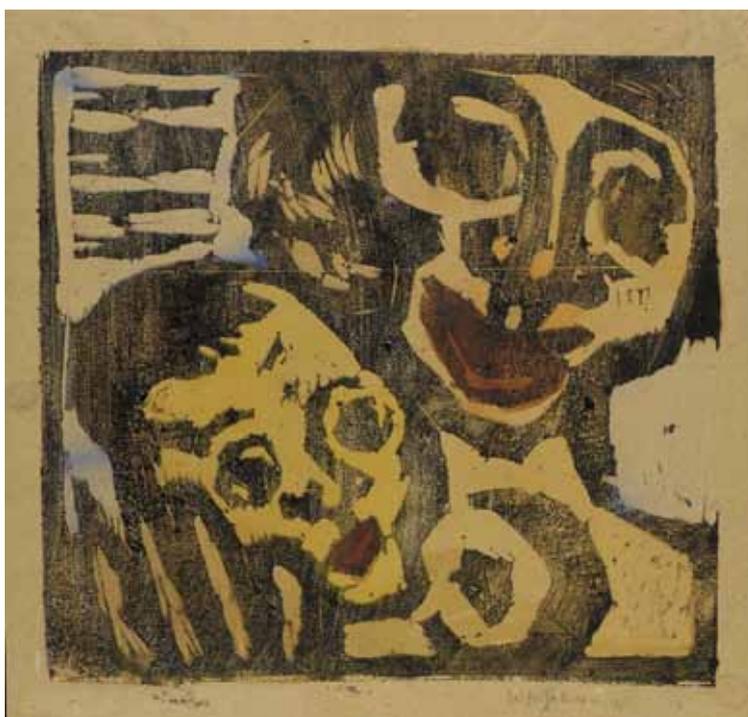


# CHILD AND ADOLESCENT MENTAL HEALTH POLICY

**Gordon Harper**



Refugee  
Mother and  
Child

William H.  
Johnson  
(1901-1970);  
Smithsonian  
American Art  
Museum, Gift  
of the Harmon  
Foundation.

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Public policy for child/ adolescent mental health aims to mitigate disparities that stand in the way of children's attaining their full potential:

- Differences in endowment
- Differences in life circumstances
- Differences in access to services

Other discussions of policy emphasize the mobilization of political will (Richmond & Kotelchuck, 1983), the translation of knowledge into practice (Harper & Cetin, 2008), or the evolution of public attitudes to children (Wise & Richmond, 2008). This chapter focuses on the mitigation of disparities. To that end, it will review recent changes that have influenced policy:

- Increased knowledge of disparities and their consequences
- New knowledge of interventions, on both the individual and the community level, to mitigate these disparities
- Increased professional and political readiness to act.

As children's emotional development is embedded in their overall development, disparities in mental health are necessarily examined in the light of disparities in overall health and well-being.

## DISPARITIES – SCOPE AND CONSEQUENCES

### Disparate endowment

Pre-modern societies did not recognize childhood as a separate developmental stage or they regarded differences in children's endowment as of little consequence. The presence in the home of extended family members and flexible role expectations often proved relatively tolerant of differences among children. But modernization has changed children's lives in several ways.

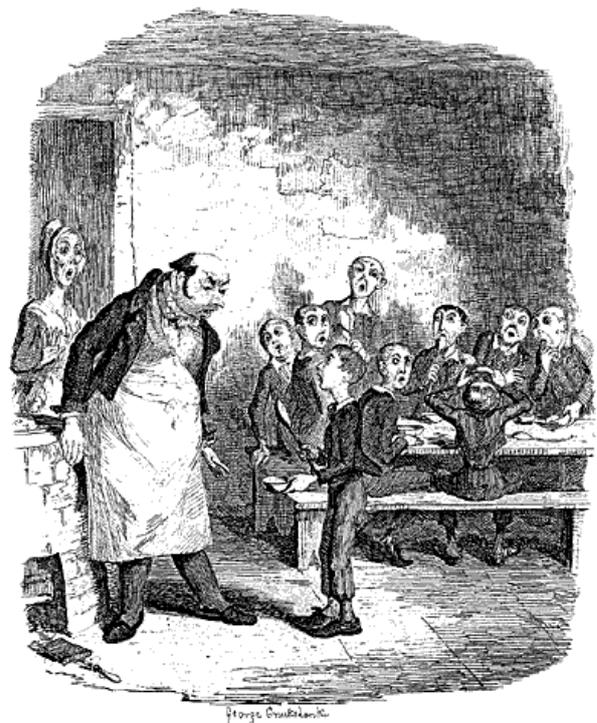
First, with urbanization and increased inter-generational mobility (away from birthplace), fewer children grow up in multi-generational families. In nuclear families, two parents alone (or, often, a single parent) have less "buffering capacity" to accommodate childhood differences than did the aunts, uncles, and grandparents of the extended family.

