Improving School Children's Mental Health in an era of HIV/AIDS

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Introduction

The challenge posed by the current colloquium for the area of child mental health is of critical importance. I will attempt a very preliminary examination of the following question:

"Why should schools be key sites for addressing children's mental health needs at this point in our history?"

The paper will proceed to consider four points:

1. Child mental health and public policy – a situation of neglect
2. Why should child mental health be a priority public health issue?
3. Child mental health problems in the context of HIV/AIDS.
4. "What is to be done" in the education context (apologies to V.I.L.).

1 Child mental and public policy – a situation of neglect

A working definition of child mental health

Definitions of child mental health extend from a broad notion of "welfare" or well being, to freedom from mental disorder. In an earlier paper, Dawes et al (1997) suggested the following definition. It incorporates both approaches and focuses on health rather than pathology:

"Child mental health refers to the degree of age-appropriate bio-psychosocial development achieved using available resources."

Positive child development can be segmented into what may be referred to as the five Cs: Competence, Connection, Character, Confidence, and Caring (compassion) (Lerner, Fisher and Weinberg, 2002). The Cs represent:

"five clusters of individual attributes – for example, intellectual ability and social and behavioural skills; positive bonds with people and institutions; integrity and moral centeredness; positive self-regard, a sense of self efficacy and courage; and humane values, empathy, and a sense of social justice, respectively." (pp. 16-17).

All are relatively easy to measure, all are indicators of psychological health, and they are useful focal points for school-based intervention.

2 Why should competency- based child mental health be a priority public health issue?

Simply because the future well being of the nation depends as much on physically healthy individuals as it does on psychologically competent and caring people. No matter how physically healthy they are, adults whose childhood experience has compromised the development of the five key competencies will be less able to play a positive and productive role in the society, and are therefore a serious risk to the well-being of their communities and the nation.

Maintaining a broad conception of children's welfare and mental health matters both for the current well being of children, and for their future.

As we strive to promote the mental health of children, we should therefore not only restrict ourselves to a narrow concern with psychopathological disorders and the treatment of those children who have diagnosed conditions.

Of course tertiary services to psychologically disturbed children are essential and need to be expanded. They are woefully inadequate.

However, if we are concerned about prevention, our efforts need to strengthen key competencies that are likely to promote positive functioning in both childhood and in the adult to be. Early intervention and sustained preventive initiatives in settings such as schools will in any event assist in reducing the numbers of those who present with disorders.

The evidence is quite clear that positive sources of support for vulnerable children at the level of the family, the school and the wider community play important roles in reducing the risks to development for children living in adverse conditions (Luthar, Cicchetti and Becker, 2000).

School environments in particular have the capacity to build the five competencies. When other components of the child's support structure are under threat or falling apart as is the case in the AIDS pandemic, schools are potentially critical resources for the containment of children's distress and for promotion of resilience and coping. Schools also permit universal level interventions over different periods of child development.

At the same time, however, when they are dysfunctional, schools compound vulnerability and undermine the competencies.

Child psychopathology and psychological distress have multiple determinants beyond the school. However, it is commonly the case that problems outside the

school express themselves in school. For example, neglect and abuse in the home may produce a child who is withdrawn and failing in school. The school staff needs to be able to recognise the child's problem as a signal of distress rather than recalcitrance, and they need to know that problems in the home may be responsible.

The need to move child mental health out of the last carriage of the policy train

Mental health issues have always occupied the last coach on the child health policy train. This is true for the so-called developed countries, but it is even more evident in less well-off parts of the world (Dawes et al, 1997). The psychological well being of communities experiencing deep poverty and threats to personal survival such as violence and abuse is understandably viewed as lower in priority than survival and provision of basic amenities. Poverty contexts are well known to pose high levels of risk to health and indeed survival, and it is crucial that they be addressed. In a context of limited resources, the first call will necessarily be for the promotion of child survival, health and safety.

In addition, many of the outcomes of threats to physical health associated with poverty, are often very visible to those in the child's immediate environment. Children do not thrive; they become obviously ill; they have clear signs of under or malnutrition; they are likely to be injured in unsafe homes and neighbourhoods; and they may develop obvious physical disabilities as a function of pre, peri and postnatal environmental insults.

It is difficult to place child mental health firmly on the policy agenda (and commit the funds) for two key reasons in my view.

First because mental health conditions, with few exceptions, do not constitute clinical emergencies, and nor do they pose a threat to the child's survival.

Second: because in many instances children's emotional suffering does not shout out to us. It is relatively invisible. It is neglected in the over-stretched emotional economy of the poverty-stressed home and the under-resourced school.

Problems of the mind and emotions do not ring the survival and well-being bells as loudly as physical conditions. There are of course obvious exceptions such as Downes syndrome, epilepsy, psychotic disorders, severe depression, and conditions such as anorexia / bulimia.

