WEEK 14 – GLOBAL SYSTEMS OF CARE

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In 2003 the WHO identified treatment gaps, promoted training, addressed evidence-based treatment, and promulgated a model national policy. Priority disorders were determined by higher frequency of occurrence, degree of associated impairment, therapeutic possibilities, and long-term care consequences.

The WHO also emphasized that the diagnosis of children and adolescents cannot be considered solely from a Western perspective. Presentation of disorder may vary across countries and cultural and societal subgroups within a country. It also emphasized the importance of determining the degree of impairment and or disability associated with the diagnosis. The specific diagnosis may be less important than the degree of impairment of the disorder and what supports the individual need to participate in his or her society.

Finally, the WHO stressed the importance of a continuum of care to ensure good quality of care, compliance of best practices, and the ability to maintain children and adolescents in the least restrictive environments. Establishing guidelines for continuum of care can help in determining benchmarks and the collection of epidemiological and or surveillance data to address treatment and services delivery.

In 2011, the WHO reported that spending on behavioral health was less than two US dollars per person per year, less than $0.25 per person per year in low income countries. Further, only 36% of people who lived in low income countries overall were covered by behavioral health legislation.

Two years later in its 2013-2020 Mental Health Action Plan the WHO defined mental health as a state of well being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. In that report, mental health for children was emphasized from a developmental aspect of mental health. That definition included for adolescence having a positive sense of identity; the ability to manage thoughts, emotions, and to build social relationships; as well as the aptitude to learn and acquire an education, ultimately enabling their full, active participation in society.

It is important to note as you move through the rest of this lecture that the definition of mental disorders for the WHO is comprised of mental and behavioral disorders that fall within the international statistical classification of diseases and related health problems. So when the WHO uses the term mental health it is equivalent to what we in the US say as behavioral health.

The child and adolescent mental health in an enlarged European union report provides a snapshot of child and adolescent behavioral health policies and practices across 15 European countries. About 50% of the countries reported prevalence rates on positive mental health in children. More specifically, 13 to 15 countries reported the existence of information about the prevalence of mental disorders, whereas just eight of 15 reported collecting the prevalence of some indicator of

positive mental health. Budgets dedicated to CAMH issues, however, were rarely clearly identifiable and are often mixed with other funds.

The systems of care in Canada and the United States also have difficulty in assessing prevalence and are underfunded to address the need for services in an increasingly larger child and adolescent population. [INAUDIBLE] reports Canadian government's attempts to address data collection about the behavioral health of children while the governments wanted the data for policy making, program instruction, priority setting, and resource allocation. None of the 64 reports that were produced could be considered monitoring reports. Baseline information about children, specific user groups of children, social determinants, characteristics of the user on general population, comparisons of regions and [? years ?] and indicators of child functioning, population health, and early identification data were the most requested. However, across the reports there were no extended criteria used which would allow comparisons across governments.

In the United States, the fragmented system of care and difficulty of normalizing data across multiple reporting agencies is still problematic. A 2013 report recommended that future surveillance should include standard case definitions of disorders to reliably categorize and count disorders, as well as to ensure comparability and reliability of estimates across surveillance systems. This will provide better documentation of the prevalence of mental disorders among school aged children and provide a more complete picture of the prevalence of mental disorders among children. Both Canada and the United States lack a strong national strategy on behavioral health for children, a national framework for indicators, and a national organization to do the measuring.

The 2011 WHO-AIMS Report covers 10 of 12 countries in South America. Six of the 10 reporting countries in South America reported having a document that explicitly stated a national mental health policy.

However, it is important to note that similar to the Latin American Caribbean and Mexico group, current policies were not always drafted or implemented by the governments in power. In addition, nine of 10 countries reported having a national health plan. Only two countries have specific behavioral health legislation.

In the eight reporting countries, the mental health budget as a percentage of the total health budget had a median of 2.05%. Eight countries reported having some coordinating structure. Eight of 10 of the reporting countries reported that the percentage of children treated ranges from 12% to 38% with an average of 23% of children and adolescents receiving services.

Like other regional reports, Asia and the Pacific Island region are difficult to compile as a single view. Asia's often divided into South Asia and East Asia and the Pacific. Considering that 60% of the world's adolescents live in the Asia Pacific region, the national and ethnic complexity of the region make it difficult to compile country comparisons.

In Health at a Glance Asia/Pacific, 27 regional countries and economies were compared. These included 22 in Asia and five in the Pacific region. It was determined that depression is the second leading cause of disease in the Western Pacific region and the fourth leading cause of disease in the Southeast Asia region.

