Mental health and risk behaviour

Alan J. Flisher[i] and Aník Gevers (Division of Child and Adolescent Psychiatry
and Adolescent Health Research Unit, University of Cape Town)

South Africa's high mortality rates are attributable to HIV, malnutrition and infectious diseases – so is it important to allocate scarce health resources to mental health interventions?

Unsafe sex, interpersonal violence, alcohol abuse and smoking tobacco account for over 50% of South Africa's total burden of disease.[1] Therefore, it is vital to address early manifestations of these problems in childhood and adolescence, not only to alleviate the burden of disease but also to alleviate the suffering of individuals and their families who are struggling with these problems.

This essay explains how child and adolescent mental health and risk behaviour pose significant problems for individuals and their families, and impact on the health, education, safety and economy of communities and society as a whole. Therefore, it is not only appropriate, but essential, to allocate resources to mental health programming in multiple settings.

The essay examines the following questions:

- Why is child and adolescent mental health important?
- Why is it important to address child and adolescent risk behaviour?
- What can be done to address these mental health and behavioural issues?
- What are some recommendations for action?

Why is child and adolescent mental health important?

Although national prevalence data of child and adolescent mental health disorders are unavailable, provincial data from the Western Cape can provide insight into the extent of the burden of disease. Approximately 17% of children and adolescents in this province suffer from psychiatric problems, such as attention deficit hyperactivity disorder (5%), major depressive disorder (8%) and post-traumatic stress disorder (8%).[2] While the National Youth Risk Behaviour Survey does not provide information about the prevalence of clinical disorders, data from the latest survey of grades 8 – 11 learners indicate that, in the six months before the survey, 24% of youth had sad or hopeless feelings; 21% admitted to suicidal thoughts; 17% had a suicide plan; and 21% had made at least one suicide attempt.[3]

Mental health disorders are accompanied by a considerable amount of impairment, suffering, stigma and family financial strain. There is also a high degree of continuity between psychiatric disorders in childhood and adolescence and those in adulthood. Seventy-five percent of adults with mental health problems experience the first onset before the age of 24 years.[4]

Finally, mental ill-health is associated with physical ill-health. One good example of this is HIV infection. Young people with a psychiatric disorder are more likely to contract HIV infection than those without such a disorder.[5] There are a number of possible reasons for this increased risk, such as inadequate sexual communication skills, susceptibility to negative peer norms, low self efficacy, decreased assertiveness, and reduced ability to negotiate safer sex. Being HIV positive can have mental health consequences, which can range from mild transient psychological distress on receiving the diagnosis, to dementia caused by the direct action of the virus on the brain.

Why is it important to address child and adolescent risk behaviour?

Risk behaviour can be defined as any behaviour that increases the risk of adverse psychological, social or physical outcomes in the short, medium or long term. The World Health Organisation estimates that up to 70% of premature deaths in adults can be attributed to behaviour initiated during adolescence.[6] This essay highlights three specific risk behaviours that have a significant public health impact; but this is not a comprehensive list of risk behaviours.

i Sadly, Alan passed away while we were editing this essay. Alan's dedication to designing effective interventions and creating awareness about the issues highlighted in this essay were evident as he worked on early drafts of the essay from home while battling a lot of pain. Though he empowered many people to continue his valuable work, his passion, expertise, and guidance will be sorely missed.

Table 7: Prevalence of substance use among school children in Cape Town and South Africa

Substance use	Cape Town[#]		South Africa[+]
	Girls %	Boys %	Girls and boys %
Cigarettes (in the month prior to the study)	25.8	33.1	21
Alcohol (in the month prior to the study)	24.5	32.1	35
Cannabis (in the month prior to the study)	8.7	21.1	10
Methamphetamine – 'tik' (ever)	11.9	13.3	–
Mandrax (ever)	–	–	7
Cocaine (ever)	–	–	7
Heroin (ever)	–	–	6

Sources:

Plüddemann A, Flisher AJ, Mathews C, Carney T & Lombard C (2008) Adolescent methamphetamine use and sexual risk behaviour in secondary school students in Cape Town, South Africa. *Drug and Alcohol Review*, 29: 1-6.