Characteristically, child mental health problems and clinical conditions that do not have their origins in organic conditions (and include mental handicap), may be clustered along three principle axes along which children express their distress and

responses to trauma. I have caricatured them as quiet misery naughtiness and craziness:

1. Internalising disorders – characterised by fear, anxiety, or depression (quiet misery – to anxiety and depression).

2. Externalising disorders – characterised by problems of conduct – and aggression (naughtiness - badness).

3. Psychotic disorders – characterised by major disturbances in thought processes, reality testing, and relationships (craziness).

While externalising and psychotic disorders tend to make themselves felt in the everyday world of the home and the school, internalising problems commonly do not unless the parent or the teacher is tuned to listen to the signs, and just as important, has the time and energy to be turned on by them. This is a crucial point, and it is an energy or cost efficiency problem if you like.

Caregivers who are under stress, and teachers whose work environments place impossible demands on them, will simply tend to attend to matters (and children) whose condition or behaviour calls their attention. This is one reason why temperamentally passive children tend to be more at risk for under-nutrition than their more difficult siblings (Richter, 1994).

The condition of many troubled children is rendered invisible in a world of day-to-day struggle and the reality of HIV/AIDS. Silent suffering in the part of children is a relief to those responsible for them. They do not cause much of a bother until their suffering begins to express itself externally in the form of 'difficult or naughty" behaviour.

While a clinician may understand the "naughtiness" to reflect distress, it is understandable that they are commonly defined by teachers and parents as bad kids – rather than distressed or troubled kids. It is interesting that if one talks to parents living in poverty, it is commonly the difficult and disobedient child who causes them concern, and not the quiet invisible and withdrawn one. Applying the "bad child" label is of course one early step in supplying this child with a negative identity. Negative identities are all too often celebrated among South African youth whose attributes and life situations have given them little hope for the future (witness if you will the number of 'no fear' and 'bad boys' bumper stickers around). In contemporary South Africa, the development of negative identities should be a major public health challenge.

3 Child mental health problems in the context of HIV/AIDS.

There are high variations in prevalence rates for child and adolescent disorders in developing countries. In the South African case, the data is sketchy and uneven in quality (Dawes et al, 1997). A major source of the problem is likely to be found in differences in research methodology, and much of the South African data relies on clinic samples. Unfortunately, these tell us little about the population at risk. The use of different research instruments in different studies is an additional source of variation (Robertson & Berger, 1994). We have no agreed benchmark assessment devices for screening child mental health problems - a variety of assessment instruments are deployed. It is not surprising that morbidity estimates vary from study to study.

In sum, there are no reliable national epidemiological studies in South Africa. We really do not know the scale of the problem.

However, we have to proceed from some baseline. If we follow the UNICEF/NCRC (1993) situational analysis, and Schoeman et al (1989), whose figures fall within the middle of a range of estimates, we can estimate a prevalence rate of 15% for child and adolescent psychological disorders, (including mental handicap). South Africa has some 18 million children under 19 years of age, and children under 15 years constitute 80% of the this group. Eighty two percent of the under 15s are African and live in high-risk urban and rural contexts.

Thus at a prevalence rate of 15%, we can expect a need for at least secondary level services for around 1.8 million African children under 15 years alone. Key areas of need which need immediate attention are urban informal settlements and rural communities.

These figures do not tell us anything of the extent of psychosocial problems in the remainder of children who do not present with clinical disorders. We need the data, but common sense will tell us that the problem is significant, and will only be exacerbated by the mental health consequences of HIV/AIDS – an issue that is only beginning to raise its head on the research horizon.

So apart from the threats to child health and well-being posed by endemic poverty and violence, at the present time and well into the future, the effects on children of issues related to HIV/AIDS will bare heavily on the preschool and school population, making themselves felt in the classroom and the playfields.

How will HIV/AIDS impact on the psychological well being of school children?

1 Increasing numbers of children will be living with living with infected caregivers.

- Stigma resulting in social isolation, emotional distress and exclusion by peers and adults. Primary Impacts on the five Cs: Confidence and self esteem compromised; emotional and social competence compromised.

- Increasing economic and food security resulting in malnutrition; no money for school fees and uniforms resulting in exclusion or school drop out. Primary Impacts on the five Cs: Physical functioning, intellectual competence and emotional competence.

- Increasing care and domestic responsibilities (girls in particular) resulting in less time for studying. Primary Impacts on the five Cs: Intellectual competence will be compromised, but arguably, a caring orientation may well be strengthened.

2 Increasing numbers of caregivers will die of AIDS related conditions and causing a child care crisis

- Further economic insecurity caused by the shock of income loss. Primary Impacts on the 5 Cs: as above

- Increased vulnerability due to low levels of supervision and monitoring (depends on age and sex: young children to abuse at the hands of both kin and others; older children to risky behaviour; girl children to commercial sexual exploitation) Primary Impacts on the 5 Cs: physical risk, low moral centeredness; low self-regard, a poor sense of social justice."

"five clusters of individual attributes – for example, intellectual ability and social and behavioural skills; positive bonds with people and institutions; integrity and moral centeredness; positive self-regard, a sense of self efficacy and courage; and humane values, empathy, and a sense of social justice, respectively." (pp. 16-17).