Second, increasingly standardized education, starting in preschool, is less flexible in the face of different endowments and developmental trajectories. To prepare children for standardized jobs, schools need to classify students. Accordingly, systems for testing of children were created, starting with the work of Binet in France in the early 20<sup>th</sup> century, which sorted children into "normal" and "abnormal" (Binet, 1903).

Third, as differences in temperament, learning style and social endowment were increasingly recognized, "different" children –initially thought to be a homogeneous group – were divided according to categorical disorders (e.g., dyslexia, receptive and

### Children's lives in the literature

- Dickens: *Oliver Twist*, *David Copperfield*
- Stowe: *Uncle Tom's Cabin*
- Hugo: *Les Misérables*



"Please, sir, Can I have some more"

Illustration for "Oliver Twist" by George Cruikshank (ca. 1837).

expressive language disorders) and along dimensional lines (e.g., overall ability, social perception, inattention and hyperactivity). Such recognition gave rise to advocacy and research organizations *grounded in an appreciation of diverse endowments* (e.g., in the US, [All Kinds of Minds](#) and [Mind Institute](#)) and to the creation of specialized services – educational, social, and clinical (Harper, 2011).

Fourth, once it became clear that children with special needs needed special programs, many came to feel that such services should be available according to need, not limited to those with family resources. Services could be made available to larger numbers through private initiatives, non-governmental organizations (NGOs), legislation, or rights-based advocacy (Harper, 2012)

### **Disparate life circumstances**

The depiction in 19<sup>th</sup>-century literature of children who grew up in conspicuous adversity (poverty, slavery, orphanhood, child abuse) increased public awareness of disparities in children's lives (e.g., Shengold, 1989). In response, universal public education was begun and destitute children were separated from the mixed populations in publicly supported “poor houses”. Civic charities supplemented the traditional role of religious organizations in caring for orphans. New institutions advocating for abused children were created, starting in New York City in 1875 (New York Society for the Prevention of Cruelty to Children; see [History](#)).

In the 20<sup>th</sup> century, public policy in many countries, notably in Scandinavia, promoted the equalization of opportunity (Hilson, 2008). Even in developed countries with incomplete commitment to that goal, like the US, civic organizations advocated on behalf of all children. Some of these started with professionals (Ptakowski, 2010; see also the websites of [Child Welfare League of America](#) and of the [American Academy of Child and Adolescent Psychiatry](#)). Others had no guild affiliation (e.g., [Children's Defense League](#)).

Such efforts have been greatly strengthened by demonstrations that *adverse childhood experiences* not only cause suffering to the child, but have measurable long-term effects (see Table J.6.1). Using methods developed by the Centers for Disease Control in the US, studies have shown the effects of disparities in early life experience on later health and well-being. In the UK, a different methodology – using the Cambridge Early Experiences Interview – has likewise demonstrated

**Table J.6.1 Adverse childhood experiences**

#### **What are they?**

- Psychological, physical, and sexual abuse
- Violence against mother
- In household – substance abuse, mental illness, prison history

#### **For what do they increase the risk?**

- Alcoholism and drug abuse
- Depression and suicide attempts
- Smoking
- Many sexual partners, STDs
- Inactivity and severe obesity

Source : Edwards et al (2005), Felitti et al (1998)

adverse effects in adolescence (Dunn et al, 2011). Similar effects can be shown to occur in a developing country: higher numbers of adverse childhood experiences predict health-risk behavior in adolescents in the Philippines (Ramiro et al, 2010).

