mental health professionals in schools	Educational and clinical psychologists, clinical social workers	0%	Unknown	0%	0%

[1]WHO AIMS, 2005

working in schools, but again the number of these professionals was unknown. In the SSIs, lack of mental health human resources and training of generalist workers in identification, management or referral of CAMH problems were mentioned as constraints to service provision in all countries, in the health sector, social services and particularly in the education sector, where children and adolescents spend a significant part of their day.

> *They are supposed to update the knowledge of teachers so that, they are able to identify some of the symptoms of deviant behaviour, symptoms of abnormal behaviour in class (…). So the counseling unit actually is supposed to be updating our schools every year, if not every term, but they don't do it.''* (Respondent 84.9, teacher, focus group discussion, district level, Ghana)

> *The issue of career guidance and counselling is an assignment given by the head teacher. In most cases, those assigned the responsibility are not trained. So, you find that they are just there…counsellors by title. They have little answers in terms of counselling and guidance''* (Senior education official 1, Uganda)

3. Factors influencing child and adolescent mental health developments

Three themes emerged from cross country analysis of SSIs which provide insight regarding the low investment in mental health-and CAMH - compared to other priority public health programmes. These were:

- The impact of stigma,
- The low priority of mental health, and
- Lack of attention to the link between poverty and mental ill-health.

4. Stigma and mental health

Across all countries stigma toward people with mental health problems was felt to contribute to active discrimination and the violation of the human rights of service users, whatever their age. Respondents suggested that this can have a significant influence on willingness to disclose and seek help, quality of health care received and access to family, community, school or work support for recovery. Stigma can be extended to the family members of the mentally ill persons, which may contribute to the family members ill treating, alienating or disowning the person with mental illness.

> *Because once you are labelled that you are mentally sick… people have negative attitudes towards you...Some parents deny their children, they think its bad omen''* (SSI, key informant user, Uganda)

Exposure to such discriminatory behaviours can begin very early in childhood and adolescence, from the family, within the school and the broader community:

> *There are parents who come here with their adult children who are nowhere near acceptance of this terrible pain that they have to bear, they just are not at a point where they are able to see their child as someone with a disability and mourn the loss of the child they didn't have, and move on and turn their life into as positive a life as possible.* (Respondent 46, manager, mental health NGO, South Africa)

> *[…]I don't think that our teachers are inclined enough to do a more fine grained analysis you know, of what the real needs of the child is, and they also tend to label a child, I think that people who have psychiatric problems are the worst labelled of all because people have no skills to deal with it and they would just shun such children and I think it's a huge big problem. And one's heart bleeds for children like that who get side-tracked because of that.* (Respondent 02, national policy maker, Department of Education, South Africa)

With respect to policy development and resource investment for mental health, misinformation and stigmatizing views amongst policy makers and programme managers can also stymie development and investment in mental health, and contribute to the low priority of CAMH on the public agenda

> *''Mental health! that is a bad disease I hate. I am not interested; I only sympathize with people who suffer from mental health''* (Politician 4, Uganda)

5. The low priority of mental health

A common theme which emerged in the study countries was the low priority of mental health relative to other health programmes, which tend to receive higher priority and attract more funding. Respondents expressed concern about the limited human resources, inadequate budget, poorly resourced and congested hospitals, the inadequacy of psychotropic drugs, lack of community mental health services and lack of intersectoral collaboration to address unmet need.

> *Even when we go for health planning workshops mental health is not recognised as one of the top 10 priorities for health problems. How they forget I don't know.* (Respondent 2, district level, Zambia).

> *....there is no universal access to mental health services. …people are mentally ill walking on the streets that we have not be able to respond to their needs. I mean generally, access to services, we have a problem, knowledge about how to have good mental health is very limited in our society.* (Respondent 6, director of department, Ministry of Health, Ghana)

6. The link between poverty and mental ill-health

Respondents across countries agreed that there is a link between poverty and mental health. Many respondents felt that

poverty could contribute to the development of mental problem-related problems, including stress, depression and anxiety.

