Promoting mental health and emotional well-being among children and youth: a role for community child health?

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Introduction

'Teenage suicides double as the future crumbles' with collapse of the economy in Argentina (Arie 2002). Schizophrenia 'linked to racism', a study reveals among ethnic minorities in London (Boydell et al. 2001).

The promotion of emotional well-being focuses on improving environments (social, physical, economic) that affect emotional well-being and enhancing the ‘coping’ capacity of communities as well as individuals (Wood & Wise 1997). What improvements in the ‘environment’ are required, and how does one ‘enhance coping’ in order to promote emotional well-being? What is the role of those working in community child health in promoting mental health and emotional well-being?

Most of the research on the determinants of the health and well-being of populations have focused on physical health problems, particularly mortality and life expectancy (Marmot & Wilkinson 1999). There is less research on the ‘upstream’ (socioeconomic) determinants of mental health problems, and even less on emotional well-being and enhancing ‘coping’ or promoting resilience. Examples of upstream determinants of mental health problems include good evidence linking the prevalence of mental health problems of children and young people to income, educational status and family structure (Sawyer et al. 2001). Male youth suicide has been linked to such upstream determinants as relative unemployment rates. Suicide has increased with increasing ratio of youth to overall unemployment rates (Morrell et al. 2001). A significantly higher risk of suicide in Australia over the past century was shown to be associated with conservative governments compared with social democratic government tenures (Page et al. 2002).

Resilience

Resilience is best understood as the capacity of the individual or community to resist or ‘bounce back’ in spite of significant stress or adversity (Newman 2002). ‘Resilience’ as a concept appears to cross national and cultural boundaries. The ‘International Resilience Project’, which collected data on children from 30 countries, described resilience as a ‘universal capacity which allows a person, group or community to prevent, minimize or overcome the damaging effects of adversity’ (Grotberg 1997). Resilience is determined by the interplay between risk and protective factors of the child, the family and the community (Commonwealth Department of Health and Aged Care 2000). Risk factors increase the likelihood that a disorder will develop or exacerbate the burden of the existing disorder. A more comprehensive approach to risk considers characteristics of the individual in the context of the family and the community. Protective factors reduce the likelihood that a disorder will develop, and also operate at the level of the individual, the family and the community. Protective factors pro-
vide a buffer as well as a reservoir of resources to deal with stress effectively. Fig. 1 provides a conceptual framework for understanding resilience at a population health level. Risk and protective factors interact at all levels, i.e. the upstream, midstream and downstream levels, to create emotionally resilient children and communities.

**The role of community child health in influencing the mid-stream determinants of mental health and emotional well-being**

What can health services do to promote emotional well-being? Over the past decade, in an attempt to influence the broader determinants of health, there has been a move for health services to work more collaboratively with other non-health sectors such as education, community services, housing, etc. Examples include Sure Start in the UK and the Families First Initiative in New South Wales (NSW), Australia (Nossar & Alperstein 1998; Hudson 2000; Eisenstadt 2002). There has also been more of an emphasis on population coverage by providing services universally, but addressing issues of equity by concentrating efforts on vulnerable and disadvantaged populations (Nossar & Alperstein 1998; Hudson 2000). However, we need more robust studies to examine interventions at a population level that prevent emotional distress and promote mental and social health (Stewart-Brown 1998).

Figure 2 is a framework for strategies that have significant potential for promoting better mental health and emotional well-being. The causal pathways through these strategies to improved emotional well-being have not been well defined. However, they may operate through the development of resilience, appropriate locus of control and connectedness to family and community.

Home visiting programmes for disadvantaged families have resulted in a decreased incidence of child abuse, child behavioural problems, youth delinquency rates, running away from home and substance abuse. Those programmes have also resulted in increased rates of graduation from high school, less maternal dependency on welfare and less maternal substance abuse (Olds et al. 1997). Some parenting programmes, such as the Positive Parenting Program, using behavioural family interventions, have been demonstrated to result in a range of improved parental mental health outcomes and positive parenting attributes as well as reduced behavioural problems (oppositional defiant disorder, conduct disorder and attention hyperactivity disorder) among young children (Sanders 1999). Early educational childcare such as the High/Scope Perry preschool programme and Head Start programmes have also resulted in a variety of mental health and associated social out-
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comes such as decreased arrests, less use of mental health services, better educational and income outcomes and greater likelihood of being in a stable relationship as an adult (Barnett 1993). Lack of social capital (lack of trust, community participation and support networks) has been demonstrated to be strongly associated with child abuse (Garbarino & Kosteln 1992; Vinson & Baldry 1999). Research on the effects of improving social capital in a community are thin on the ground, but the potential for better outcomes is significant. A number of well-studied school programmes have resulted in improved emotional well-being (Tilford 1997). Perceived connectedness by adolescents to family and school was strongly associated with better mental health outcomes (emotional distress, suicidality, violence) and less risk-taking behaviour (tobacco and marijuana smoking and alcohol use) (Resnick et al. 1997). Programmes in schools building school connectedness, such as the Gatehouse project in Melbourne, have demonstrated decreased rates of bullying and marijuana use, reductions in uptake of tobacco smoking among adolescents and adolescents with fewer friends who smoke (Burns 2002). Transition points represent a fulcrum for developmental stress and are an opportunity for supportive interventions for maintaining resilience. Many of the above strategies are currently in the process of, or being, implemented to varying degrees, for example through Sure Start in the UK, the Families First initiative in NSW, Australia, and similar versions are being developed in some of the other states of Australia and Sweden (Sundelin 2002). Although there appears to be some cohesion and synergy in the thinking and delivery of strategies for children in the early years, this is less evident for adolescents.