This argument links readily to increasing knowledge of brain development (Spennath et al, 2011). In the US, the American Academy of Pediatrics, invoking an eco-biodevelopmental model, uses the evidence that toxic stress from adverse experiences and environmental influences leaves a “lasting signature on the genetic predisposition” of the child (Shonkoff et al, 2011) to argue for a transformation of child healthcare (Garner, Shonkoff 2012).

Public awareness of the persisting effects of disparities has been fostered by research on inter-generational social mobility (DeParle 2012; Jäntti et al 2006). These studies have shown different rates of social mobility in some countries (notably the US) than in others. That is, despite popular belief in “upward mobility”, children’s class of origin powerfully shapes their future well-being.

### **Disparate access to services**

In the US, Knitzer (1982) and others criticized existing services for troubled children. They showed that:

- Most troubled children received no mental health services at all
- Available services were often fragmented between schools, mental health and social services
- Conventional services often disempowered parents who already felt alienated and helpless.

Initiatives to decrease disparities in services supported by foundations and the federal government followed. These initiatives, operating in dozens of



Yoo Soon Taek, wife of UN Secretary General, Ban Ki-moon, visiting the Centre for Neurodevelopment and Autism in Children (BSMMU).  
Photo: Bangladesh Association for Child & Adolescent Mental Health

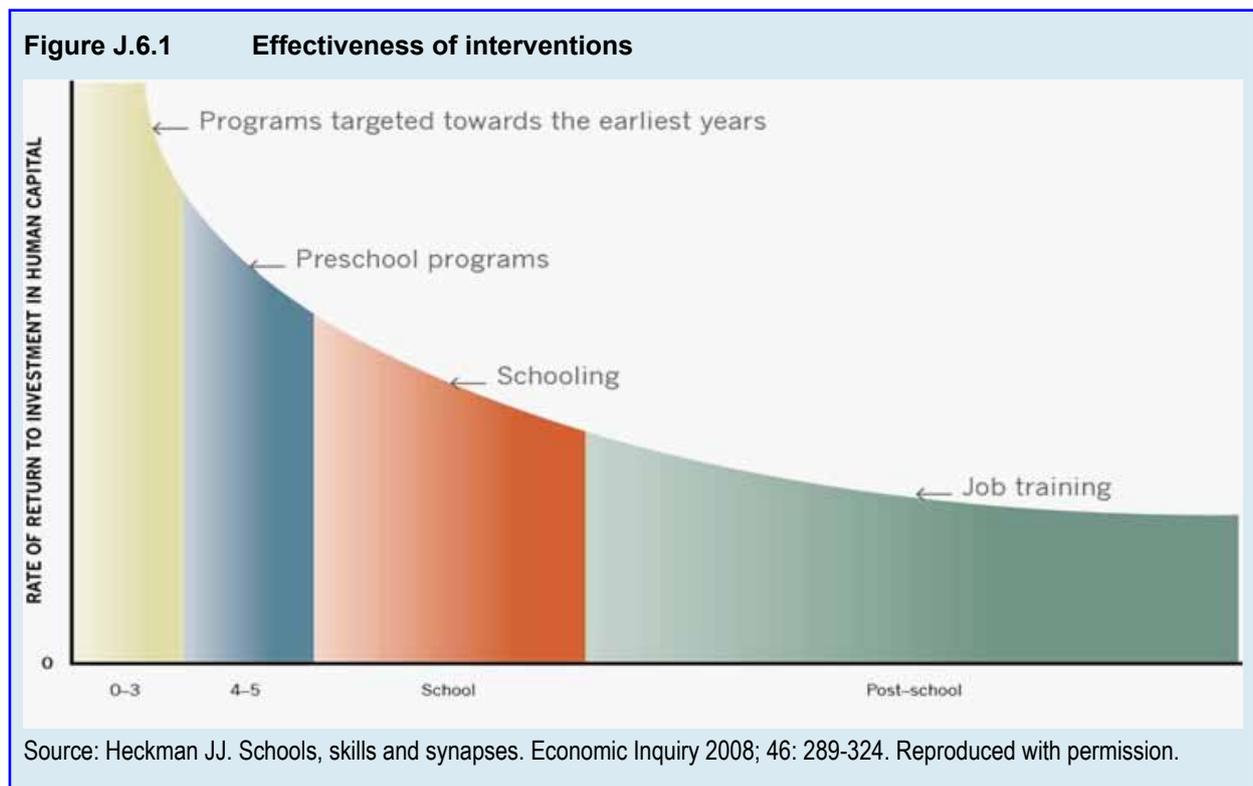
States and communities, have increased screening for emotional-mental-behavior disorders and encouraged new kinds of services (e.g., [National Initiative](#) and Substance Abuse and Mental Health Services Administration [www.samhsa.gov/samhsa](http://www.samhsa.gov/samhsa)) meant to be more respectful and inclusive of parents.