\+ Reddy SP, James S, Sewpail R, Koopman F, Funani NI, Sifunda S, Josie J, Masuka P, Kambaran NS & Omardien RG (2010) *Umthente Uhlaba Usamila – The South African Youth Behavioural Survey 2008*. Cape Town: Medical Research Council.

Sexual risk behaviour

According to the National Youth Risk Behaviour Survey, 38% of South Africa's youth have had sex, with 13% reporting being under the age of 14 years at sexual debut.[7] There is considerable evidence that rates of sexual risk behaviour are high. According to the Human Sciences Research Council (HSRC), 8.5% of 15 – 24-year-olds reported having had sex before the age of 15 years; 14.5% had a partner who was more than five years older than themselves; and 30.8% of males aged 15 – 24 years had more than one sexual partner in the 12 months prior to the study.[8]

Among sexually active grades 8 – 11 learners, 41% reported more than two sexual partners in their lifetime and 52% reported more than one sexual partner in the three months before the survey.[9] In addition, 12% of these learners reported using alcohol or drugs before having sex. While these behaviours are certainly cause for concern, young people also seem to engage in healthy sexual behaviours. For example, rates of condom use were high among the youth responding to the HSRC study, where 87.4% of males and 73.1% of females reported using a condom at last sex.[10]

Substance use

Table 7 presents substance use data from a Cape Town study (a representative sample of 4,605 grade 9 students at 15 high schools) and from the National Youth Risk Behaviour Survey. A further study involving 1,561 grades 8 – 10 learners in Cape Town reported that those using crystal methamphetamine ('tik') had higher rates of aggression, depression and generic mental health problems.[10]

Violence

More data are available for interpersonal violence. Tables 8 and 9 present data on prevalence of violent behaviour and bullying in schools, indicating that South Africa's youth are engaging in very high levels of violent behaviour. In addition, a study among grades 8 and 11 students in Cape Town about intimate partner violence indicated that 20.7% reported perpetrating partner violence and 16.4% reported intending to do so (measured by survey items asking whether the respondent would use violence against a partner in the future, specifically if the partner angered the respondent).[12]

High levels of violence also emerged in the National Youth Risk Behaviour Survey, where 10% of learners reported being forced to have sex and 9% admitted to forcing someone to have sex. In the previous month, 27% of learners reported feeling unsafe at school and 15% admitted to carrying a weapon; while 31% reported being in a physical fight and 19% reported being a member of a gang in the previous six months.[13]

Table 8: National prevalence data on violent behaviour collected from 260 primary and high schools (number = 12,794)

Behaviour	Prevalence (%)
Threatened at school	14.5
Assaulted at school	4.3
Robbed at school	5.9
Sexual violence at school	3.1

Source: Burton P (2008) *Merchants, skollies and stones: Experiences of school violence in South Africa*. Cape Town: Centre for Justice and Crime Prevention.

Table 9: Prevalence of bullying among grades 8 and 11 learners from Cape Town and Durban schools (number = 5,074)

Behaviour	Prevalence (%)
Bully	8.2
Victim	19.3
Bully-victim	8.7

Source: Liang H, Flisher AJ, Lombard CJ (2007) Bullying, violence, and risk behaviour in South African school students. *Child Abuse & Neglect*, 31: 161-171.

Associations between risk behaviours

Involvement in one risk behaviour increases the chances of involvement in other risk behaviours. An earlier study among high school students in the Cape Peninsula found that, in comparison to learners who reported no risk behaviour, those who engaged in any one of the following risk behaviours were more likely to engage in some of the others: cigarette smoking; sexual intercourse; going out at night beyond the neighbourhood and walking home alone; attempting suicide; using cannabis; not wearing a seat belt.[14] The existence of this co-variation between risk behaviours has been confirmed in several subsequent studies. For example, adolescents who had used methamphetamine in the past 30 days were more likely to have engaged in vaginal, oral, and anal sex.[15] Thus, the health risks associated with engaging in risk behaviours are amplified by additional and simultaneous involvement in other risk behaviours.

