Partnering for the World's Children

Why Collaborations Are Important

Paramjit T. Joshi, MD[a,*], Bennett L. Leventhal, MD[b], Joaquin Fuentes, MD[c]

KEYWORDS

• Children • Mental health • Global • Psychiatric disorders • Collaboration

KEY POINTS

- Most psychiatric disorders have their onset in childhood and adolescence when prevention and early intervention can prevent a lifetime of suffering, disability and stigma.
- We share in a global responsibility to transcend cultural and political boundaries to identify childhood-onset psychiatric illness as an international public health crisis.
- The often intertwined contributions of psychosocial, economic, political, cultural, religious, and community variables have an enormous psychological impact on the lives of children and both their physical and mental health.
- Today's problems of poverty and violence will never subside unless we invest in the physical, mental, and emotional development of the next generations.
- We are now in the unique position of having potentially increased the scientific knowledge through research to start addressing these issues in a comprehensive way.
- We must be able to collaborate with colleagues across the world to pursue common goals.

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[a] Department of Psychiatry & Behavioral Sciences, Children's National Medical Center, George Washington University School of Medicine, 111 Michigan Avenue Northwest, Floor 2.5 West, Suite 700, Washington, DC 20010, USA; [b] Child & Adolescent Psychiatry, Department of Psychiatry, Langley Porter Psychiatric Institute, University of California San Francisco, Box 0984-CAS, Room LP-152, 401 Parnassus Avenue, San Francisco, CA 94143-0984, USA; [c] Child & Adolescent Psychiatry, Policlínica Gipuzkoa, Paseo de Miramón 174, Donostia-San Sebastián 20014, Spain
* Corresponding author.
E-mail address: pjoshi@childrensnational.org

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INTRODUCTION

Today's world finds few places in which children can live in peace, free from violence, deprivation, strife, and hardship; a sad reality. These youth, children, and adolescents of the world, are our future and yet we are permitting them to be exposed and vulnerable to the worst perils of our times.[1] Each and every day millions of children globally are deprived of their right to live in safety, with adequate food, water, shelter, education, and health care, as well as the chance to be reared in caring and loving families with supportive community environments. Daily, children in every corner of the world face the possibility of being kidnapped, killed, orphaned, abandoned, neglected, and/or abused. The reasons are manifold: political, environmental, economic, psychosocial, physical, and even medical or psychiatric illness in their caregivers. And, because of the impoverishment of many families, as well as the disruption of traditional family structures, an increasing number of children have to fend for themselves on the streets. Although the reasons are well known or even understood, there is still no organized move to end this tragedy for our children. The most recent World Health Organization (WHO) Atlas report suggests that the number of children and adolescents facing significant adversity is growing at an alarming rate, and that increasing numbers of children are at risk of deprivation, damaged health, developmental disruption, and premature death.[2] With such a severe, chronic problem, the question becomes: Who will stand up for the world's children?"

BACKGROUND

Mental health is but one part of a child's overall health, development, and ability to learn. The developing brain is a fragile part of each child's body that depends on physical and emotional sustenance from caregivers and the environment. According to the National Institute of Mental Health (NIMH), in the United States, at any point in time, 1 in 5 children has a diagnosable mental disorder and 1 in 10 suffers from a psychiatric illness that is severe enough to impair how they function at home, school and/or in the community.[3,4] The vast majority of psychiatric illnesses appear in childhood and adolescence (50% by age 14 years and 75% by age 24), but the average lag time between the onset of symptoms and the initiation of treatment is 8 to 10 years, even though it has been demonstrated that early diagnosis and intervention for these disorders will impact their prevalence and course, as well as the level of impairment in adult life.[3,4] If children are not screened and treated, these childhood-onset psychiatric disorders persist and contribute to a cycle of school failure, poor employment opportunities, poverty, and suffering that will then affect their descendants.

Children and youth with untreated psychiatric illness have more difficulties in school, more involvement with the criminal justice system, and fewer stable and long-term placements in the child welfare system than do their peers. Although psychiatric disorders impact children from all types of families and at all economic levels, there are certain conditions that can increase the needs for mental health services. Many of the world's children are subject to the most significant of these conditions: living in poverty, witnessing violence, or having a parent who suffers from depression. There are well-researched associations between socioeconomic status and indices of both physical and mental health.[5,6] We need to seize all opportunities to improve health care for millions of children around the world, and we must be able to collaborate, remain organized, and share common goals, so we can speak with one voice on the world stage.