## EFFECTIVE INTERVENTIONS TO MITIGATE DISPARITIES

The public in many countries increasingly recognizes that disparities in childhood endowment, life experiences and access to services need not simply be accepted but can become the focus of public policy. This awareness led to action on behalf of children, constituting a “global movement for health equity” (Marmot et al, 2012) in which mental health must take its place (Raviola et al, 2011).

Reflecting what Sridhar (2011) called the shift from clinical gaze (medicine) to community gaze (epidemiology) to economic gaze, clinical evidence has been supplemented by evidence from health policy and economics. A review of efforts to mitigate inequality in early childhood (Walker et al, 2011; Engle et al, 2011) indicates that:

- Adverse life experiences include nutritional deprivation and toxic/infectious exposures as well as events like child abuse
- Early-life adversity measurably impairs functioning in later childhood and adolescence
- Interventions ranging from iodine supplementation to early childhood parenting support have a mitigating/protective effect
- These interventions extend from iodine supplementation to wealth transfers to family group conferencing (Titcomb et al, 2005)
- Intervention is more effective early than late (see Figure J.6.1).



The limitation of the economic argument, of course, is that it provides no support for the humane and promotive care of those whose disabilities limit their potential as “human capital.” The counter position argues in terms of the burden of disease and invokes human rights (Kieling et al, 2011).

The challenge of effecting and evaluating such interventions is very different in developed and developing countries. In the US, much emphasis has been placed on demonstrating processes, like increased participation in care and the degree to which implementation adheres to intentions (fidelity), as opposed to child- and family-level outcomes. Process, indeed, is much easier to measure than outcomes. A private agency, the [National Quality Forum](#), has generated some developmental and mental health indicators, mostly focused on what providers *do* (screening, follow-up, etc).

To move beyond measures of process (access, participation, fidelity, etc), the concept of the “Triple Aim” has been promoted by the [Institute for Healthcare Improvement](#) (Berwick et al, 2008). The “Triple Aim” looks at health outcomes, consumer experience, and cost per member. Similarly, in the UK, the Health of the Nation Outcome Scales for Children and Adolescents ([HoNOSCA](#)), developed by the University of Manchester and the Royal College of Psychiatrists looks at actual functional outcomes of children and youth with mental illness. Measures have been developed by various governments. For instance, in Scotland the government has published a detailed set of indicators, encompassing both mental health and mental illness (Scottish Government, 2011).

While disparities persist in developed countries (e.g., Canada; Kutcher et al, 2010), special challenges attend the needs and the policy responses in less-resourced (developing) countries. These challenges have been described for less-resourced countries as a group (Belfer, 2008; Omigbodun, 2008; Eaton et al, 2011) and for particular countries: Brazil (Couto et al, 2008), Mexico (Espinola-Nadurille et al, 2010) and Lebanon (Fayyad et al, 2010). The challenges include low levels of resources to support care, unreliable networking infrastructure, and tension between traditional and modern approaches to healing. The World Health Organization mhGAP report (Dua et al, 2011) specifically addresses these challenges.