Finally, there are strong grounds to conclude that mental ill-health and risk behaviour are associated with each other. A recent literature review identified 89 studies published between 1990 and 2007 that reported an association between substance use and psychopathology among adolescents.[16] Similarly, a study among Cape Town high school students found that exposure to violence is associated with depression, anxiety and post-traumatic stress disorder.[17]

What can be done to address mental health and behavioural problems?

Clinical services are perhaps the most obvious response to child and adolescent mental ill-health and risk behaviour. Traditionally these services have generally served a treatment or rehabilitative purpose. In support of this type of response, there is a large and growing body of evidence that many child and adolescent psychiatric disorders can be effectively treated using psychotherapy and/or psychotropic[ii] medication.[18] These specialised services are essential and need to be strengthened.

However, mental health services for children and adolescents need to be broadened to include mental health promotion and primary prevention in order to support optimal development and well-being and to prevent the occurrence of mental health or risk behaviour problems. Interventions need to be integrated into multiple settings and remain consistent across individual, interpersonal, community, and socio-structural levels.[19] As mental ill-health is associated with physical ill-health and risk behaviour, this implies that interventions should be as comprehensive as possible. It is, for example, ill-advised to focus on an adolescent's substance misuse without also addressing associated mood disorder or sexual risk behaviour.

There is a need for a multi-pronged approach that supports the implementation of services for different groups of youth, and for various groups of people who are influential in young people's lives.[20] Universal interventions are broad and provided to a general population (eg all pre-school children), whereas selected interventions provide services to particular groups (eg vulnerable or at-risk youth) or at critical stages of children's development). Indicated interventions are services aimed at people who are struggling with particular mental health and behavioural problems (eg youth with a psychiatric diagnosis). Parents, primary caregivers and youth service providers should also receive interventions that will support child and adolescent mental health. These interventions will strengthen the people and environments that are particularly influential in youth's lives and well-being.

Child and adolescent mental health care cannot only be confined to specialised mental health care settings. Indeed, a continuum of mental health services can and should be offered in various settings. This includes health promotion, prevention, treatment and rehabilitation services at primary health care clinics, schools, youth and community centres, faith-based centres, non-governmental organisations (NGOs), media outlets and homes. For example, the Healthwise programme described in case 2 on the next page implements a health promotion and primary prevention programme in schools and communities. Consistent messaging and support across these domains will ensure that youth are fully supported in their mental health and development and that problems are either prevented or detected early for intervention.

Interventions also need to address the economic and socio-cultural factors that continue to exacerbate mental health disorders and risk behaviour. For example, the culture of violence in South African society not only contributes to individual distress, but it also supports continued violent

ii Psychotropic medication is any pharmaceutical used primarily in the treatment of mental illnesses to improve emotional, perceptual, or behavioural symptoms of these illnesses through their action on brain functioning.

behaviour among children and adolescents. Exposure to corporal punishment, domestic violence, and community violence gives youth the message that violent behaviour is a normal response, particularly in conflict or discipline situations. Young people will only learn that violent behaviour is unacceptable when society stops condoning such violent behaviour and starts promoting pro-social behaviour, for example, by equipping parents and teachers with positive discipline strategies and enforcing non-violent policies and legislation (such as the South African Schools Act[21]).

Interventions do not need to be limited to workshop or traditional therapy formats. Indeed, creative ways to address mental health and risk behaviour among youth across traditional and non-traditional fields are essential. Below are some suggestions to help various role-players to begin thinking about actions they can take as individuals in their professional or personal capacity.

What are some recommendations for action?

It is important that all role-players stay informed of developments in child and adolescent mental health and participate in continuous training. Just as important are building connections and partnerships to co-ordinate efforts to support child and adolescent mental health, and to improve mental health services. The following recommendations outline how people from different groups can support child and adolescent mental health. Risk behaviour is conceptualised as a component of child and adolescent mental health, thus any mention of mental health interventions includes interventions that target sexual behaviour, substance use, and violent behaviour.