Often, because of the trauma and turmoil in their lives, children and youth in the child welfare and juvenile justice systems have a higher prevalence of psychiatric disorder

than do children in the general population. Being a victim of abuse and neglect, being removed from one's family, or living in multiple foster homes can each separately lead to mental health problems; when experienced together, these circumstances multiply the risk for developmental disruption and psychiatric illness. In the United States, considered by most to be a "first world" country, 50% of children in the child welfare system have mental health problems and, in the juvenile justice system, 67% of youth have a diagnosable psychiatric disorder.[7,8]

In the decade to come, we will experience continued population growth worldwide (although at a slower rate compared with the recent past) and with this will come an increasing global need for mental health care for our children and their families. Health care is changing worldwide and we need to ask difficult though important questions of ourselves so that we are better prepared for the future as child and adolescent psychiatrists: What will the delivery of mental health services look like in the near future? Will the treatments be evidence-based? How much will services cost and will our patients be able to afford them? Will our patients get better and how will these outcomes be measured? As child and adolescent psychiatrists, we are uniquely qualified to integrate knowledge about human behavior and development from biological, psychological, familial, social, and cultural perspectives with scientific, humanistic, and collaborative approaches to the diagnosis, treatment, and promotion of mental health in children and adolescents. But, what will be the unique role of child and adolescent psychiatry in the new health care systems?

The Rights of Children

The WHO Mental Health Action Plan 2013–2020 establishes human rights as one of the basic cross-cutting principles for their approved mental health comprehensive plan.[9] It is now well-established that children have rights that entitle them to family-based care, protection, and a fair chance in life. Each child must be loved, protected, and respected[10]; and every child must have the opportunity for an education and access to comprehensive medical care, including psychiatric and psychological services.

SUMMARY OF THE UNITED NATIONS CONVENTION ON THE RIGHTS OF THE CHILD

In 1989, governments worldwide promised all children the same rights by adopting the United Nations (UN) Convention on the Rights of the Child, also known as the CRC or UNCRC.[11] The Convention was intended to change the way children are viewed and treated. It is the most complete statement of children's rights in history. The Convention describes not only rights but also what a child needs to survive, grow, and live up to their potential. These rights and needs apply equally to every child, no matter who they are or where they live. All UN member states, except the United Sates, have ratified the CRC. The UNCRC is charged with ensuring that the Convention is properly observed by the countries that have signed it. The Convention has 54 articles in total. Articles 43 to 54 speak to how adults and governments must work together to ensure that all children's rights are being honored. The following is the list of the Articles that pertain to children[11]:

Article 1
Definition of the child
Everyone younger than 18 has all the rights in the Convention.

Article 2
Without discrimination

The Convention applies to all children, whatever their ethnicity, gender, religion, abilities, whatever they think or say, and no matter what type of family they come from.

Article 3
Best interests of the child
The best interests of the child must be a top priority in all actions concerning children.

Article 4
Protection of rights
Governments must do all they can to fulfill the rights of every child.

Article 5
Parental guidance
Governments must respect the rights and responsibilities of parents to guide and advise their children so that, as they grow, they learn to apply their rights properly.

Article 6
Survival and development
Every child has the right to life. Governments must do all they can to ensure that children survive and grow up healthy.

Article 7
Registration, name, nationality, care
All children have the right to a legally registered name and nationality, as well as the right to know and, as far as possible, to be cared for by their parents.

Article 8
Preservation of identity
Governments must respect and protect a child's identity and prevent the child's name, nationality, or family relationships from being changed unlawfully. If a child has been illegally denied part of his or her identity, governments must act quickly to protect and assist the child to reestablish his or her identity.

Article 9
Separation from parents
Children must not be separated from their parents unless it is in the best interests of the child (for example, in cases of abuse or neglect). A child must be given the chance to express his or her views when decisions about parental responsibilities are being made. Every child has the right to stay in contact with both parents, unless this might harm the child.

Article 10
Family reunification
Governments must respond quickly and sympathetically if a child or the child's parents apply to live together in the same country. If a child's parents live apart in different countries, the child has the right to visit both of them.

Article 11
Kidnapping and trafficking

Governments must take steps to prevent children being taken out of their own country illegally or being prevented from returning.

Article 12
Respect for the views of the child
All children have the right to say what they think in all matters affecting them, and to have their views taken seriously.

Article 13
Freedom of expression
Every child must be free to say what he or she thinks and to seek and receive information of any kind as long as it is within the law.

Article 14
Freedom of thought, belief, and religion
All children have the right to think and believe what they want and also to practice their religion, as long as they are not stopping other people from enjoying their rights. Governments must respect the rights of parents to give their children guidance about this right.

Article 15
Freedom of association
Every child has the right to meet with other children and young people and to join groups and organizations, as long as this does not stop other people from enjoying their rights.

