Shifting perspectives: Towards a holistic understanding of child and adolescent mental health

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> *"There can be no keener revelation of a society's soul than the way in which it treats its children."*
>
> *Nelson Mandela, 8 May 1995*

Mandela's words speak deeply to our love and care of children, and our intuitive recognition of the benefits of investing in the well-being and development of the next generation. When Mandela spoke those words of hope at the dawn of our democracy, he also challenged us all to get it right for children. So, to what extent have we fulfilled our constitutional promise to 'heal the divisions of the past and establish a society based on democratic values, social justice and fundamental human rights; and to improve the quality of life and free the potential of all citizens'?

Children and adolescents' mental health is deeply rooted in the environments in which they live, and their health, well-being and hope for the future are steadily – and at times brutally – being eroded by poverty, violence, discrimination, and a climate crisis driven by the exploitation of human and natural resources. This matters not only for children today, but for the future of our society, as children's exposure to multiple risks and insults accumulates over time, causing long-term harm that ripples out across generations. This issue of the *South African Child Gauge* also challenges the reader to consider what is needed to promote mental health, well-being and resilience, and enable South Africa's children to thrive.

In this chapter we explore how children may move along a continuum of mental health in response to their changing life circumstances. We describe how young people in South Africa continue to experience a significant burden of mental disorders, and how children's mental health is shaped in powerful ways by their psychosocial, political, economic and physical environments. Finally, we consider how children's rights can be used as a tool to enhance the provision of mental health services, address the social and environmental determinants of health and create an environment that supports children's optimal health and development.

What is the mental health continuum?

When we think of mental health problems or mental disorders, we tend to think in binary terms, as if there is some imagined point at which a person moves from being well to unwell. Having a line is important for diagnosis to enable treatment, but mental health is more complex than this and thinking in binary terms is not useful, especially given the fear and stigma associated with mental disorders that often prevents people from speaking out, seeking care or offering help. For many, mental health is understood as a subjective feeling of well-being and happiness. Yet, this is only part of the story, as mental health is crucially about our ability to cope with life's challenges and respond in appropriate ways to stressors and negative events. Another source of confusion is the way in which concepts such as mental health, mental well-being, mental illness or mental disorders are used interchangeably. This often leads to a narrow focus on treatment of mental disorders, with little effort to promote mental health and well-being. It is therefore helpful to conceptualise mental health and well-being as falling on a continuum,[2] as illustrated in Figure 1.

On the one end of the continuum, children are thriving. They feel good about themselves, are in optimal relationships and perhaps feel a contentment about their place in the world. They are able to cope and respond appropriately to everyday stressors. In this formulation, mental health relates to children's overall capacity to live their lives with agency

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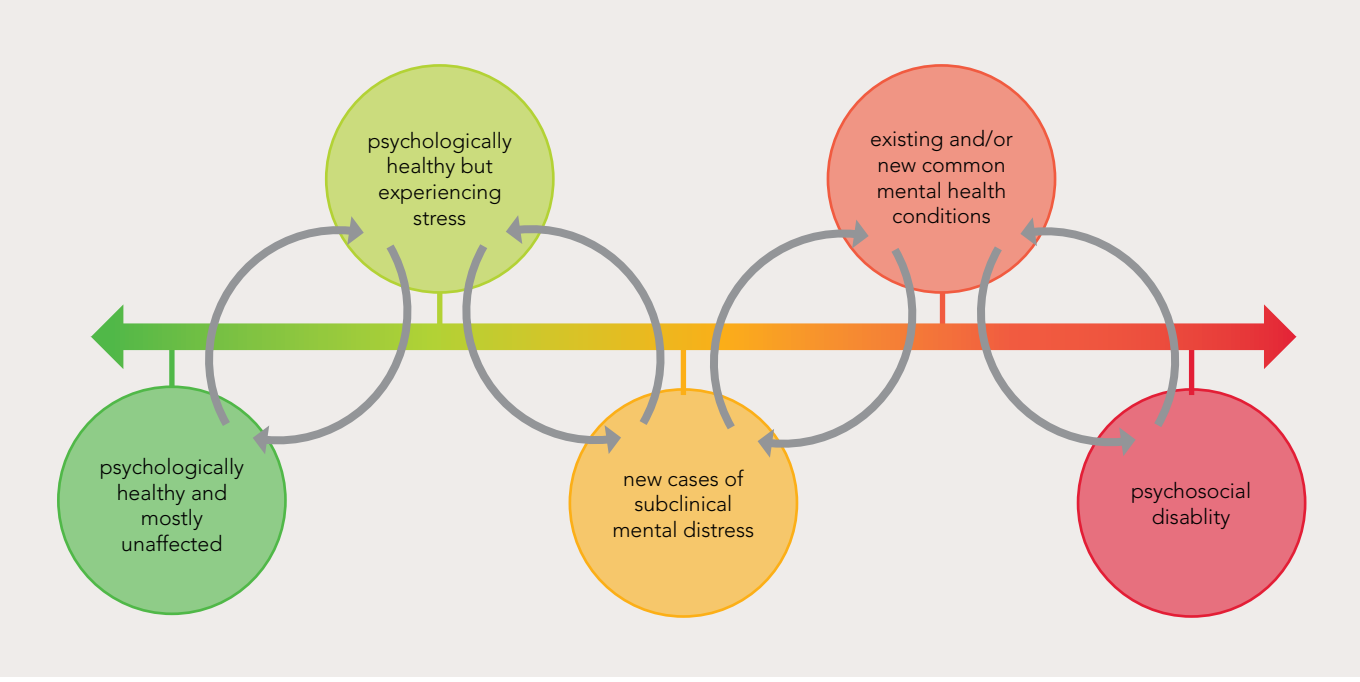
in the world, engaging their developmental potential for thought, emotions and behaviours in ways that enable them to cope with the everyday stresses of life. It is about their capacity to have meaningful relationships with others with whom they can be fully themselves, to be productive in study or work and to contribute to their community.[1] Children and adolescents who are 'thriving' experience contentment and happiness, and possess the ability to self-regulate, manage adversity and engage with life tasks with enthusiasm and to full potential. Young people who are 'surviving' still cope with their everyday routines, but may be worried, anxious, and distressed about one or more life areas. Children who are 'struggling' experience regular feelings of anxiety or low mood, worry excessively, have difficulty coping with their schooling or work, and may have poorer quality relationships. This does not constitute a mental disorder, but children may find the tasks of daily life more difficult, may start to exhibit signs of subclinical mental distress, and may take up maladaptive, self-soothing behaviours such as substance use. In these situations, children may need additional support, and intervening early helps to prevent them moving further along the continuum. Without intervention, a young person may move to a mental state of feeling severely anxious or depressed, not coping with their daily tasks, avoiding social interaction or engaging in more risky behaviour while experiencing significant emotional pain and suffering, and may even consider taking their own lives. Early recognition to mobilise supports to enable children to address these life challenges is therefore essential and can build resilience and promote recovery and a return to thriving (see Case 2).[2]