Another approach to balancing appreciation of what is done (process) and what is being sought (outcome) is to use a “logic model”. This approach makes

**Triple Aim** (Berwick et al, 2008)

- Health outcomes
- Consumer experience
- Cost per member



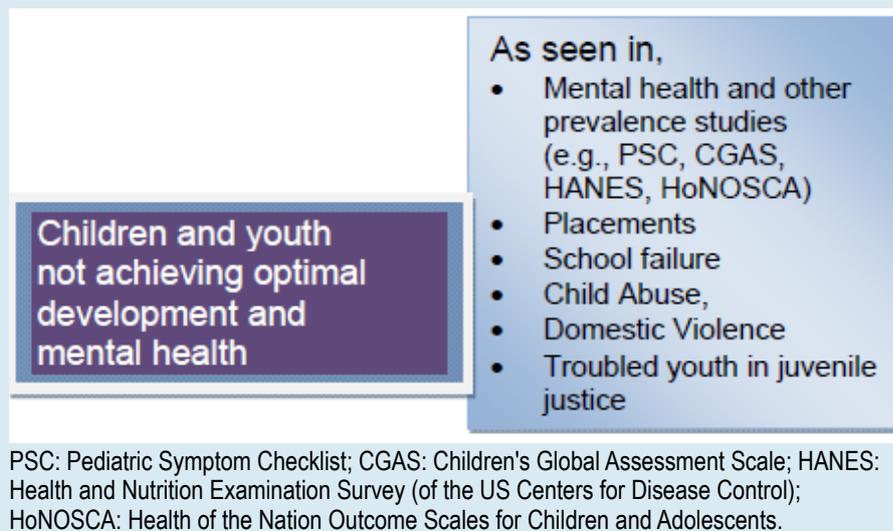
Staff and children at a mental health service in Duhok, Iraq.

Photo: Abdulbaghi Ahmad

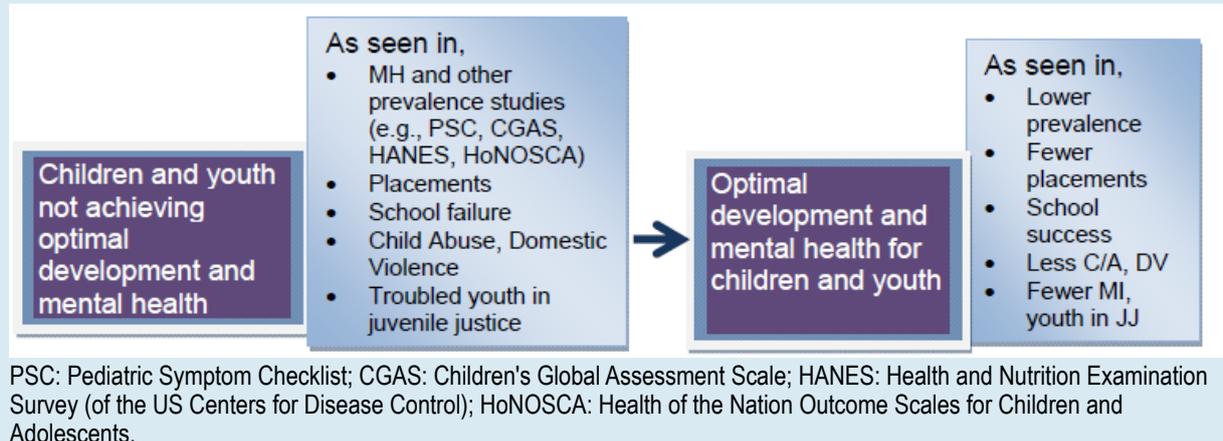
explicit the outcomes that matter while making it possible to test both the analysis of the identified problem and the relative contributions of each intervention to the desired outcomes. The logic model goes through several steps, starting with specification of the problem to be addressed and how it is assessed (Figure J.6.2). In the next step, the desired goal is similarly stated, also specifying how it is to be assessed (Figure J.6.3). The problem is then analyzed, in terms of contributing factors that lend themselves to intervention (Figure J.6.4). Finally, with intervention, change in each identified factor is measured and related to change in the original problem (Figure J.6.5).

