

The Health and Disability Commissioners Act 1994 protects the rights of patients to be treated with respect, dignity and independence; to be free of discrimination; to have proper standards of care; to be fully informed; to make informed choices and to give informed consent; to have protection of privacy; and to have the right to receive support. Patients also have rights to privacy under the Privacy Act 1993, which governs access to medical notes and the sharing of patient information. If patients feel that these standards have not been maintained, they have access to legal redress (Human Rights Commission, 2010).

Summary

New Zealand has a history of mental health legislation dating back to its beginnings as a modern state. The current legislation allows compulsory assessment and treatment for people with mental disorders in hospital or the community in limited circumstances if there is a significant risk to the individual of harm or poor self-care, or a significant risk of harm to others. However, the core principle underlying the doctor–patient relationship is respect of the autonomy of the patient to make informed decisions and to consent to any treatment, and this is strongly supported by legislation, with oversight from a number of institutions.

When compulsory treatment is deemed necessary, this is subject to judicial oversight and there are multiple opportunities for appeal. Importantly, patients who are subject to compulsory treatment continue to have their rights protected. There is an expectation that treatment will be delivered in the least restrictive environment, hence the extensive use of community orders, and that collaboration and consent to treatment are encouraged.

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SPECIAL
PAPER

Child and adolescent mental health in sub-Saharan Africa: a perspective from clinicians and researchers

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There is a widening mental health treatment gap for children and adolescents in sub-Saharan Africa. The region has few economic or human resources dedicated to the mental health of children and young people. The World Health Organization's Mental Health Gap Action Plan and the push for mental health to be included in the Millennium Development Goals have raised the profile of child mental health but comparatively few studies have estimated prevalence rates or assessed needs or tested interventions in African countries. In most countries there is no clear pathway to access treatment, especially in-patient facilities. This article considers these issues from clinical, educational and research perspectives.

There is a widening mental health treatment gap for children and adolescents in sub-Saharan Africa (SSA). This is compounded by: the occurrence of a major demographic transition; and the burden of communicable and non-communicable illness in the region (Global Burden of Disease Study, 2015) and its impact on psychopathology in children. In relation to the first point, improved childhood survival in resource-poor rural and urban areas has led to an increase in the proportion of children aged under 14 years, as reported by the United Nations Children's Fund (UNICEF, 2013). As is the case in most low- and middle-income countries (LMICs), SSA has few economic or human resources dedicated to the mental health of children and young people. The Mental Health Gap Action Plan produced by the World Health Organization

(WHO, 2010) and the push for mental health to be included in the Millennium Development Goals have raised the profile of child mental health on the continent, but comparatively few studies have estimated prevalence rates or assessed needs or tested interventions in African countries. In most countries there is no clear pathway to access treatment, especially in-patient facilities.

Establishing need: use of screening and diagnostic tools

High-quality research on child mental health is necessary to understand the scale of the problem in Africa (Kieling *et al*, 2011). There are few African studies on child mental disorder; those that have been done are geographically scattered and have reported variable results (Cortina *et al*, 2012). Consequently, assumptions about African children (such as an approximate prevalence of child mental disorder of 10–20%) are extrapolated from global studies or results from LMICs elsewhere in the world (Belfer, 2008). Much of the variability in the reported research results is brought about by heterogeneous methods of screening and diagnosis. But even when similar screening methods are used, different reporting thresholds among different cultural or socioeconomic groups can create bias (Ho *et al*, 1996). Prevalence rates cannot be appropriately extrapolated from the results obtained with a screening questionnaire unless that instrument has undergone clinical validation, for example through the use of a diagnostic psychiatric interview (Goodman *et al*, 2012).

While diagnostic psychiatric interviews are necessary for meaningful research, few or no diagnostic interviews have been validated in an African context, particularly among the expanding poorer sections of society. One important difficulty relates to language: in many African countries the local population will speak several languages, with varying degrees of proficiency; many minority mother tongues are not taught in schools; and many people are not familiar with written forms of the language (often even local field workers).

Another issue is that questionnaires devised in high-income countries are difficult to adapt to low-resource settings. For example, it is important in child psychiatry (in both research and clinical practice) to describe psychopathology across different settings, incorporating the perspectives of parents (home), teachers (school) and the children themselves. This is not always possible in a low-resource environment. Firstly, a child may not have access to education and so questions relating to schooling will not be meaningful (e.g. ability to sustain attention for completing homework or concentration in getting organised for classes). For those children who do attend school, a different challenge arises – parents have little contact with teachers, and teachers may not know their pupils well, as class numbers may exceed 100. Secondly, obtaining a parent's perspective may also be difficult where grandparents, an aunt or an older sibling may be the main carer, while the parents go

to the city to work, or the main carer is inaccessible due to farming or other responsibilities.

What is needed are measurement tools that take socioeconomic and cultural differences into account, and qualitative studies that explore context-specific social expectations and standards for behaviour in childhood.

