Mental health of children and adolescents: epidemiological, assistance and bioethical considerations

Helvécio Neves Feitosa
Miguel Ricou
Sérgio Rego
Rui Nunes

Abstract

This paper examines the Epidemiological aspects of children and adolescents with mental health problems in the world and in Brazil, this age range most common disorders, the etiology of such disorders, with emphasis on family environment, finding a strong association between domestic violence and the occurrence of such disturbances. It addressed the crisis in health services supply for children and adolescents with mental disorders in Brazil, and the lack of trained professionals to deal with this group of patients. Bioethics aspects involved in assistance are discussed also, with emphasis on these patients' vulnerability in exercising their autonomy. It finishes by considering that to encompass the bioethics principle of justice, it is imperious to establish and to implement community mental health services, specialized in assisting children and adolescents, particularly in poor regions as well as at the periphery of large cities.

Key words: Mental health. Bioethics. Vulnerability. Child. Adolescent.

Helvécio Neves Feitosa Physician, specialist in Obstetrics and Gynecology, Doctor in Obstetrics, Doctorate in Bioethics at Portugal-Brazil PhD Program in Bioethics, Medical School, University of Porto-FMUP / CFM, professor of Medicine, University of Fortaleza (Uniform), Ceara, Brazil

The estimated prevalence of psychiatric disorders in childhood and adolescence in international population epidemiological studies shows a wide variation, ranging from 1% to 51%[1-5]. Despite the methodological limitations of studies investigating the prevalence of these disorders in different cultures (instruments, definitions of disorders), several studies indicate rates of between 9% and 16% in developed countries [2]. In England, for example, we found 10% prevalence of psychiatric disorders in childhood when we investigated 10,500 families [6].

The literature review of epidemiological studies published between 1980 to 1999, In Latin America and the Caribbean identified ten studies with

Miguel Ricou
Psychologist, Master in Bioethics, Professor of Bioethics and Medical Ethics, Medical School, University of Porto, Professor of Bioethics and the Masters in Education degree in Social FMUP, Porto, Portugal

Sergio Rego
Physician, Doctor in Public Health, senior researcher at the National School of Public Health Sergio Arouca, Fundação Oswaldo Cruz, editor of the Brazilian Journal of Medical Education, assistant coordinator of the Graduate Program in Applied Ethics, bioethics and public health, UFRJ, Fiocruz , UFF and UERJ, and chairman of the Bioethics Society of the State of Rio de Janeiro, Brazil

Rui Nunes
Physician, Professor of Bioethics, Faculty of Medicine, University of Porto, Coordinator of Program Portugal-Brazil on Doctorate in Bioethics FMUP / CFM, Porto, Portugal

prevalence rates of these problems between 15% and 21% [7,8]. The different diagnostic classifications and methodologies used for measuring explain part of this variation, together with possible social and cultural differences existing in different regions and countries [9,10].

The most common childhood mental disorders include conduct disorders, attention disorders and hyperactivity, and emotional disorders. These disorders are important insofar as they impose suffering on young people and those with whom they live, and also because they interfere with the psychosocial and educational development, with the potential to cause psychiatric and interpersonal relationship problems in adult life[11].

The genesis of mental health problems in children and adolescents is linked to several factors: genetic determinism; brain disorders, like epilepsy; violence; loss of significant kinfolks; chronic adversities; acute stressful events; problems in the development; adoption; living in shelters; in addition to cultural and social problems that significantly impact child development [12].

Associations between behavior problems and family environment variables have been found consistently. The quantity or quality of adverse events from the family is seen as particularly detrimental to child development, being a factor that leads to behavioral problems [13,14].

In a specific situation - Depression in children and adolescents - the scientific interest is recent, because until the 70s it was believed that this disease entity was rare or even nonexistent in this age group [15]. Lately, several authors have called attention to the phenomenon of depression in this age group. In a review article on depressive disorders, Bahls [15] found the result of 0.4% to 3% for major depression in

in children and 3.3% to 12.4% in adolescents.

A systematic review of recent literature on empirical studies found that maternal depression has a negative impact on the mental health of school-age children, thus the occurrence of behavioral problems, psychopathology, mental retardation, loss in self-concept, social performance, and emotional regulation. These factors were observed regardless of time of first exposure to maternal depression, as well as the designs of the studies (longitudinal or transverse), becoming thus a risk factor for child development – a loss intensified by the presence of psychiatric comorbidities [16].

