

(5) Parochialism

This, the opposite of internationalism, represents the natural, but wrong, tendency to be partial towards familiar and local research. This creates a bias against low-income countries and can be referred to as the 'Chamberlain effect', named after Neville Chamberlain, the British Prime Minister in 1938, who declined to intervene in Hitler's takeover of Czechoslovakia, on the grounds that 'this is a far-away country of which we know little'. We have to realise that no country on this planet can be regarded as too far away.

(6) English language

We are remarkably lucky in the UK that English is now the language of international communication. However, it is a fiendishly difficult language in which to write good scientific papers, and many authors from low-income countries whose main language is not English know this to their peril. It is therefore extremely easy to reject a paper that might otherwise be important on the grounds that it reads badly. Of course, if it is badly written it will not convey the authors' message, but it is right and proper to make some allowance for this in assessing contributions from those who do not have an English ghost writer waiting constantly by their side.

(7) Laziness

This is left to the end because it is linked to all the previous six points. An editor usually has to work harder with authors

from low-income countries than with those from richer ones in order to get their papers to the printed page. If laziness intervenes, it is much easier to press the reject button than to put in the extra effort required. It is always possible to get an editor on a bad day, when the level of work is overwhelming, and under these circumstances the author from a low-income country is at a distinct disadvantage. My advice is to persist despite adversity.

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THEMATIC PAPERS – INTRODUCTION

Child and adolescent psychiatry services in low- and middle-income countries

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The theme in this issue concerns the interface between child psychiatric services in low- and middle-income countries and the availability of such services in higher-income countries. In neither context are such services ideal, and resources are relatively slim when compared with demand. The key issues are discussed in three terms: first, of the need for nations to have a general statement of child and adolescent mental health policy (Shatkin *et al*); second, of the need to establish international child and mental health research networks to foster research in low- and middle-income countries (Erlich & Plener); and third, of the circumstances that exist for providing such support to children in one such country, Pakistan (Khan *et al*).

The major concern of all three sets of contributors is that there are very few countries with policies that address the mental health needs of this client group. Since the Convention on the Rights of the Child was implemented in 1989 by the United Nations, children have had, on paper at least, the opportunity to seek mental health support in all 193 countries that have ratified the agreement. There is a serious lack of resources in many of these countries. We

know from international efforts to investigate the prevalence of mental health problems that they will affect up to one in five children, irrespective of culture. Shatkin *et al* reviewed the provision of services in all participating countries and found that only 35 had any sort of mental health policy for children, and of these only a minority provided good-quality and flexible care. In all cases, child and adolescent psychiatry was subject to the same range of policies as adult psychiatric services, however inappropriate that might be in objective terms. Clearly, the Atlas project, in which they attempted to gain an overview of child mental health provision around the world, is of potentially great value and significance, but it failed to gain adequate relevant information from many countries because there was no statutory authority tasked with collecting or providing it.

There is a need for more epidemiological information about the range and nature of child mental health problems in low- and middle-income countries, and in order to gain such knowledge we need to have more appropriate trained researchers in child psychiatry where those studies are needed. Stefan Ehrlich and Paul Plener describe how they are

aiming to establish websites to assist those working in the field to conduct research, with supervision and advice 'at a distance'. They founded the organisation Young Investigators in Biological Child and Adolescent Psychiatry, in Germany, with the aim of improving communication and collaboration between young psychiatrists starting out in this area of research. They would like to attract child and adolescent psychiatrists from low- and middle-income countries to join their network, although they acknowledge that the priorities of such psychiatrists may be very different to their own. The increasing availability of e-communication offers an exciting and novel way of promoting research in areas of the world where there are few local experts.

Finally, we consider the specific case of Pakistan, where Drs Khan, Shehzad and Chaudhry consider the difficulties in providing child psychiatry services in a country of 169 million people, of whom 40% are under the age of 15 years.

There is no specific allocation of funding in Pakistan to this specialty, and no demarcated pathway by which children can be referred for assessment and intervention. Sadly, children are often admitted to adult psychiatric wards, where there is no particular medical or nursing expertise on how to manage their problems. One hope for the future may be a joint paediatric-psychiatric liaison service, but this has yet to take firm root. They emphasise the urgent need for protocols to assist in the management of children. There is also a potential role for mentoring by 'senior volunteers' from the Royal College of Psychiatrists, in a scheme that is attempting to bring senior professionals in the UK into dialogue with psychiatrists (such as those in Pakistan) who would value a mentor. This application of e-communication has the potential to foster the development of a special interest in managing children's mental health among psychiatrists who have trained in adult psychiatry.

THEMATIC PAPERS – CHILD AND ADOLESCENT PSYCHIATRY SERVICES

Child and adolescent mental health policy worldwide: an update

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Few countries worldwide maintain policies specifically designed to address the mental health needs of children and adolescents. Yet policies are essential to guide the development of systems of care, training programmes for practitioners, and research endeavours. Without policy, there is no clear pathway for programme development, no specific commitment from government, no expression of governance, no guide to support funding, and no clarification of who exactly is responsible for providing services to children and adolescents. In 2004, we published a report aimed at identifying child and adolescent mental health policies worldwide (Shatkin & Belfer, 2004). The present review expands upon that report and provides an up-to-date assessment of these policies.

As in our prior study, we define a policy as a guide that dictates actions, such as programme development, financing, and access to care. Policy can be formally enacted by law or adopted by decree. Regardless of the level of detail, in all cases policy provides a recognisable document with the presumed force of law. Although there is great discrepancy in the way various countries execute mental health policy in general, the near absence of policies designed specifically to address the mental healthcare needs of children and adolescents, combined with poor execution of those few policies that are currently in existence, is an ever-growing concern. Given that children and adolescents have no political power, policies must be designed to ensure that they are able to access even the most basic mental healthcare.

Background

The United Nations' 1989 Convention on the Rights of the Child outlines the basic rights to which children are entitled. The right to mental healthcare is a key tenant of the document, and the absence of policies designed to address the mental healthcare needs of children and adolescents stands in direct opposition to the rights established by the Convention. Despite the Convention's ratification by 193 countries, there has been no international enforcement or movement to create mental health policies, leaving most children and adolescents without adequate care.

When considering the lack of child and adolescent mental health policies, one of the most troubling findings is the enormous discrepancy between needed and available resources. Certainly, the mental healthcare available to children and adolescents is far from commensurate with the burden of need. One-half of all lifetime cases of mental illness are now recognised to begin by the age of 14, and three-quarters by the age of 24, thereby rendering children and adolescents an extremely vulnerable group but with little protection (Kessler *et al*, 2005). Worldwide prevalence rates of child and adolescent mental health disorders approximate 20% (one in every five young people), with little variation found among the types of disorders seen across various cultures (US Department of Health and Human Services, 1999; Belfer & Saxena, 2006). Despite effective treatments, there are long delays, sometimes decades, between the first onset of symptoms and the