In 2010 2.6 million children, or one of three of all children who died before the age of five lived in the Asia Pacific region. In 2011, WHO examined 10 of the 11 countries in their Southeast Asian region known as SEARO. Of those seven of the 10 SEARO countries reported a dedicated mental health policy. Only 32% of the population is covered within that region.

This discrepancy is explained because India, the most populous country in SEARO, does not have a dedicated mental health policy. Eight of the 10 countries reported having a mental health plan. Only four of 10 of the SEARO countries reported having mental health legislation. Three of 10 SEARO countries allocate less than half of 1% as their median budget to mental health.

Australia does have a national mental health strategy and a National Mental Health Commission. It also established a national health performance framework and an initial set of mental health services key performance indicators. Its Mental Health Information Strategy Standing Committee is responsible for identifying national key performance indicators and benchmarking in mental health services while its national minimum data set subcommittee provides technical advice about mental health data to the standing committee.

There is a minimum data set for early childhood education and care. It is estimated that approximately 7.3 million or 45% of Australians age 16 to 85 will experience a common mental health related condition such as depression, anxiety, or substance use disorder in their lifetime. Behavioral health problems were estimated to be responsible for 13% of the total burden of disease in Australia. Over seven billion dollars annually is spent on mental health related services in Australia, and $4.5 billion was spent on state and territory specialized mental health services.

Africa is often broken into sub-Saharan Africa and North Africa. Sub-Saharan Africa includes all countries that are fully or partially located south of the Sahara, which is also referred to as East, Africa West Africa, and South Africa. North Africa generally covers Algeria, Egypt, Libya, Morocco, and Tunisia.

There are 55 recognized countries in Africa. When we talk about diversity, consider that the sub-Saharan region of Africa contains over 1,000 languages, which is around one sixth of the world's total number of languages. Behavioral health issues are usually considered very low priority in health service policies in Africa. In Africa, where the majority of morbidity and mortality occurs from communicable diseases and malnutrition, behavioral health is at the bottom of the list. In addition, beyond complex and or natural disasters in Africa have resulted in burgeoning refugee and displaced populations.

Of the 45 member states surveyed in the WHO's 2011 Mental Health Atlas Project, 30 reported they have an existing mental health plan and 20 reported they have existing mental health policies. 70% of African countries allocate less than 1% of the total health budget to mental health. Africa also has the lowest rate of mental health outpatient facilities at 0.06% per 100,000 people. Of the five countries in Africa who responded in the Atlas survey, none had any prevalent promotion or prevention programs in schools.

The countries and territories of Latin America and the Caribbean are often organized into two groups, Central America, Mexico, into the Latin Caribbean who are comprised of Spanish speaking countries, and the non-Latin Caribbean who are comprised of English, Dutch, and French speaking countries. The sub regions are very different from each other. For example, the non-Latin Caribbean includes countries and territories of different size, different populations from 5,000 to 2.5 million inhabitants, different socioeconomic statuses, and different geographical locations on the continent or on islands. The languages spoken are also very different.

In Central America, Mexico, and the Latin Caribbean, eight countries had developed a national mental health policy within the last three to four years. Nicaragua did not and Haiti had recently begun preparing one. In the non-Latin Caribbean, eight of 16 countries or territories have an explicit policy that was recently adopted. The rest have no specific mental health policy.

Only a minority of countries had specific behavioral health legislation. The Dominican Republic, Mexico, and Cuba were the only ones that had legislation in Central America, Mexico, and the Latin Caribbean area. In the non-Latin Caribbean area, only one country-- Belize-- did not have specific behavioral health legislation.

Behavioral health funding is also problematic. In the countries of the central America, Mexico, and the Latin Caribbean, the median behavioral health budget was 0.9%. In the non-Latin Caribbean countries the median was 3.5%. All of the countries in Central America, Mexico, and the Latin Caribbean have some central coordinating structure. In the non-Latin Caribbean, only five countries and territories have coordinating entity at the Ministry of Health.

The percentage of children and adolescents receiving treatment in the Central America, Mexico, and the Latin Caribbean area ranges from 8% to 40% with a median of 23%. In contrast in the non-Latin Caribbean, the average number of children and adolescents receiving treatment is just 7.5%, making it the lowest region.

So within even the Caribbean there are major differences among the Latin and non-Latin Caribbean. However, as with North America, the lack of a standard definition for surveillance makes it much more difficult to determine prevalence, need, and services for children and adolescents with behavioral health problems.