The situation in Brazil

In our country, psychiatric epidemiology studies in childhood and adolescence are piling up in recent years but are considered still as few in relation to the needs identified by empirical research [10]. Pioneering research conducted in an area of Salvador used a child psychopathology questionnaire for children aged 5-14 and found a prevalence of 13% [17]. However, the reliability and validity of the instrument used were not evaluated. A second study in another area of that city, with 829 children of similar age showed a prevalence of 10% of moderate to severe cases and 13.2% mild or doubtful, using the survey of psychiatric morbidity in children (QMPI) [18]. The overall prevalence rate for the year was23.2%, distributed as follows: 15.3% of neurotic and psychosomatic disorders; 6% of mental retardation, 1.6% of developmental disorders, and 1.2% for other rarer diagnoses. Girls showed more neurotic and psychosomatic disorders and boys more developmental disorder and mental retardation. Older children showed higher rates in more severe disorders [19].

Statistical data from epidemiological studies that investigated mental health problems in Brazilian children and adolescents, using the Strengths and Difficulties Questionnaire (SQD) that includes five subscales - hyperactivity, emotional problems, conduct problems, interpersonal relationships and pro-social behavior - fell in the range of 12% to 15% when rated by young people, between 8% and 10% in educators' view, and between 14% and 18.7% in the parents' perspective[20-22]. There were also socio-economic differences in relation to different community situations. One study found that the overall prevalence of mental disorders was 15% among young people, 22% for those living in slums, and 12% for residents in urban or rural areas [23].

Assis et al [24] monitored for a period of one year, in a longitudinal study with 300 children, and they investigated the incidence of mental health problems diagnosed by the guardians (using the Child Behavior Checklist instrument – CBCL) and teachers (using of Teacher Report Form - TRF). Researchers

Os dados estatísticos de investigações epide-

found that there were 2.7% of incident clinical cases, according to parents, and 4%, according to teachers., there was an occurrence of 3.5% (parental information) and 4.9% (teachers) for internalized problems; 4% and 5.7% for the externalized ones, and 1.3% 2.4% for problems related to attention, respectively.

Another national survey in the city of Taubate, in the state of São Paulo found the prevalence of clinical/borderline cases of mental disorders among schoolchildren (n = 454) of 35.2%. Parents/caregivers who believed in corporal punishment as an educational method practiced physical aggression towards their children more frequently (64.8%).Logistic regression models revealed that the attitude of hitting with a belt was associated with behavior problems or mental health problems in general among schoolchildren in the presence of other risk factors: child gender (male), parents/caregivers with mental health problems and adverse socioeconomic conditions [25]. The authors concluded that the high prevalence of mental health problems among schoolchildren and its association with educational methods and mental health problems among parents/caregivers indicate the need for psycho-educational intervention to reduce physical abuse and mental health problems in childhood.

Paula, Duarte and Bordin [26], aiming at estimating the prevalence of mental health problems in children and adolescents, with and without global functional loss, in a low income urban community (in Sao Paulo Metropolitan Region), and to estimate public services capability in the city as well; and to correlate the ability to support childhood /adolescence need for mental health treatment, observed the following prevalence of mental health problems: 24.6% when dismissing global functional loss and 7.3% with global functional loss (cases in need of treatment).

The annual capacity to assist the overall cases of functional loss was 14% of current demand, and it would be necessary about seven years to be treat everyone. The authors concluded that mental health problems are frequent among the studied population and the existing public services infrastructure is not prepared to process, in time, the cases that need treatment.

Association between violence and mental health problems

Domestic and international studies identified association between experiencing forms of violence and presenting mental health problems throughout the growth and development cycle. Research conducted with children aged 6 to 10 years in a poor and violent neighborhood in Washington, United States (U.S.), indicated that exposure to this type of phenomenon (being victimized or a witness) is associated with symptoms of mental distress, such as anxiety, depression, sleep disturbance and intrusive thoughts [27]. In another study, the association between family violence and

community problems of internalizing and externalizing behavior, pointing out that the strong relationship between community violence and mental functioning of children happens because their sense of security is threatened, with negative repercussions on their growth and development[28]. In other publications, there was an association between violence victimization and physical problems, lack of concentration in school, sleep disturbances and hyper-surveillance [29-31].