Article 16
Right to privacy
Every child has the right to privacy. The law should protect the child's private, family, and home life.

Article 17
Access to information from mass media
Every child has the right to reliable information from the mass media. Television, radio, newspapers, and other media should provide information that children can understand. Governments must help protect children from materials that could harm them.

Article 18
Parental responsibilities; state assistance
Both parents share responsibility for bringing up their child and should always consider what is best for the child. Governments must help parents by providing services to support them, especially if the child's parents work.

Article 19
Protection from all forms of violence
Governments must do all they can to ensure that children are protected from all forms of violence, abuse, neglect, and mistreatment by their parents or anyone else who looks after them.

Article 20
Children deprived of a family

If a child cannot be looked after by his or her family, governments must make sure that the child is looked after properly by people who respect the child's religion, culture, and language.

Article 21
Adoption
If a child is adopted, the first concern must be what is best for the child. The same protection and standards should apply whether the child is adopted in the country in which the child was born or in another country.

Article 22
Refugee children
If a child is a refugee or seeking refuge, governments must ensure that he or she has the same rights as any other child. Governments must help in trying to reunite child refugees with their parents. When this is not possible, the child should be given protection.

Article 23
Children with disabilities
A child with a disability has the right to live a full and decent life in conditions that promote dignity, independence, and an active role in the community. Governments must do all they can to provide free care and assistance to children with disabilities.

Article 24
Health and health services
Every child has the right to the best possible health. Governments must provide good-quality health care, clean water, nutritious food, and a clean environment so that children can stay healthy. Richer countries must help poorer countries achieve this.

Article 25
Review of treatment in care
If a child has been placed away from home (in care, hospital, or custody, for example), he or she has the right to a regular check of his or her treatment and conditions of care.

Article 26
Social security
Governments must provide extra money for the children of families in need.

Article 27
Adequate standard of living
Every child has the right to a standard of living that is good enough to meet his or her physical, social, and mental needs. Governments must help families that cannot afford to provide this.

Article 28
Right to education
Every child has the right to an education. Primary education must be free. Secondary education must be available to every child. Discipline in schools must respect

children's human dignity. Wealthy countries must help poorer countries achieve this.

Article 29
Goals of education
Education must develop every child's personality, talents, and abilities to the full. It must encourage children's respect for human rights, as well as respect for their parents, their own and other cultures, and the environment.

Article 30
Children of minorities
Every child has the right to learn and use the language, customs, and religion of his or her family, whether or not these are shared by most of the people in the country in which the child lives.

Article 31
Leisure, play, and culture
Every child has the right to relax, play, and join in a wide range of cultural and artistic activities.

Article 32
Child labor
Governments must protect children from work that is dangerous or might harm their health or education.

Article 33
Drug abuse
Governments must protect children from the use of illegal drugs.

Article 34
Sexual exploitation
Governments must protect children from sexual abuse and exploitation.

Article 35
Abduction
Governments must ensure that children are not abducted or sold.

Article 36
Other forms of exploitation
Governments must protect children from all other forms of exploitation that might harm them.

Article 37
Detention
No child shall be tortured or suffer other cruel treatment or punishment. A child shall only ever be arrested or put in prison as a last resort and for the shortest possible time. Children must not be put in a prison with adults and they must be able to keep in contact with their family.

Article 38
War and armed conflicts: see "Optional protocols"

Governments must do everything they can to protect and care for children affected by war. Governments must not allow children younger than 15 to take part in war or join the armed forces.

Article 39
Rehabilitation of child victims
Children neglected, abused, exploited, or tortured or who are victims of war must receive special help to help them recover their health, dignity, and self-respect.

Article 40
Juvenile justice
A child accused or guilty of breaking the law must be treated with dignity and respect. Children have the right to help from a lawyer and a fair trial that takes account of their age or situation. The child's privacy must be respected at all times.

Article 41
Respect for better national standards
If the laws of a particular country protect children better than the articles of the Convention, then those laws must stay.

Article 42
Knowledge of rights
Governments must make the Convention known to children and adults.

OPTIONAL ADDITIONS

In 2000, the UN General Assembly adopted 2 optional additions to strengthen the Convention. One required governments to increase the minimum age for recruitment into the armed forces from 15 years and to ensure that members of their armed forces younger than 18 did not take part in armed conflict. The other provides detailed requirements for governments to end the sexual exploitation and abuse of children. It also protects children from being sold for nonsexual purposes, such as other forms of forced labor, illegal adoption, and organ donation.