The evidence for effective intervention has been reviewed (Kieling et al, 2011) as well as the obstacles to implementation of better-evidenced practices (Hoagwood, 2003). Creative approaches include the location of practice in a “meta-system,” (Kazak et al, 2010). Illustrative examples include the work of Fayyad and colleagues in Lebanon (2010) to train community health workers to identify and help troubled children at the village level and the ambitious program in Brazil (Couto et al, 2008), to develop centers of psychosocial care at the community level throughout the country. An approach to early intervention

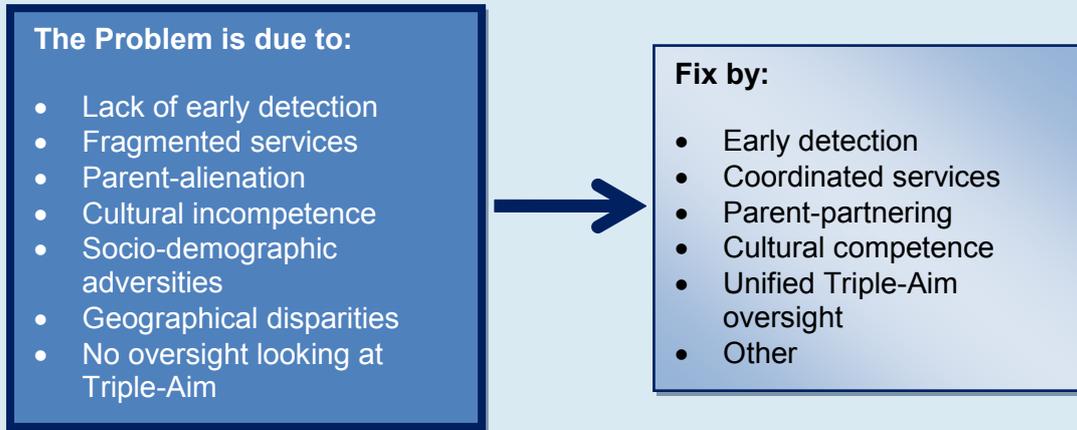
**Figure J.6.2 Logic model: defining and measuring the problem**



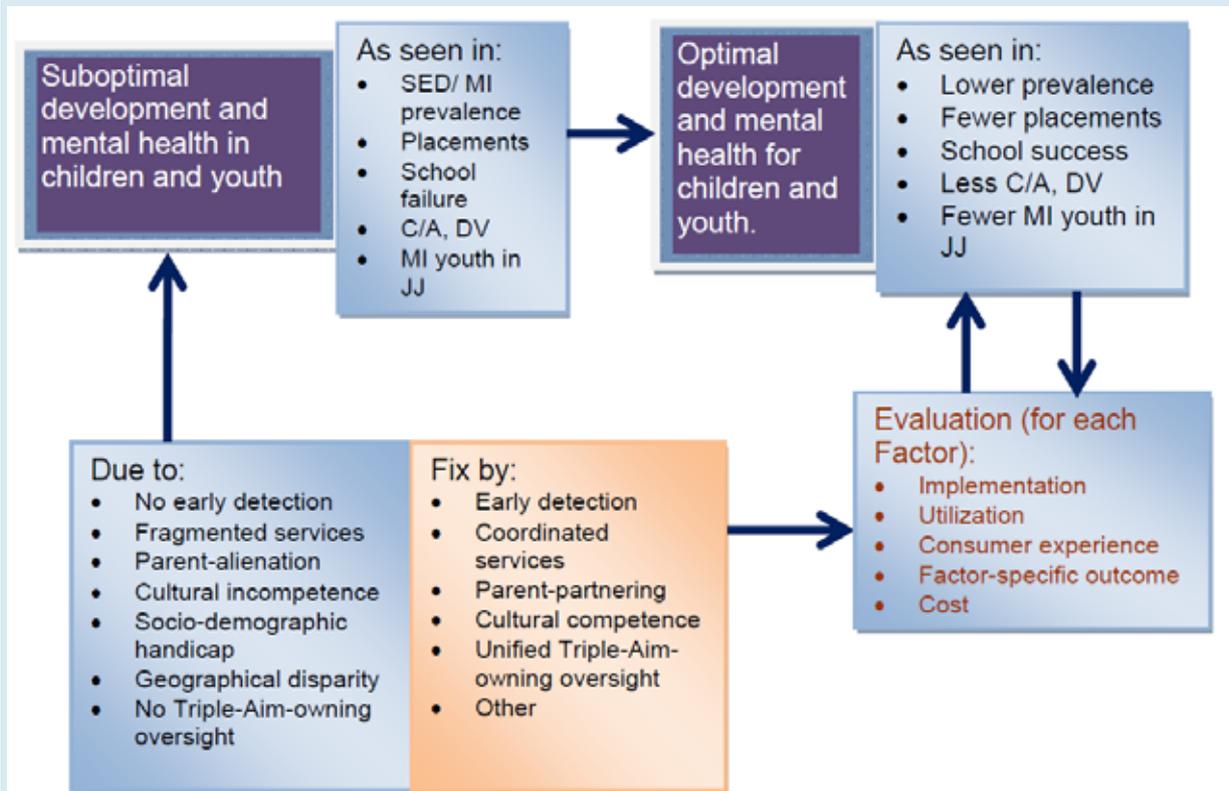
**Figure J.6.3 Logic model: defining and measuring the goal**