In Brazil, several authors have noted the relationship between violence and mental health problems in children and adolescents [8,23-25,32-35]. There was greater incidence of conduct disorders and psychiatric disorders among children and adolescents who have witnessed violence among their parents, and who are educated by strict discipline, which includes acts such as *hitting with a belt* [23,25]. Children and adolescents whose mothers shout excessively, beat, spank or punish severely, among other inappropriate reactions, are twice as likely to present mental health problems compared to those non-exposed to such practices [33]. The lack of positive supervision coupled with negative educational practices, such as negligence, inconsistent punishment, and physical abuse are indicators of behavioral problems [34]. In one study, adolescents exposed to family and urban violence showed to have twice as many mental health problems. Those exposed to family violence were shown to be. threefold more likely to have problems than those exposed to urban violence, evidencing the importance of family relationships for good mental health condition [35].

The crisis in supplying services for children with mental health problems in Brazil

Attention to Brazilian children in the area of child mental health is an imperative need with increasing demand. The lack of services and specialists in this area is of concern, a fact that contributes to a great difficulty by health professionals in general to refer children with some type of emotional difficulty. The few existing services have long waiting lists and children do not always receive adequate care [36].

To illustrate the scale of the problem of care in this specific area, research was carried out in a Basic Health unit (BHU) located in the West Zone of São Paulo, in which research subjects were the parents and guardians of children aged 5 years to 11 years and 11 months, in addition to pediatricians in service [9]. The authors used qualitative and quantitative methods of research, with the application of scales for tracking complaints and behavior problems, home visits, review of medical records and questionnaires sent to parents about the concerns related to children's difficulties and description of their child's behavior, and semi-structured interviews with BHU pediatricians.

When analyzing the performance of professionals and the health system in face of children mental health problems, from the scientific literature of the area, the authors suggest that research, policy and practice of mental health care are more geared for the adult population and for the anti asylum movement, while those directed toward children and adolescents remained scarce. Pediatricians and other primary care teams' role was assessed, and numerous deficiencies in this performance were pointed out, such as: difficulty in early identification of mental health problems in children; too little appreciation of this problem and deficiencies in training to detect mental disorders.

In assessing the sensitivity and specificity of the detection capability of mental health problems in children by the pediatrician, the researchers found a low detection sensitivity by that professional. They emphasized that many parents usually do not report mental health complaints to pediatricians, which can result also from a lack of active search by them on this kind of problem. They signaled the importance of creating an enabling environment for the recognition of emotional disorders in children.

The survey also found that pediatricians are often unaware of opportunities for intervention in children who have some kind of emotional problem and that certain acts, such as listening more to the family, talking to the child, among others, are considered unscientific, remitted to common sense. Pediatricians revealed some disbelief about the mental health services since they are few and present in an insufficient number of places, in addition of been unfamiliar and unreliable, compared to the work offered. The authors pointed out the need for change in medical professionals' training, aiming to improve early diagnosis and appropriate referrals.

When taking the presented complaints and diagnoses from public mental health services as basis, we find that the vast majority refers to *learning problems* or at school, commitments that do not necessarily require the intervention of a mental health professional [37]. In Boarini's opinion, in addition to the lack in enough supply to care for children who need specialized mental health care, the majority of professional time is taken up in sessions, often expendable. From this angle, we can infer that the mental health professional, when occupying himself with cases in which his intervention would not be necessary, ends up contributing to an even greater deficit in relation to the demand of children who really need psychological help. When caring for *learning difficulties* within the mental health services, this professional replays issues that are the most striking proof of the ineffectiveness of the medication/psychologizing of school difficulties[38]. Despite the previously stated, we must consider that we must not relativize the need for specialized care for learning problems. In many circumstances, such problems are only the *tip of the iceberg* of other events of great density and clinical relevance that really require specialized mental health professional care.

It is worth mentioning another aspect that complicates the care of children with mental health problems. For cultural reasons, among others, the child's referral to mental health service carries with it prejudice or stigmatization, both by parents and teachers as well - many times - from the mental health professional himself. That is, the child is sent to mental health services because, supposedly, he has a problem, but when he is assisted new problems may arise from the very prejudice that still surrounds the services[37].