There even needs to be a bill of rights for children that speaks to the challenges facing our youth and their parents and caregivers. And, although each of these declarations seems self-evident, despite the guarantees of so many countries, the rights of children are routinely ignored or flagrantly violated. All children are vulnerable, but it is those with disabilities and, especially, the high-prevalence, high-impact disabilities associated with psychiatric illness that are at the greatest risk.

A CALL TO ACTION

The stakes are high. Although many challenges face our developing youth, psychiatric disorders represent perhaps the most common, high-impact, chronic problem for which there are the most limited resources. One in 5 children either currently or perhaps as many as 50% will have a disorder at some point during their lifetime, many of which will be seriously debilitating.[3,4] The seriousness of this situation is amplified because fewer than 20% of those affected will receive appropriate treatment, and virtually all of those who receive care will be in the highly developed nations. This means that it is more likely than not that children in the developing world will receive no care at all, and the consequences are severe.

- More youth and young adults continue to die from suicide than from all natural causes combined. It is argued whether suicide is the second or third most common cause of death. For example, according to WHO, suicide is the second leading cause of death among those 15 to 29 years old, and 75% of global suicides occur in low-income and middle-income countries.[12] This is a specious argument. We know suicide is much more common that all other medical illnesses and is only possibly exceeded by accidents and homicide. Ninety percent of those who die by suicide have a psychiatric disorder that was diagnosed before death. And, despite recent advances in treatment, we have not yet been able to make much progress in reducing the rates of youth suicide, except in countries that have strong laws restricting access to guns, like Australia, which must also be noted to have a strong multifaceted approach to youth suicide.[13]
  - Approximately 50% of students younger than 14 with a psychiatric illness will drop out of school, with members of racial and ethnic minority groups dropping out at higher rates, as do those from low-income families, from single-parent households, and from families in which one or both parents also did not complete high school.[4] This all suggests that powerful psychosocial factors interact with the presence of illness to place youth at risk.
  - Seventy percent of youth in juvenile justice systems have at least one psychiatric diagnosis.
  - The longer patients with mental illness stay ill, the more expensive it is to manage (this loss includes cost of care and lack of productivity in work/society).

Timely access, standards of care, and perceptions about mental illness remain challenges. An 8-year to 10-year delay between the onset of symptoms and intervention is simply unacceptable: imagine the international outrage if this were the case for cancer. Time and resources invested in the child's care, both early in life and early in the course of illness, will have a significant impact on their future health, quality of life, and cost of care. Thus, we must prioritize timely, early, multidisciplinary assessments for children. This sort of collaboration and attention to details and evidence-based care will create a brighter future for our patients and their families.

In recent times, there have been very visible tragedies involving our youth. All-too-frequent examples include shootings in the United States, the kidnapping of girls in Nigeria, and selling of children for labor or sex trafficking in Southeast Asia, to mention a few of the many. These have included all manner of violence and privation, and, after each of these, it has been suggested that long-standing mental health problems either contributed to or will be the consequences of these awful events. After each of these events, there is a momentary resolve by leaders and citizens to bring the issues of the rights of children and their mental health back to the national and international stage; yet, with the 24-hour news cycle, these stories quickly disappear from the prominent media outlets, and little has been done systemically. The underlying problems are not addressed, and children remain at risk and in jeopardy. These stories that produce media frenzies are but the tip of the iceberg, as millions of youth around the world struggle with psychiatric illnesses with no hope of help. How many will have their educational, social, and vocational development disrupted or, worse, commit suicide because they did not get needed services? Indeed, why in the twenty-first century are we even asking this question?

Children's mental health has been identified for too long as one of the most underserved areas in all of medicine. It is a discipline that is understaffed, underfunded, poorly reimbursed, and poorly understood from a research perspective. The vast

majority of the mental health professionals are in developed countries, such as the United States. Even in the United States, uneven distribution and lack of access means that only 25% of children in need receive services and, even then, the delays are inordinate and the services often inadequate. Children throughout the world are even worse off. There are countries like India with less than a dozen trained child and adolescent psychiatrists, and some countries have none at all. WHO reports that the number of general psychiatrists, not child psychiatrists, is 30 per 100,000 in Switzerland, 1 per 100,000 in Turkey, and in Liberia the figure is 0.06 mental health professionals per 100,000. Equally shocking is that many countries do not even have public policy related to children's mental health.[2]

It is often said that one of the reasons for the lack of appropriate children's mental health care is the absence of science about the causes and treatments of childhood-onset psychiatric disorders, but the data are to the contrary. Although blood tests are not yet available, the neurobiology and genetics of childhood-onset disorders are becoming increasingly clear. As with other areas of medicine, despite the lack of specific etiologies for clinical syndromes, there are evidence-based, safe, and effective pharmacologic and psychosocial/environmental interventions for the most prevalent of disorders. Because psychiatric illness is very much a "childhood" issue that greatly affects a child's overall health, development, learning abilities, and future competitiveness in society, it is time for these advances to be applied to children throughout the world.