**Figure J.6.4 Logic model: analyzing the problem – identifying contributing factors for intervention**



**Figure J.6.5 Logic model: which factors have changed? How have they helped the problem get better?**



PSC: Pediatric Symptom Checklist; CGAS: Children's Global Assessment Scale; HANES: Health and Nutrition Examination Survey (of the US Centers for Disease Control); HoNOSCA: Health of the Nation Outcome Scales for Children and Adolescents; C/A: child and adolescent; DV: domestic violence; MI: mental illness; JJ: juvenile justice; SED: serious emotional disturbance.

used in diverse communities is the fostering of the parent-infant relationship, both through the “Touchpoints” method developed by Brazelton (Sparrow, 2010; Sparrow et al, 2011) and “Supporting Security” developed by Wittenberg (2009).

**Touchpoints**

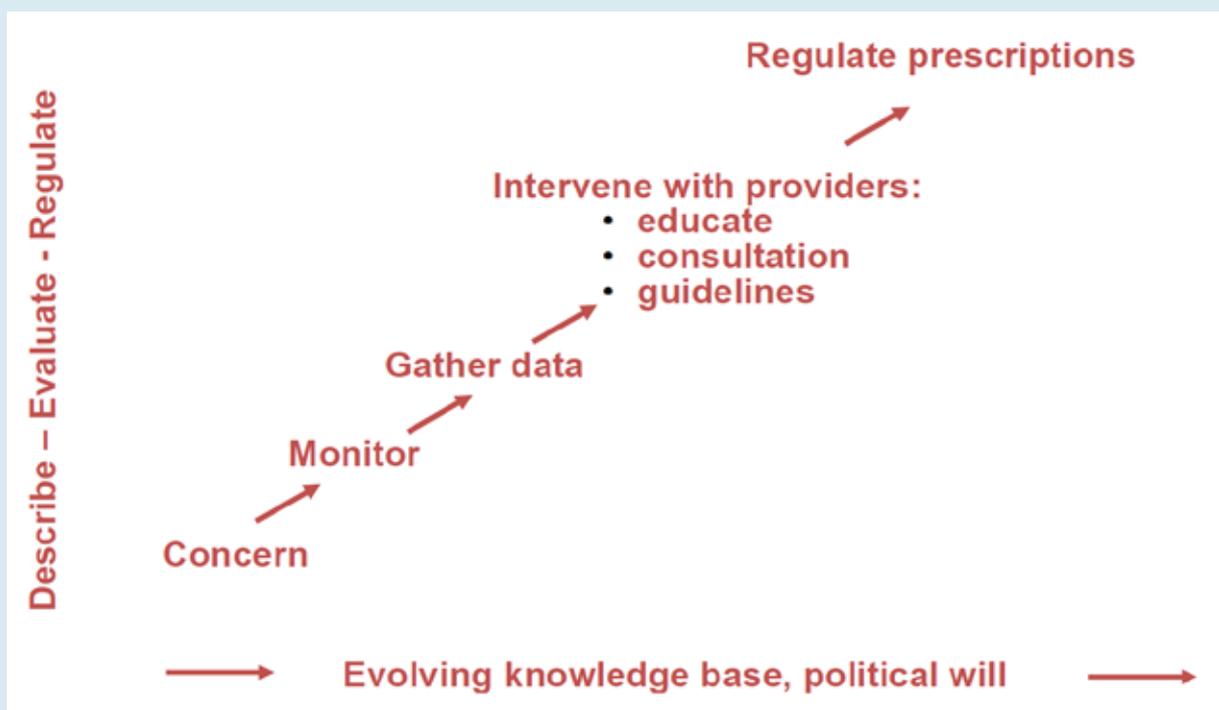
The Brazelton Touchpoints Center has used a strengths-based, developmental, relational, and culturally informed approach for family-self strengthening and community-self strengthening in over 160 communities. Social connectedness, parental self-efficacy and community collective efficacy revive the capacity to envision the future of children and community with hope. Such connection and hope are critical ingredients, often overlooked, for one generation to be able to nurture the next. In addition to connecting to others and to the future, families and communities also draw strength through connecting to the past through cultural identity. Rooted in dynamic, developmental systems theory, this approach empowers parents and other family members to discover and rely on the resources within themselves, their children and their communities.