Bioethical approach

In addressing bioethical issues of mental health in children and adolescents, we should define preliminarily some conceptual frameworks. The concept of adolescence, now widely adopted, defined by the World Health Organization (WHO) *Meeting on teenage pregnancy and abortion*, conducted in 1974, states that *adolescence is a period in which: a) the individual progresses from a point of initial appearance of secondary sex characteristics to sexual maturity; b) the individual's psychological processes and the identification models progress from childhood to adult stage c); the transition is made from total dependence to a socioeconomic status of relative independence*. According to WHO, *age-specific limits must not be applied to define adolescence, which is a social classification, and varies both in its composition and its implications*. It considers, however, the period of 10 to 20 years as encompassing most of the above proposed changes, although the large degree of inter and intra-cultural variation is known [39].

Although widely used, the concept of adolescence set by WHO, distinguishing it from the infant stage (or child) is not unanimous. The United Nations (UN) on the document Convention on the Rights of the *Child* [40], establishes in its article 1: *For purposes of this Convention, a child means every human being below the age of eighteen years unless under the Law applied to the child, majority is attained earlier*. In Brazil, the Statute of the Child and of the Adolescent – ECA [41] establishes in its article 2: *Is considered a child for the purposes of this Law, the person until the age of twelve incomplete, and adolescents between twelve and eighteen*.

One of the key issues in the care of children and adolescents with mental disorders relates to the ability to exercise autonomy by these people. Right from the start, there is the perception that the exercise of this fundamental bioethical principle is compromised doubly: either by age or by mental state. What stands out in the discussion, therefore, is the most effective way to protect such individuals who, because they are in a position to hypo-sufficiency due to personal disabilities, do not have the full right to choose, or do not enjoy the full potential of self-government of free will as to the regency of own fate, an achievement reached little by little,

through biological and social events parameters. Such principle involves the protection of privacy, reliability and the demand for actions that are based on an informed consent, to oppose any coercive manifestation, even if justified by any social benefits [42,43].

In Brazilian law, the current Civil Code provides that, as a rule, *each person is capable of rights and duties in the civil order*. In parallel, are absolutely forbidden to personally carry out such acts those who, *because of illness or mental disability do not have the necessary insight* and are relatively constrained in the way and sort of acts that they can practice (...) *those who, due to a mental disorder, have reduced discretion and the exceptional persons who lack full insight* [44]. According to Cohen and Salgado [43], in such a situation, of *absence or loss (total or partial) of full psychic ability and self-government, come into action the mental health professionals (psychiatrists, legal psychologists, and social workers, for example) with the greater goal of making the patient regain self-awareness, autonomy, freedom, and respect for self and others*.. This role requires competent professionals, not just from a technical standpoint, but especially rich in human understanding, prudence, courage, compassion, and ethical sensitivity.

The issue of patient's autonomy is not a settled issue in Brazil, particularly when it comes to children and adolescents. For children, we thought advisable to work with two levels of competence: the very young ones, still not able to properly understand the information and therefore absolutely incapable of participating in the decision-making. With these children, we believe that professionals and parents should interact by informing, and explaining what will happen even if they believe that nothing will be understood. We are talking about children effectively at an early age. With others, more mature, one should seek their understanding of the facts and know-ledge. We must spend a significant effort to get them to understand what is happening and even get their consent. In legal terms, it is obvious that in both situations, parents or guardians are those who give the final word (or *agree*), but from the ethical point of view we believe that the exercise of autonomy must accompany *pari passu* the child's growth and biopsychic maturation.

It is known that the child goes through a process of progressive development that leads to achieving full independence in maturity, which in modern societies, is situated around 20 years of age. Understanding the construction of the concept of autonomy in light of the development moment in which a child or adolescent is, one should consider different characteristics' [45]: it is a process that is continually evolving, because as the skills are perfected, new skills are acquired , new experiences are accrued and integrated, capable of extreme changes in time; the acquisition of skills is progressive, without jumps,

following a predetermined order, with reasonable predictability; the time and pace at which development proceeds are individualized, which means that two individuals of the same age may be at different stages of development; by considering the intelligence, the development becomes extremely influenced by factors extrinsic to the individual, such as experiences, stimuli, environment, education, culture and others, which reinforces their extremely individualized evolution.