Research: risk and resilience

Certain universal child attributes or environmental influences confer greater risk of mental health problems. However, the constellation of such risk factors – the frequency at which they occur and their distribution in child populations – differs geographically. For example, in SSA, infectious diseases with neuropsychiatric sequelae such as malaria and HIV/AIDS are more prevalent than elsewhere in the world (Global Burden of Disease Study, 2015). Chronic neurological illnesses like epilepsy are more common and often go untreated, leading to a worsening of their cognitive and psychiatric consequences (Wilmsurst *et al*, 2014). In urban informal settlements, toxins such as lead have been linked to neurodevelopmental problems. The increasing number of children surviving developmental insults will add to the burden of neuropsychiatric and neurodevelopmental disorder. Adverse social circumstances such as war trauma, child abuse and neglect, being orphaned, food insecurity and poverty are also important in the development of mental disorder. Protective factors for children from research-poor contexts need further investigation.

Clinical perspective

Belfer & Saxena (2006) reported that in only 27% of countries are there designated child and adolescent mental health beds. In most African countries there is approximately one child psychiatrist to 4 million people. Children are usually taken to a traditional healer because of beliefs that mental and neurological problems have spiritual causes. As such, there is considerable stigma, and many of these children face rejection from their communities and in some cases their own families. There are few programmes to educate communities about the nature of mental illness and little help for desperate families.

To access free clinical care people often have to travel long distances on public transport to an urban treatment centre. The referral structure is supposed to be based on district health workers but in reality most referrals are from schools, orphanages and day care centres, and paediatric colleagues. Some children are brought by their carers without referral. Ethiopia has two child and adolescent clinics, both located in Addis Ababa, but no in-patient facilities for children. In Uganda a child psychiatry training programme for all health cadres has been launched in Kampala, and there is an in-patient facility at Butabika hospital. In Kenya and Malawi, if children reach services they are most likely to be seen by a medical officer or a paediatrician untrained in child mental health.

In East Africa approximately two-thirds of new patients presenting to the child and adolescent psychiatry service have epilepsy; the majority of the remainder present with intellectual disability or neurodevelopmental disorders (often manifesting as disruptive behaviour). Symptoms of post-traumatic stress are often reported and psychosis starts to be seen in adolescence, but depression, anxiety, suicidality, self-harm and emerging personality disorders rarely reach mental health services. This is likely to be the pattern in other SSA countries. The clinic is seen as a last resort – after the traditional healer, priest, imam or, more rarely, the district health worker has been unable to help. Follow-up visits are not usually possible, and the psychiatrist has to give advice and prescribe medication with the expectation that the child will not be seen again.

Intervention

The guidelines to the Mental Health Gap Action Programme (WHO, 2010) recommend a range of psychosocial and pharmacological interventions for low-resource settings, but many commonly used drugs are still not available in SSA. The pharmacopeia is limited to typical antipsychotics, with olanzapine and risperidone as options in some settings. Tricyclics are usually available, while selective serotonin reuptake inhibitors (SSRIs) are more difficult to source. The anti-epileptic drug most frequently available is phenobarbitone, a controversial drug due to its reported cognitive and behavioural adverse effects (Wilmshurst *et al*, 2014), while the availability of other anti-epileptic drugs, anxiolytics and mood stabilisers is unreliable and psychostimulants are difficult to access.

A wide range of psychosocial interventions have been tried in LMICs but further evidence of their efficacy is needed (Kieling *et al*, 2011; Fazel *et al*, 2014). Intervention studies in SSA targeting children with disorder are few, but some encouraging work has been done on school-based interventions, and for trauma and post-traumatic stress disorder. Ideally, interventions should be administered by personnel from community, education and health services, should be inexpensive, and should be time efficient, as poor carers have significant demands on their time in the form of caring for multiple children and subsistence farming or other low-paid work.

Sustainability and public policy

The problem with intervention is establishing both its long-term sustainability and usable national health policies, and this continues to be a challenge in SSA. Notably, though, there are low-income African countries, such as Mozambique and Botswana, that do have national mental health policies for children (Shatkin, 2004).

Training and education

Belfer & Saxena (2006) have shown that most primary care providers, educators and others are not sufficiently trained in child mental health.

However, some training in child and adolescent mental health is provided through educational collaborations in Ethiopia, involving the University of Toronto (Canada), Ludwig Maximilian University of Munich (Germany) and King's College London (UK), and in Uganda run via the Butabika hospital link to East London NHS Trust (UK). Kenya and Malawi may soon follow suit.

Conclusion

For progress to be made in SSA, efforts need to focus on developing appropriate screening and diagnostic tools with which to conduct prevalence studies and needs assessments. Subsequently, there must be national policy and guidance based on these research findings, which lead to training of healthcare professionals and appropriate realistic intervention for low-resource settings. These steps are slowly happening in medical and adult psychiatric settings. For children and young people, promising steps are being made in adapting school-based interventions and parenting courses for these settings and there is increasing investment in educating clinicians. Further work is progressing in adapting and creating new screening and diagnostic measures, and in understanding context-specific risk and resilience factors. This will eventually provide a knowledge base for research and policy.

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