> *''You see even children want to have money in their pocket to feel part of the society. You know if you can't meet certain basic requirement, you are not able to pay your bill and look at the family properly…the brain is designed to take some amount of pressure if it exceeds it, it breaks it down and that will lead to mental problems. So a healthy brain depends on a healthy pocket.''* (Respondent 84.6, teacher, FGD, district level, Ghana)

In turn, mental illness can have an impoverishing effect by resulting in loss of income through reduced ability to study and work, or loss of income due to care-giving. Respondents in Uganda, for example, noted that in addition to users being unproductive when hospitalized or on treatment; their carers also spend the time that would have been spent on productive work nursing these sick relatives. In the family context, loss of income, and the stress of financial difficulty can erode the mental wellbeing of the whole family. This theme was echoed in other countries, as well:

> *R: You must put bread on the table for your kids. When you go … somewhere needing employment, maybe you are given forms there to fill in with 'Have you ever had any mental illnesses?' and then once you say yes you have had- or the other 'have you ever attended a psychiatrist?'- say 'yes' you won't get that job because those people think that you are really mad so there's nothing better you can do... And then you don't have any money. You go to the government and ask for a grant or something…they say 'No you are fit enough.* (Respondent 55, mental health user and advocacy group member, South Africa).

Respondents felt that that CA with mental health problems have not been sufficiently targeted as beneficiaries of existing poverty reduction strategies in the study countries. Some respondents suggested that an active lobby for the economic empowerment of mental health service users and their families is needed to promote their inclusion as beneficiaries of national poverty reduction strategies.

> *''…Unless the leaders of this country start tackling real issues concerning the population; particularly poverty, we are going to see a continued increase in the numbers of people who will break down. There is the issue of drugs. Young people frustrated because they are not employed, and many of those employed but not having enough to maintain themselves are breaking down''* (SSI, Politician 2, Uganda)

Discussion

Results indicate that provision of mental health-related services for children and adolescents in the study countries is sparse at best. These findings are in keeping with the literature which identifies CAMHS as a largely neglected area within the mental health field.[4,5,31] Mental health legislation still needs to build in provisions for the protection of the rights of children and adolescents with mental health problems.[19] National mental health policies and plans are outdated or lacking and CAMH is poorly represented in these documents.[6] Where policies are in place, country plans and allocation of resources to support implementation is not sufficiently in place, with a scarcity of well developed child and adolescent mental health services in these countries, or at best, some services provided within existing adult services.[5] Resources will continue to be limited, and to effect positive changes in the availability of CAMHS to children and their families, policy makers and planners will need to be innovative to expand and optimally use available resources to improve child and adolescent mental health services.[31]

As a first step, results support the need for revision and formal adoption of national mental health legislation, policies and plans in these countries. Legislation should protect the rights of children receiving mental health care, and these can be informed by the provisions set out in the WHO Legislation Checklist, 2007.[19] CAMH should be included as a priority concern within national mental health policies and plans, to contextualise CAMHS within the broader range of mental health priorities. Depending on country capacity, clear policy directions, priorities and targets should ideally be set in a stand alone child and adolescent mental health policy and plan. If included in the national mental health policy, a separate well articulated section should define the scope and targets of the envisaged CAMHS for the country. Clarity on country policy directions for CAMHS will provide an agreed upon basis for very necessary lobbying to raise the profile of CAMH as a key issue on policy makers and programme managers agendas within health and other sectors. Results suggest that lobbying strategies would need to include education to overcome misinformation and stigmatizing myths about mental health.

Secondly, due consideration should be given to the fact that the needs of children and adolescents span several sectors, including health, education, social development, justice, and sports and recreation. It is therefore essential to integrate CAMHS into general health services, and into child-focused programmes in other sectors which have a role to play in child and adolescent health and wellbeing.[4,31] Health, as the lead sector for mental health, should adopt an intersectoral approach to child and adolescent mental health. The principle of inter-sectoral collaboration should be adopted for policy and service development for children and adolescents, to ensure that optimal use is made of available resources across sectors.[11]

An important cross- sectoral issue which has been neglected is the mental health-poverty link. The identification of people with disabilities as a vulnerable group to be fore-fronted in poverty alleviation initiatives is

prioritized within national poverty reduction strategies, but the focus in implementation tends to be on people with physical disabilities, not on people with mental disabilities. Further, the economic empowerment of youth is an integral part of poverty reduction strategies of these countries, but again, the inclusion of children and adolescents with mental health care problems has as yet not been well integrated into poverty reduction strategies in these countries. In South Africa, a care dependency grant is available from 1 year to less than 18 years for physically and intellectually disabled children requiring permanent care or support services, and mentally and physically disabled women and men who are unable to support themselves due to their disability may be eligible for a disability grant from 18 to 60 years (women) or 18 to 65 years (men).[32] Beyond this, children and adolescents with mental health problems have not been targeted as beneficiaries of existing poverty reduction strategies in the countries in this study. There is a need to consider the impact of poverty on child and family mental health in the development of poverty alleviation programmes and in the implementation plans of all sectors. From a child, youth and family perspective, mental illness may contribute to intergenerational limitations on family economic mobility. Loss of or reduced income through mental ill-health may leave parents less able to provide for their own and their children's basic nutritional, educational and other household needs. In addition parents' ability to provide an emotionally supportive environment to foster psychosocial development of their children may be limited during bouts of illness.[5] Reduced quality of childcare in turn may pose an increased risk to optimal development of the child. Where children develop mental illness, they may be at risk for slower academic progress, with reduction in opportunities for gainful employment and social mobility in adulthood.[4]