Jean Piaget's research on how cognitive development takes place, how thought and knowledge evolve, allowed the identification of universal stages through which thinking evolves, in an invariant sequence. These stages are the sensorimotor, pre-operational, concrete operations and formal operations [46]. The third stage above, which occurs at approximately seven to 12 years, marks the beginning of logical thought, although still on a concrete level, extending it to understanding of the other and the possible consequences of many of their acts. The child is able to think logically if he has the support of concrete objects. They acquire the notion of conservation and the rudiments of logic. The stage of formal operations, which will occur from adolescence on, characterizes by the ability of abstraction and testing hypotheses, turning scientific reasoning feasible. The evolution of moral judgments is based on the heteronomy autonomy dimension, i.e. the, child goes from a moral authority imposed from outside, by others, to a moral autonomy of the individual conscience.

Therefore, the process of understanding the consequences of their actions starts at around six to seven years and matures by the end of adolescence. Thus, the terms of care, the minor has the right to make choices about diagnostic or therapeutic procedures - but in risk situations and facing procedures of some complexity, become always needed, in addition to the consent of the minor, the participation and consent of their guardians. The child or adolescent who refuses to give his assent should be heard, especially when the expected outcomes are uncertain [47].

The assent of the child, with or without mental disorders, for research, diagnosis, or therapy is complex and there is no consensus in the literature. The controversies include the definition of what is consent, the age at which researchers should get it from children, who should be involved in the procurement process, how to solve disputes between children and their parents, what amount and quality of information should be available for children and their families, how much and what information children want and need to know, the methodology used to promote children's understanding of the information provided, and what constitutes a model of decision-making that is effective, practical and realistic [48].

According Unguru, Coppes and Kamani [48], in the U.S., the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, in 1977, based on the concept of respecting children as individuals, pointed to the need to recognize and respect their will, considering their cognitive development and maturity. The Commission suggested that the consent must be sought for all potential research subjects since seven years old. The aforementioned authors make a distinction between assent and consent. They clarify that to see the first as corollary of the second would be to overestimate the importance of understanding, by the child, of risks and benefits, which are key aspects of the consent directed to adults. To match assent to consent would be to include children in an unfair model, with the potential to limit their ability to participate in research. Children do not need to evaluate all components of consent. Their ability to make decisions requires that their choices be voluntary, reasonable, and rational. And especially important: the child must understand the information relevant to their choice. From a legal standpoint, the word assent is used here to distinguish it from consent, which is provided by people who are adult and fully capable (according to the law - the Brazilian Civil Code) to make decisions.

Thus, before requesting the assent of a child, it is crucial for the researcher to establish their level of understanding. Besides the information that the child needs to know, a second important aspect to consider is what they would want to know, a point not always taken into account in research involving children. Because of their understanding being a key element in the process of assent, it becomes imperative to improve the methods of facilitating the understanding by the children, when conducting researches. One way to accomplish this is by talking to them and taking them seriously. The understanding of what they need to know is the logical result of dialogue with them.

To that end, not considering terminological distinction between assent and consent, the International Symposium on Bioethics and the Rights of the Child (or *Declaration of Monaco*) [49], occurred in 2000, ruled that: *The health care of children should include due consideration for information, consent and, where appropriate, by the refusal of consent by the child according to their increasing degree of autonomy*. It also established that: *This principle must be strengthened, particularly in relation to examinations and/or specimens collection performed on children, which should only target the interests of the child health imperative that cannot be met otherwise*.

In the clinical care of patients with mental or neuropsychiatric disorders, the current position, of having an active and responsible attitude from the patient (exercising of independence) is far less emphatic, given the specific conditions thereof, with regard to emotional and cognitive vulnerability[50].

Biopsychic and emotional immaturity of children and adolescents enhances such a state of vulnerability. In this particular situation, the classification of people as vulnerable, not only in the realm of biomedical research, but also in the field of health care, requires the mandatory ethics of defense and protection so that they are not mistreated, abused, injured.