More recently, with mounting evidence from studies such as the Milliman report on adults with mental health disorders, integrating general medical and psychiatric care (integrated care) is essential, as it results not only in improved outcome but also measurable financial savings.[5] On a purely economic basis, early identification and effective treatment of childhood-onset psychiatric disorders is cost-effective and results in decreased lifetime care costs, as well as increased earning potential for the individual. In other pediatric chronic conditions, such as obesity, asthma, and diabetes, early detection and intervention have produced a positive effect on patients' health as they enter adulthood and have led to improved lifetime outcomes. For psychiatric illnesses, the data are very similar: early recognition and timely intervention can delay or prevent the onset of psychopathology and result in faster, more complete recovery. It also can decrease the frequency and severity of relapses. A 33-year follow-up study of children with attention-deficit/hyperactivity disorder (ADHD) demonstrated the value of early treatment. Children who did not receive intervention experienced an increased likelihood of incarceration and early death in adulthood compared with matched controls.[14] These and other findings highlight the importance of extended monitoring and treatment of children with ADHD.[14] In another study, children at high risk for psychosis who received early identification and treatment did not develop a psychotic disorder, demonstrating that the course of psychosis is not fixed, as was previously believed.[15]

In June 2014, President Obama held a White House Summit on Mental Health, the first in 15 years, focusing on pediatric psychiatric disorders. In a subsequent national meeting of government policy makers, NIMH leaders, and leaders of child and adolescent psychiatry and pediatrics, there was an attempt to find solutions for how best to address the pressing needs of individuals experiencing a psychiatric illness in the United States. This was prompted by a public outcry in light of a spate of horrific public massacres. And, once again, with the decline in media attention, came a decline in this effort, as well. How can this happen when so many recognized that the time for leadership is now and that there must be a change in the conversation about mental health? The discussions have ended once again. This means that we are failing both the

children who perish in such tragedies and those who we are fortunate enough to still have in our care. There is a social and moral imperative to support the 1 in 5 children who need care now. Physically and mentally healthy children are more likely to become physically and mentally healthy adults. These children will grow up and enter our armed forces, our intelligence communities, our workforces, and our governments.[16] This demand is not just in North America, but for children on each and every continent.

CHALLENGES AND OPPORTUNITIES

President Obama's New Freedom Commission on Mental Health concluded that "no other illness has damaged so many children so seriously." This is true for the United States and around the world. Given these challenges and opportunities, the following initiatives are critically required.

Providing Timely Access to Care

Children are rapidly developing, so that even a modest developmental disruption can have wide-ranging impacts on later life. A missed few weeks of school due to depression, anxiety, or inattention can mean a lifetime of trouble with reading, writing, or mathematics. Time and resources invested in a child's care at or before the onset of symptoms will result in a quantifiable improvement in future health, quality of life, and cost of care. To meet this challenge, primary care providers must have better training for screening and initiating care. The primary care providers also need back-up from many more child and adolescent psychiatrists, psychologists, social workers, nurse practitioners, and others who must be trained and available to devote the necessary time and attention to the care of children.

Developing Standards of Care

"Mental health" is a term that is far too vague, and has been allowed to be too broadly defined. It is time to think about "psychiatric illnesses," which, like other medical disorders, involve an organ system that interacts with the environment in health and disease. Psychiatric illnesses are disorders of brain function that interfere with cognition (including memory and learning), emotion, and behavior. In child and adolescent psychiatry, these symptoms must be examined in a developmental context. As with developmental medical disorders, it takes a multidisciplinary team working closely together to provide adequate evaluations. There is an ample evidence base to set universal standards for these assessments and treatments, as well as the standards for training to participate in the care of children with psychiatric disorders. Establishing these universal standards for care and training will go a long way in leveling the playing field when it comes to the evidence-based treatments.

Stop the Stigma and Discrimination

Stigma and bias are powerful forces that not only lead to the abuse of individuals with psychiatric disorders, but it is even more ominous how they shape national and international policies on availability and accessibility to services. Barriers based on bias and stigma must be removed, and psychiatric illnesses must be placed on equal footing with all other medical conditions that deserve the attention of health and public health systems. For the many conditions that require acute care, patients and families should be offered not only access, but also encouragement and support for care. For many with chronic psychiatric illness, they should receive services for their chronic psychiatric condition in the same manner and integrated with the care received by

others with similar chronic disorders. Stigma not only leads to abuse of patients with psychiatric disorders but makes them feel bad about themselves, a reflection of poor societal practices and governmental policies that foster fear, contempt, and hatred for children and families faced with the challenges of psychiatric illnesses. Psychiatric illness is the leprosy of the modern era. This bias is a global problem, with cultural, political, and geographic ramifications that must be addressed openly and clearly at the highest levels.