The third crucial step to strengthen CAMH is the optimal use of available human resources. Levels of mental health resources in these countries are low, and specialist mental health professionals are extremely scarce. Available generalist human resources within community, non-governmental and governmental structures serving children and adolescents will need to be capacitated to identify and intervene within their capacity for the containment, management and referral of CAMH problems.[5,31] Patel et al (2007) suggests that primary health care workers, school counselors, community social workers and juvenile police workers be included in generalist training.[5] Some generalist capacity development can be done intersectorally. Training, case conferences and workshops can be held with staff across sectors serving the CA population in a district, encouraging intersectoral solutions to clinical work in the district by creating opportunities for staff across sectors to meet each other and discuss clinical management issues at these meetings, for example. Post training mentorship and clinical support can improve generalists willingness to implement new skills. Where mental health and specialist child and adolescent mental health service providers are not available to provide this support, countries should invest in building such capacity[4,5], and where they do exist, these specialists' focus should go beyond clinical service provision to include capacity development and outreach support to generalist staff within the districts.[31]

Untreated mental disorders of childhood and adolescence can persist into and have a major impact on adult life and adjustment to adult roles and responsibilities.[5,33] To reduce the negative impact of mental illness on childhood development and on later adult life, CAMH service provision should focus on prevention, early detection and treatment of mental disorders.[17,31] Patel et al (2008), for example recommend programmes to strengthen and capacitate children and adolescents themselves (including life skills and self-help programmes), families (including parenting skills and preschool education programmes), and community structures and systems (such as schools, local nongovernmental organisations, and the health system).[31] These systems should be encouraged and capacity built to integrate CAMH perspectives into their existing programmes and services. The use of non-clinical settings (such as schools and community youth programmes) and tools (such as the internet) for psycho-education, self help and life-skills teaching are suggested as accessible ways to promote the mental health of young people.[5] Research to inform the development, implementation and effectiveness of such interventions in low and middle income countries is still needed.[5,11] The Lancet Global Mental Health Group has set an agenda of priority intervention research for child and adolescent mental health which focus on burden reduction.[34] These include research to inform training, support and supervision in the recognition and provision of basic treatment, effectiveness of school-based interventions, integration of CAMH into existing CA health programmes, policies and systems, community interventions for CAMD, and parenting and social skill interventions in early childhood care

There are a number of limitations to this study, which need to be acknowledged. Firstly, the SSIs were of purposively selected respondents, in order to obtain a wide variety of perspectives and experiences in relation to CAMH policy development and implementation. It is possible that there may be certain respondents whose perspectives were not captured by those sampled. Secondly, among the respondents, their understanding of key CAMH issues will have been informed and limited by their own experience and expertise. Thirdly, the low priority of CAMH in the four countries also impacted on the quality of data that were available regarding current CAMH service provision.

Conclusion

In conclusion, a multi-pronged approach to scaling up attention to CAMH is needed. Anti-stigma initiatives should include a focus on children and adolescents with mental health problems to overcome the negative impact of stigma on mobilization of public attention to the burden of mental ill health on CA, and the low priority of this programme on the public health agenda, relative to other health priorities. There is a need to lobby for greater priority of and investment in mental heath on the public health agenda, and to include CAMH as a focal area

within that lobby. The existing international focus on protecting the rights of children and adolescents should be engaged to draw attention to the rights of children and adolescents with mental health problems, and this should be reflected in mental health related legislation and policy. Clear policy directions, priorities and targets should be set in country level child and adolescent mental health policies and plans to provide guidance to policy makers and programme managers. Effective work with CAMH should be intersectoral to optimally engage the limited available resources within each sector. A core cross-sector consideration for policy and programme development is the link between poverty and mental health: the economic empowerment of youth and families with mental disability should be included in country level poverty reduction strategies. CAMHS will be strengthened by capacitating generalists within all sectors, and by more comprehensive use of available specialist (CA) mental health specialists for training and support to these practitioners in local settings. Finally clinical service provision for CAMHS should be expanded to include interventions at community level, engaging and supporting youth, parents and local organizations to promote the mental heath on children and adolescents within their community.

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