Case 2: The Healthwise intervention

The Healthwise intervention seeks to reduce risk behaviours in youth by delivering the programme in life-orientation classes in schools and various complementary, health promoting activities in communities. These activities focus on providing youth with opportunities to engage in positive behaviours during leisure time, such as community service activities or playing games with friends in safe environments. Youth learn and practice various skills to aid them to make decisions, regulate their emotions, resolve conflict, and overcome boredom in healthy ways.

This programme was developed, monitored and evaluated with a multi-disciplinary team in the Western Cape in conjunction with collaborators in Pennsylvania, USA. Initial results from a study assessing the impact of the programme in Cape Town schools indicate positive effects of the intervention, but a full report is awaited before recommendations to scale up the programme can be made.

Source: Caldwell L, Smith E, Wegner L, Vergnani T, Mpofu E, Flisher AJ & Mathews C (2004) HealthWise South Africa: Development of a life skills curriculum for young adults. *World Leisure*, 3: 4-17.

Mental health professionals

- Stay informed about developments in child and adolescent mental health interventions and continuously monitor and evaluate interventions and programmes that are being implemented.
- Integrate health promotion and illness prevention into treatment and rehabilitation services.
- Engage other key stakeholders and provide guidance on how to strengthen their roles in child and adolescent mental health interventions.

Other health care and social service professionals

- Integrate mental health screening into primary health care services.
- Integrate basic mental health promotion and illness prevention interventions.
- Liaise with mental health care professionals in providing comprehensive treatment to patients and make referrals for specialised care when appropriate.

Parents and primary caregivers

- Use positive parenting skills (eg positive reinforcement, behavioural modification) and build strong family relationships to support a child's development.
- Take care of own mental health as this will help with parenting and provide a good role model for the child.
- Seek help from social services, counsellors, or health care providers when concerned about a child and find out what can be done to support the child and the rest of the family.

Teachers and school administrators and youth leaders

- Build partnerships with NGOs, social services, community leaders, other schools, researchers, and mental health care professionals to create a health promoting environment at school.
- Understand how to detect and deal with or refer children or adolescents who are struggling with mental health, behavioural, and/or academic problems.
- Integrate universal mental health promotion and illness prevention programmes into school activities such as life-

orientation classes, school assemblies, extra-curricular clubs and other classes in the academic programme.
- Establish a wellness committee of staff and students who organise mental health promotion campaigns for the school community.
- Provide supportive services to youth who are struggling or have recently overcome mental health challenges.

Activists and advocates

- Create awareness about child and adolescent mental health and the need to integrate interventions at multiple levels.
- Advocate for the implementation of child and adolescent-friendly policies.
- Develop poster campaigns and self-help booklets with information, resources and activities that address pertinent youth mental health and risk behaviour.

Researchers

- Develop and evaluate programmes for a variety of settings and mental health issues along the full continuum of services.
- Disseminate information about child and adolescent mental health in accessible ways to all levels of stakeholders.
- Liaise and partner with multi-disciplinary service providers on the development, evaluation and dissemination of effective interventions and associated training.

Corporate entities, publishers and mainstream media

- Display brochures, magazines and adverts that promote child and adolescent mental health and suggest resources for difficulties with mental disorders or risk behaviour.
- Provide funding for child and adolescent mental health campaigns and interventions.
- Run advertising campaigns, develop self-help resources or publish stories or articles that address mental health and risk behaviour, and provide positive role models for children, adolescents, parents and teachers.

Policy-makers and legislators

- Integrate child and adolescent-friendly mandates and policies that support interventions in multiple settings and at individual, interpersonal, community and socio-cultural levels.
- Allocate resources for training, staff support, service delivery, monitoring and evaluation of evidence-based interventions along the full continuum of services for child and adolescent mental health.
- Develop a strategic plan that co-ordinates interventions.

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