Performing Clinical and Translational Research

Rapid advances in neuroscience and genetics open great clinical and translational research opportunities, including the possibility of identifying molecular targets and pathways for innovative pharmacotherapeutics, as well as the use of biomarkers that allow for earlier detection and provide endpoints for intervention trials. Technological breakthroughs during the past few years have helped us to understand, identify, and intervene in many medical issues before they manifest symptoms. Therefore, any discussion of the biological basis of psychiatric disorders must include genetics and behavioral neuroscience. Indeed, we are beginning to fit new pieces into the puzzle of how genetic mutations influence brain development. In 2009, NIMH launched the Research Domain Criteria (RDoC) project, which is developing a mental disorders classification system for research, based more on underlying causes than on symptoms. It is hoped that the RDoC project will go beyond our current disorder classification system to look at the behavior systems and fundamental brain circuits that cut across many disorders.[17]

Fostering Models of Cross-Disciplinary Integration

The first principle stated by the WHO Mental Health Action Plan (2013–2020) is "equity." Equity speaks to the critical need for universal health coverage.[2] The time has come to ensure a cross-disciplinary mental health assessment for children, spanning pediatrics, psychology/psychiatry, social work, physical medicine and rehabilitation, neuropsychology, and neurology. We must foster collaborations among specialists from neurology, psychiatry, genetics, and behavioral disciplines, with seamless integration between clinical and academic spheres. In addition, partnerships with nonmedical specialties and stakeholders are crucial, as well as clearly defined roles for such entities as the offices of education, employment, judiciary, housing, social, and other relevant public and private sectors. Further, the payment system needs to support such a collaborative approach to care.

Increasing Funding for Research on Psychiatric Disorders

Enhanced funding for research is needed, and we need to advocate for and invest in our future research efforts. We need to take advantage of breakthroughs in genetics, the launch of the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) initiative supported by President Obama, and the progress with the Human Connectome Program under way at NIMH.[18,19] It is necessary to foster public/private partnerships in securing much needed funding that is both sustained and sustainable to advance the field.

Funding and Enforcement of Mental Health Parity with Other Medical Illnesses Is Essential

There must be the clear expectation that mental health services are an integral part of the care system for children and adolescents. They not only must be created with the

same vigor and quality as other health care but also be given similar resources to provide this essential element of health care for children and adolescents.

The Child and Adolescent Mental Health Atlas highlights the gaps in mental health care for children around the world and proposes steps for how to bridge these gaps.[2] The WHO, Department of Mental Health and Substance Abuse, supported the development of the Atlas project. The project provides systematic information on country resources for mental health program development, including policy availability, professional resources, and mechanisms for financing services. The Child and Adolescent Mental Health Atlas is a part of this series of publications.[2] The work on the Child and Adolescent Mental Health Atlas was carried out by WHO, in close collaboration with the World Psychiatric Association (WPA) Presidential Global Program on Child Mental Health and in collaboration with the International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP). The WPA has a history of long-standing and fruitful collaboration with WHO in the area of mental health.

The Atlas proposes the following urgent needs.

Enhanced Information

There is a need for enhanced information on child and adolescent mental health disorders and the resources available to provide care. The Atlas recommends the implementation of WHO's Assessment Instrument for Mental Health Systems (WHO-AIMS) that can assist in this process.[20]

Policy

The Atlas urges ministers of health and other interested parties in all countries to help bridge the gaps in policies around children's mental health issues with the new *WHO Child and Adolescent Mental Health Policies and Plans Manual*, which is a great resource providing a guidance in developing policy and establishing appropriate governance.

Training

Atlas has shown that there are gaps in mental health training among primary care providers, educators, and others. Training for these professionals would certainly enhance access and resources and allow for early identification and intervention, which is a very much desired goal.

Financing

The need for sustained and sustainable financing of services is crucial. Such services cannot be sustained indefinitely on funding and/or grants from nongovernmental organizations and the like. If governments around the world are serious about providing mental health services to their children, they have a moral obligation to step forward and provide the funding for sustained and quality services and provide parity between adult and child services.

WITH WHOM DO WE PARTNER AND WHY IS PARTNERING IMPORTANT?