The *International Ethical Guidelines for Biomedical Research on Human Subjects* from the Council for International Organizations of Medical Sciences (Cioms) defines vulnerable individuals as *those with diminished capacity or freedom to consent to or refrain from consenting* [51]. Included among these are children (Guideline 14) and people who, due to mental or behavioral disorders, are unable to give adequate informed consent (Guideline 15). The resolution 196/96 [52] of the National Health Council (CNS), which establishes guidelines and rules for research involving humans in Brazil, defines *vulnerability* as *the state of individuals or groups who, for whatever reason or reasons, have their ability to self reduced, particularly with regard to informed consent*. In parallel, according to the same resolution, *incapacity* refers to the *potential research subject that has no legal capacity to give their consent, must be assisted or represented in accordance with governing Brazilian legislation*.

When there is severe mental disorder, the stigma of the disease leads very often to the loss of autonomy for its carrier, which causes their actions and speech to be only perceived as symptoms of the disease by which he is victimized. The mental health professional becomes thereafter, almost always the only accredited interpreter of his patients, able to decide, with agreement of the family, about the future of these people; they exercise very often an absolute power over them, ranging from freedom of movement to the form of treatment they should receive [43]. It should be emphasized, however, that the mere fact that the individual has a mental illness does not make him without autonomy. It is recognized, in general, that only the crises can temporarily limit it absolutely.

Applying the principle of autonomy, in such situations, is not extensive enough to allow absolute freedom, nor to the patient nor to the medical professional who treats him. What is sought is a relationship based on trust, competence and confidentiality in that the parties always interact unevenly [53]. In the specific case of children and adolescents with mental disorder, the exercise of autonomy is an aspiration unlikely to be achieved in most circumstances, because there is no escape from the custody of the legal guardian.

The delegation of autonomy to a third party is complex, because their interests do not always coincide with the best interests of the represented. It must be emphasized that, in the case of children, their limited ability to self-determination is reduced even further, while the same is not true for adolescents in general. In the same horizon, the aforementioned *Declaration of Monaco* [49] emphasizes that

the protection of rights must be enforced for children with disability. Scientific progress and its applications, in particular regarding the prevention and treatment, must benefit the children with disability and never lead to their exclusion or marginalization.

In terms of research, CNS Resolution 196/96, mentioned above, provides that in cases where there is no restriction on the freedom or clarification required for the appropriate consent one must still observe: *in research involving children and adolescents, individuals with disturbance or mental illness and individuals in situations of substantial reduction in their capacity to consent, there must be clear justification for the choice of research subjects, as specified in the protocol, approved by the Ethics Committee for Research and meet the requirements of informed consent through the legal guardian of the subject, without suspension of the individual's information within the limit of their capacity*.

Final considerations

The severity of the impact of mental disorders in childhood and adolescence, as well as the high prevalence of such disorders, especially in the poorer regions, indicate the need and importance of the establishment and implementation of community mental health services for children and adolescents. These services must be primarily concentrated in areas of lower socioeconomic level, where rates of mental disorders are higher in line with the bioethical principle of justice. They should also prioritize the most common treatable disorders, offer diagnostic evaluation, standardized, and tested treatment at the lowest possible cost [11].

In Brazil, Fleitlich Goodman [23] are of the opinion: *for community services in child mental health to be more cost-effective, one should modify the standard treatments adopted by other cultures or adapt them so that these treatments also are effective in different Brazilian socio-cultural contexts as rural areas and slums*.

It is important to train professionals who specialize in mental health, preferably hired in the attended community, who may offer simple and effective treatments for a low cost [11]. We emphasize that the existence of community services for the most common mental disorders does not eliminate the need for specialized hospital services to a smaller group of young people with severe and more resistant to treatment mental disorders (e.g., adolescents with psychotic disorder or anorexia nervosa). For improving the quality of care, still at pre-hospital care, a coherent proposal would be to build reference centers in secondary level for this group of patients, with a multidisciplinary treatment team, with participation of pediatricians, psychiatrists, psychologists and social workers, who could constitute training centers related to medical residency programs in mental health and pediatrics,

as well as professional training in other involved areas.

Prevention and treatment of mental disorders in childhood and adolescence have an actual impact on the future of young people, which favors a reduction in crime, substance abuse, school failure and dropout, development of personality disorders and mental disorders in adulthood, in addition to making possible for them to develop greater capacity to act as future parents and citizens. This prevention should be done at all levels, especially in the family and at school, in face of the knowledge of the unquestionable association between family and urban violence with mental disorders in childhood and adolescence.