Touchpoints does not exclude the contributions of professionals and their institutions. Nor does it minimize the impact on children, families and communities of adversities such as food, air and water insecurity. It offers a way of being, along with specific ways of doing and saying that re-equilibrate the power imbalance and disrupt the monopoly on knowledge and technology deemed pertinent to childrearing. Touchpoints also applies this attitude and strategies to organizations and systems of care. Such a paradigm shift creates different relationships between professionals and agencies and the children and families they serve. This approach also connects families with each other and with what we call traditional and informal community resources.



Click on the picture to view a short video (5:08) about Touchpoints.

**Figure J.6.6 The evolving state role regarding psychoactive medications**



### **Evolving public awareness, professional and political will**

The growth of public and professional awareness of disparities in children's lives and of the possibilities of intervening is evident in many places. In the US, the [National Institutes of Health](#) has established a National Institute on Minority Health and Health Disparities which has funded close to a dozen centers focused on health disparities around the country. However, none of these seems to be devoted specifically to child health, let alone child mental health.

Regarding mental health, the WHO mhGAP report mentioned above details the enormous distance between need and what is provided. The case for national policies for child development and child mental health has been pointed out in countries as diverse as Canada (Kutcher et al, 2010) and Brazil (Couto et al, 2008) and on the international level (Belfer, 2008). A more active role for youth themselves is seen in the use of "[peer mentors](#)" in the US and of young people as "health agents" in Tanzania (Kamo et al, 2008).

The degree of organized activity around the world on behalf of children's mental health, far greater than imagined even a decade ago, is reflected in the *Bulletin* of the International Association of Child and Adolescent Psychiatry and Allied Professions (IACAPAP).

### **AND THE CHALLENGES...**

Although children in many countries now benefit from public awareness of disparities, their impact, and effective interventions, challenges remain. Several of these bear mentioning:

- How to balance the competing appeals of models of care that are professionally driven (and may be parent-alienating) and those that are parent-driven (and possibly anti- or non-professional)?
- How can we use innovations like peer mentors/ peer specialists to diminish troubled youths' sense of defect and enhance their sense of mastery?
- How to balance interventions early, for prevention, and those later, when disability and dysfunction have appeared?
- In countries where services in the mental health, educational, and social services have developed apart from each other, how can services be integrated?
- Where health insurance is used to support mental health service, how to balance the requirements to demonstrate "medical necessity" with preventive needs and with the need for help beyond the acute phase?
- Amid promotion from manufacturers and the appeal to parents of medications that promise to be effective and easy, how to keep child mental health from becoming a reductionistic, single-perspective field?
- How to define a comprehensive, population-based approach to child development and child mental health, given competition among those, parents and professionals alike, who would focus on one group to the exclusion of others (as happens currently, with those who advocate for and those who fear the consequences of increased entitlements for those with some form of autism)?
- Finally, as interventions for child mental health become more

recognized, more potent, and potentially harmful, policy must address the challenge of ensuring that services are safe and effective, not just remunerative to provider and satisfactory to consumer. The stages of development of the State's role in overseeing medication services, evolving from bystander to interested observer and enabler to monitor and standard setter is represented in Figure J.6.6.

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Grade 8 students taking part in the pilot phase of the Respect 4U intervention at a secondary school in Masiphumele, a township outside Cape Town, South Africa. Photo: Julius Oatts