International Organizations

It is vitally important that all child and adolescent psychiatric organizations around the world come together and form strong collaborations around common themes. Although each organization has its own resources, meetings, policy statements, and advocacy efforts to strengthen the common purpose, it will be advantageous for each to support the other and, when possible, share resources and globally promote identical policies for children's mental health. In the end, there really is power in numbers. If organizations such as the American Academy of Child and Adolescent

Psychiatry, IACAPAP, WPA, Economic and Social Commission for Asia and the Pacific, and Asian Society for Child and Adolescent Psychiatry and Allied Professions, to name a few, will partner on behalf of our children, we will improve children's rights, as well as make strides in early identification and intervention for psychiatric illnesses that affect children. Together, we can more effectively advocate for the proper and fair allocation of resources, promote evidence-based treatments, and support investment in research efforts to uncover the etiologic substrates of disorders, along with better and more effective treatments.

Each of the individual organizations and professional societies has good ideas. Each has been creative in their own way. By sharing this creativity and strategies that have proven successful, we each do not have to start over. No one organization can or should try to do it all or all by themselves. As an example, it will be in everyone's best interest to list the rich and extraordinary resources available on our Web sites and provide links in one place that connects all of the other resources available from other child and adolescent psychiatry organizations, so that these can be readily accessed by anyone across the globe.

It is our responsibility to be able to provide for our children in a holistic manner and provide a safe living environment that encompasses a multifocal approach so that children can reach their potential and have a real opportunity to grow and develop socially, emotionally, and physically so that they can become independent and productive members of society and be able to contribute to life in a meaningful manner. A special liaison also must be established with international agencies responding to humanitarian emergencies (including isolated, repeated, or continuing conflict, violence, or disasters).

Pediatricians and primary care physicians have an important role to play in identifying and initiating treatment of mental health disorders, especially given the documented shortage of child and adolescent psychiatrists.[21–23] Yet, many challenges remain to ensure that pediatricians and primary care physicians have the skills, knowledge and time to properly identify and treat mental health concerns and to make appropriate referrals.[24,25] A collaborative "medical home" model is needed to address access to mental health care. Moreover, a fundamental change in our approach to the diagnosis and treatment of childhood psychiatric illness is needed. Psychiatric illness does not generally arise solely from family stresses or environmental influences. There is evidence that discernible molecular aberrations in genetics, brain structure, function, and cellular signaling and connectivity can place individuals at increased risk for mental illness from early childhood.[26] Only after these endogenous alterations are identified, through further research studies, can mental conditions be assessed and treated as medical conditions. They then can be approached and "cured" by personalized, precise treatments, rather than lumped into misleading categories, resulting in nonspecific, often ineffective treatments.

It is a major challenge to integrate basic mental health care into primary care; however, this will be a core element of getting mental health parity right. It can be done well, improving health and reducing costs, but barriers must be addressed. We know that most children are treated by their pediatricians or other primary care practitioners rather than by child and adolescent psychiatrists. Improving basic mental health care in the primary care setting is a great need, opportunity, and sensible goal. We have the responsibility to embrace and take the lead in moving this forward. At the same time, we must also ensure cross-disciplinary assessment for children. Furthermore, standardization and integration of mental health care, such as electronic medical records and integrated databases, will be important.

Currently, we are taking care of organ systems instead of the total patient. The future lies in transforming the understanding and treatment of mental illnesses through basic

and clinical research; paving the way for prevention, recovery, and cure by looking at the pathophysiology, predictive biomarkers, and preemptive interventions; and viewing mental illnesses as developmental disorders.[27]

The time has come to shift the dialogue about children's mental health. The different strategies that we have been using have not worked. In medical school, we were taught to think backwards: to diagnose things after they occur, to cure things after they happen. But what if we flip this model by looking forward, anticipating, and intervening before the symptoms appear? Ultimately, it is not just about keeping our children healthy, but also about creating a society of healthy adults. As pediatricians and child and adolescent psychiatrists, we are already trained to think forward. We think developmentally by asking, for example, What do we expect at 2 months, 4 months, 8 months, and 2 years? This is the approach needed to ensure that we are capturing the mental health needs of our children.[27]