Even in children and adolescents with mental disorders, one must take care to provide the exercise of the bioethical principle of autonomy, according to their maturity and level of understanding, as well as the degree of control of mental illness. In older children or adolescents, there is room for the achievement of full autonomy, this being the norm for adolescents, since it considers the aforementioned restriction.

To allow for the participation of children and adolescents in decisions about their health (as well as the participation of legal guardians), there is a need for clarification about the disease, the prognosis and the diagnostic and therapeutic procedures to be adopted, with the risks, the benefits (expected outcomes) and costs associated with each of the alternatives involved. This information should be comprehensive and in language that can be understood by patients and their families. Only after ensuring that all issues relating to diagnosis and treatment of disease have been clarified and understood, it becomes possible to take decisions together. Being the legal guardian usually the parents, in theory the advocates of the interests of the child, they are, in principle, those who decide, but assent of children and adolescents should always be sought, provided that the child is identified by the treatment team as able to understand and assess their problem.

While there are differences between the principle of beneficence, advocated by health team, and the autonomy of the family, in the absence of imminent danger of death, one must expand the dialogue, involving other care team members and extended family (grandparents, uncles and others). The exception is in situations where there is imminent danger of death, in which the assent by the minor and consent by parents or legal guardians may be considered presumptive, which is universally accepted and meets the requirements of law and the governing Medical Code of Ethics.

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Resumen

La salud mental de los niños y adolescentes: consideraciones epidemiológicas, de asistencia y bioéticas

En este trabajo son presentados aspectos epidemiológicos relativos a los niños y adolescentes con problemas de salud mental en el mundo y en Brasil, los trastornos más comunes en este franja de edad, y la etiología de tales trastornos, con énfasis en el entorno familiar, en el cual se encuentra una fuerte asociación entre la violencia doméstica y la ocurrencia de tales perturbaciones. Se hace una discusión de la crisis en el suministro de servicios de salud para niños y adolescentes con trastornos mentales en nuestro país y la escasez de profesionales preparados para trabajar con este grupo de pacientes. Se discuten también los aspectos bioéticos involucrados en la asistencia para expresarse, con énfasis en la vulnerabilidad de estos pacientes con relación el ejercicio de la autonomía. Finalmente se considera que para abarcar el principio bioético de la justicia, es urgente implantar e implementar servicios comunitarios de salud mental especializados en el atendimiento a los niños y adolescentes, especialmente en las regiones carentes de nuestro país y la periferia de las grandes ciudades.

Palabras-clave: Salud mental. Bioética. Vulnerabilidad. Niño. Adolescente.

Resumo

A saúde mental das crianças e dos adolescentes: considerações epidemiológicas, assistenciais e bioéticas

Neste trabalho são apresentados aspectos epidemiológicos relativos a crianças e adolescentes com problemas de saúde mental, no mundo e no Brasil; os transtornos mais comuns nesta faixa etária; e a gênese de tais transtornos, cuja ênfase recai no ambiente familiar, no qual se constata forte associação entre a violência doméstica e a ocorrência de tais distúrbios. É discutida a crise de oferta de serviços de saúde para crianças e adolescentes com problemas de transtorno mental, bem como a carência de profissionais treinados para lidar com este grupo especial de pacientes. Os aspectos bioéticos envolvidos na assistência também são discutidos, com destaque para o estado de vulnerabilidade desses pacientes com relação ao exercício da autonomia. Ao final, se considera que para abarcar o princípio bioético da justiça urge implantar e implementar serviços de saúde mental comunitários, especializados no atendimento a crianças e adolescentes, principalmente em regiões carentes, bem como na periferia das grandes cidades.

Palavras-chave: Saúde mental. Bioética.Vulnerabilidade. Criança. Adolescente.

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Contacts

Helvécio Neves Feitosa - *helvecionf@uol.com.br*
Miguel Ricou - *mricou@med.up.pt*
Sérgio Rego - *rego@ensp.fiocruz.br*
Rui Nunes - *ruinunes@med.up.pt*
Helvécio Neves Feitosa - Rua Martinho Rodrigues, 1.301 Bloco B, aptº 704, Bairro de Fátima, CEP 60411-280. Fortaleza/CE, Brasil.

Authors participation in the study

Helvecio Feitosa elaborated the article and the others participated with suggestions and review.