The role of community child health in influencing the upstream determinants of mental health and emotional well-being

How can health workers influence the upstream determinants of health, and should they? Rose (1992) stated that 'the primary determinants of disease are mainly economic and social, and therefore its remedies must also be economic and social.
Medicine and politics cannot and should not be kept apart. Advocacy is of utmost importance to influence the upstream determinants of mental health and emotional well-being. This can be accomplished through a number of strategies including: (1) influencing government policy on income distribution, investment in education, socioeconomic equity, investment in the early years and building social capital through the publication of data linking health outcomes to the aforementioned factors; (2) influencing government legislation with respect to issues such as gun control, vilification laws, etc. through developing position papers based on research; (3) influencing government and community attitudes with respect to caring, compassion, tolerance of and valuing of diversity, based on data and rational argument.

Issues related to ethnic minority populations

Ethnic minority communities may come from a range of diverse sociocultural and linguistic backgrounds. This diversity makes it impossible to generalize about how well or badly minority groups are faring with respect to mental health and emotional well-being. Factors that moderate the expression of health/ill-health in minority groups range from type of acculturating group (whether voluntary or forced), social and cultural characteristics of the group and racism to language used and fluency, and individual characteristics (Aponte & Johnson 2000).

Issues of racism and discrimination, marginalization, poverty, social disadvantage and refugee status are powerful upstream forces with which children and families from minority backgrounds have to contend. However, research studies from the UK (Hackett et al. 1991), US (Loo & Rappaport 1998) and Australia (Australian Institute of Health & Welfare 1998; Davies & McKelvey 1998) suggest that mental health pathology in non-English speaking groups is less than that of the mainstream population. Other studies have found that the effects of culture on child behaviour are modest (Weine et al. 1995). Empirically grounded cross-national comparisons of the prevalence of child mental health problems have hinted at ethnocultural variations in problem behaviour. (Bird 1996; Crijnen et al. 1997). However, little has been done to elucidate the factors that contribute to better mental health outcomes and influence emotional well-being of children growing up in diverse sociocultural environments, despite the negative upstream forces.

Issues related to indigenous communities

Indigenous communities, particularly those living in Australia, the US and Canada, have had to contend with major dispossession of land and culture, loss of autonomy, violence, violation of human rights and forced separation and incarceration in reserves. In addition to the higher rates of mortality and morbidity and shortened life span among indigenous people, many studies report a higher prevalence of psychopathology compared with the mainstream populations (Blum et al. 1992; Brady 1993; Kirmayer 1994; Kvernmo & Heyerdahl 1998). However, methodological problems in cross-cultural assessments, including ‘cultural distance’ introducing negative bias in teachers evaluating indigenous children’s behaviours, are common (Dion et al. 1998). Unlike western society, some indigenous peoples tend to define health as not only the ‘social, emotional and cultural well-being of individuals, but also the whole community, and include the cyclical concept of ‘life–death–life’ (National Health and Medical Research Council 1996). Although the overwhelming issues of poverty, marginalization and racism operate negatively in many indigenous children’s lives, the resilience-promoting factors of family and community connectedness and cultural identity are positive attributes of these communities that should be capitalized upon.

Conclusion

Would more child psychiatrists, psychologists or community paediatricians have prevented the ‘epidemic’ of teenage suicides in Argentina? Can we minimize the harm from negative upstream effects on mental health and emotional well-being? There appears to be sufficient evidence that the strategies
described above, when delivered in a multisectoral, proactive, population-targeted (as opposed to individual-targeted) manner, may reduce the incidence of emotional and behavioural problems in children and youth and promote resilience and emotional well-being. All the strategies discussed are complementary and are unlikely alone to result in significant mental health gain. Similarly, each strategy would need to be adjusted to suit each specific community or ethnic/cultural group. One size will not fit all. It is also important that these strategies or group of strategies be appropriately and properly funded and evaluated or else, in 50 years, we will still be none the wiser regarding our assertions.

References


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