Pediatricians have a critical role in the identification children at risk, including the roles of parents and caregivers in this process. Not only must the child be assessed, but also the family and other elements in the environment. For example, we know that women frequently experience postpartum depression, as well as depression in general. Because maternal depression can have severe adverse impacts on the developing child, appropriate care of the children includes screening mothers who may suffer from depression or other mental health problems. Children whose mothers are depressed have a higher prevalence of mental health problems.[28] Low-income mothers with young children have shown rates of depression ranging as high as 40% to 60%, and a large percentage of these mothers have never spoken to any medical professional about their depressive symptoms.[28] Maternal depression threatens attachment and bonding, which are psychological processes critical to an infant's development. Living with a mother suffering from depression also can have negative effects on a child's cognitive and social-emotional development, behavior, and language acquisition. These problems do not just impact infants, but also can impact older children: behavior disorders, attachments disorders, depression, and other mood disorders in childhood and adolescence can occur more often in children of mothers with major depression.[29,30] The importance of maternal health to a child's development, has led the American Academy of Pediatrics (AAP) to expect pediatricians to routinely screen mothers for depression during prenatal and postpartum visits to heath care providers. As the AAP notes, treating a child includes optimizing that child's healthy development and healthy family functioning.

Role of the Medical Home

The rapid expansion of the medical home model is changing the face of medical care for children. The basic notion is that all medically relevant care is provided in a single setting. Pediatricians and/or other primary care providers will not only be adjacent to but, rather, integrated with the rest of the health care providers, ranging from dentists to nutritionists and mental health professionals. The medical home provides excellent care that is accessible, family-centered, comprehensive, continuous, coordinated, compassionate, and culturally competent while including concerted outreach to families, with an emphasis on the cultural context, and integration with schools and recreational, vocational, and other community services.

Schools

In almost every country, schools (partnering with health and mental health organizations) are being seriously considered to be the largest provider of mental health services to children, among children who receive mental health services. Because the

overwhelming majority of children attend school, schools are an ideal location to identify children with mental health needs and provide them with appropriate services. Students and parents also are familiar with school facilities and staff, which helps lessen the stigma of seeking help for mental health issues. These children also are more likely to drop out or fail out of school: up to 14% of students with mental health problems receive mostly poor or failing grades and up to 44% drop out of high school. In the course of a school year, children with mental health problems may miss as many as 18 to 22 days of school, so if the mental health services are provided at school this can be reduced. School-based mental health programs should be expanded to reach all students in every country across the globe.[31]

Communities

Early intervention is another critical concept and includes both community-based services and transition services. Children live, play, and go to school in a community, so another important approach is to think about how to enrich the community to serve the children. Families and communities are becoming increasingly sophisticated in understanding health. Many health and health-related services are now routinely delivered in the community. Family and children must be the focus, and family support is critical. The community-based team can include family counseling, social services, sibling projects, primary care and other medical providers, the school, and religious and spiritual supports. Other facets of family support are respite services, educational workshops, group sessions, parent-to-parent outreach, and a parent library of resources. Prevention efforts and solid support are most effective when they involve stakeholders and local community partners. This community approach must consider empowering children, adolescents, and families with mental disorders and psychosocial disabilities.

SUMMARY

There are few human tragedies that stir sympathy and concern more deeply than seeing children suffer for any reason. However, the often-intertwined contributions of psychosocial, economic, political, cultural, religious, and community variables have come to be appreciated as confounding factors having an enormous psychological impact on the lives of children and both their physical and mental health. Children are not born to hate, hurt others, or take revenge. What happens, then, in places like the Congo where boys are recruited to become soldiers? How do stone-throwing youngsters become suicide bombers? How do youngsters here at home in the United States take a gun to school and indiscriminately shoot at their classmates and teachers? Why do children younger and younger with every passing generation want to die by suicide? These are but a few of the vexing questions that beg answers arising when analyzing the effects of unmet mental health needs.

Today's problems of poverty and violence will never subside unless we invest in the physical, mental, and emotional development of the next generations. All of us continue to struggle to make sense of what happened on September 11th, and what continues to happen in places like the Middle East, Afghanistan, Tibet, Central Africa, and other parts of the world. It is hoped that our experience of shared vulnerability and common purpose can be productively incorporated into the work we do with children and families all over the world. We are now in the unique position of having potentially increased the scientific knowledge through research to start addressing these issues in a comprehensive way.[32] The work across many disciplines of children's mental health care needs our sincere attention to spur progress on all of the

fronts to effectuate the shortcomings in the current approach. Mental health concerns globally are coming out of the shadows at a time of major change in health care, and we need to seize all opportunities to improve health care for millions of children. We need to remain optimistic that together we can all work to advance our field, preserve our identity as child and adolescent psychiatrists, and provide the best care that we can to our patients. To do this, we must be able to collaborate with colleagues across the world, hold hands and pursue common goals and agendas, so we can speak with one voice on behalf of our children.

In the words of the Chilean poet, Gabriela Mistral:

Many things can wait.

The child cannot.

Now is the time

His blood is being formed,

His bones are being made,

His mind is being developed.

To him, we cannot say tomorrow,

His name is today.

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