- Increased food insecurity. Primary Impacts on the 5 Cs: as above.

- Loss of crucial documents leading to school exclusion and problems with access to social grants. Primary Impacts on the 5 Cs: Threats to physical well-being, and loss of opportunities for learning.

- Girl children leave school to care for young children. Primary Impacts on the 5 Cs: loss of opportunities for learning.

- Increased mobility between places of residence may lead to changes in school and loss of learning opportunities

3 Increasing numbers of children with HIV/AIDS will be at school.

4. Increasing numbers of teachers will be living with AIDS and dying of the associated infections.

- We do not know the scale of the problem yet, but there is no doubt that that there will be teachers attrition due to illness and death. Children will be affected by this loss at two levels: emotional and in terms of reduced teacher capacity – and reduced capacity therefore to prepare our young for the future. At the very least, there is an urgent need to train surviving teachers to assist school children to cope with the loss of those who have passed on, and to train new generations of teachers to replace them.

- What is clear is that many thousands of children will face the death of kin as well as other carers such as teachers with whom relationships will have developed. There is a profound sense that many children will have to live with multiple losses due to the death of these people. There is little doubt that the experience of common place death will have a considerable impact on the emotional life of these children.

5. "What might be done?" in the education context

We started with the question:

"Why should schools be key sites for addressing children's mental health needs at this point in our history?"

The answer is that particularly in the current and future HIV/AIDS crisis, the school has a role to play that is beyond the traditional educational focus.

As family support systems are increasingly compromised and children affected by AIDS have few supportive resources left to them, the school has the potential to be a place of refuge, support, and care. Positive school environments can do much to provide sound developmental settings for children who would otherwise have few resources on which to build their competences. This is well established.

The answer to the challenge that faces us does not lie in squads of therapists in schools. Many children will need specialised counselling services. However, addressing the problem with tertiary level solutions is neither cost effective nor

efficient. The solution also does not lie in expecting teachers to go beyond their over-stretched schedules to become therapists to children – although many do already.

Rather it lies in creating school environments within which children feel safe and supported, rather than excluded and vulnerable. It lies in creating school environments that care for children in a much broader sense. Children who grow up feeling cared for will be more likely to feel psychologically able to care for others. It means understanding the different needs of children at different levels of development. Six year olds require different responses to 12 year olds.

For school staff to be able to create a caring environment for children, school heads and teachers must feel cared for and supported by their departments and ministries. At present many clearly do not feel cared for. Creation of a caring enabling school environment requires a fundamental commitment to enabling schools to play this role, and accountability for those who undermine that role. It is a huge challenge. We know that there are significant threats to the ability of schools to play this role. For example:

- Schools characterised by poorly trained staff, poorly motivated staff, poor staff-pupil ratios, low levels of staff and pupil discipline, poor leadership and in particular low levels of accountability among staff constitute high risk environments for children and staff. Such institutions are likely to contribute significantly to poor cognitive, emotional and behaviour outcomes.

- Evidence suggests that in many cases, whole school development is needed for such institutions in parallel with the introduction of no more than the most simple interventions to reduce commonly occurring key risks to children's mental health - violence; sexual abuse).

Finally, complex interventions for teachers and children simply will not work if the support base for such interventions is lacking.

Conclusion

President Mandela, in his acceptance speech on being awarded the Nobel Prize, said that children are:

"at once the most vulnerable citizens in any society, and the greatest of our treasures".

As well as signifying his particular interest in matters affecting children, the former president's statement echoes a growing awareness that the foundations of adult health and psychological functioning are laid during childhood and adolescence.

South Africa has a powerful Bill of Rights, and has ratified the UN Convention on the Rights of the Child. These provisions have stimulated considerable advances in the provision of health services to young children in particular.

However despite these positive changes, the evidence suggests that our children are not being treated as Madiba would have us treat them, and indeed as they deserve to be treated.

It is often said, all too glibly that "The Children are our future". To that end, we strive to create a future generation that carries forward our heritage and values. This is the way we attempt to guarantee our cultural survival.

What our children take forward is nurtured in the many developmental settings we create for our children, be this in terms of their health and psychological well being, their opportunities for work, and their capacity to create positive relationships with others.

I therefore prefer to reverse the "Children are our future" slogan, and substitute the phrase: "We are our children's future".

What this does is place the responsibility for the development of the five Cs, and the current well-being of today's child and tomorrow's adult, squarely where it belongs: in the hands of the current parent, carer and teacher.

Because children are a relatively powerless and excluded group, it is particularly those who spend significant time with children, who must be primarily responsible for providing the conditions that lay own the socio-cultural and blueprints for the future of the next generation. These templates include key dimensions of mental health outlined above that can be promoted in school. Where those closest to the child are vulnerable and when their caring capacities are compromised, then it is the role of the state to step in as the enabling agent.

The promotion of the mental health of the child in the school must start with the systemic health of all levels of the educational environment. A key factor in all this is the full professional and legal accountability of all the individuals who play a role in that system. If indeed our children are truly "precious" and if indeed we wish a positive future for them, then the way forward is clear.

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