Within this mental health framework, children's capacity for engagement is shaped by their experience of mental health problems and their state of mental well-being: where mental well-being refers to children's subjective experience of psychological, emotional and social well-being, and their sense of satisfaction with themselves as people and of the quality of life they are leading .[1-4]

Mental illness can also be described on a continuum, ranging from a mild, time-limited illness to a longstanding, severely disabling condition. For example, a young person might experience a once-off episode of disabling clinical depression following a complicated bereavement and then fully recover, another might experience episodic disabling anxiety with major life transitions, while a third might experience a longstanding, persistent mental disorder which may give rise to a psychosocial disability that requires significant psychiatric, community and family support to assist the child or adolescent to cope at school or university, to enjoy creative and meaningful pursuits, to find and keep a job and to have satisfying relationships with others across the lifespan. So, children with mental disorders can – with support – experience well-being, thrive and lead a satisfying life.

Figure 1: The mental health continuum



Adapted from: Sherr, L., Cluver, L., Tomlinson, M., Idele, P., Banati, P., Anthony, D., Roberts, K., Haag, K., & Hunt, X. *Mind Matters: Lessons from past crises for child and adolescent mental health during COVID-19*, UNICEF Office of Research – Innocenti, Florence, 2021.

Box 1: Commonly used mental health-related terms

Mental well-being: A subjective sense of psychological coherence, emotional stability and social connectedness in environments that are experienced as supportive, promoting the flexibility and resilience to adapt in situations of stress and adversity (adapted from Keyes, 2002).[2]

Mental health: Ability to act with agency in environments that support best efforts to reach potential, capacity for meaningful relationships with other people, the skills to adapt and cope with adversity and common stresses of life and to contribute to one's community.[3]

Mental health problems: A disturbance in mental health and well-being that results in emotional and interpersonal distress and some difficulty coping with everyday stressors, but not severe enough to warrant a clinical diagnosis of a mental disorder (adapted from Lancet Commission, 2018).[1]

Mental disorders: Disturbances of thought, emotion, behaviour, and relationships with others that lead to substantial suffering and functional impairment in one or more major life activities, as identified in the major classification systems such as the WHO International Classification of Diseases and the Diagnostic and Statistical Manual of Mental Disorders.[1]

Psychosocial disability: Refers to young people's experience of enduring mental and emotional distress 'in interaction with various barriers…(which) hinder their full and effective participation in society on an equal basis with others'.[5]

Recovery: A process of change through which individuals experiencing enduring mental health problems improve their health and wellness, live a self-directed life, and strive to reach their full potential.[6]

Why is this important?

Acknowledging that all of us exist somewhere on this continuum, and that across our lives all of us can experience any aspect of this continuum in response to life experiences, is a fundamental way of de-stigmatising mental health problems. For example, the vagaries of mood, of everyday sadness and anger, are not the same as having a mental disorder. Anxiety, even for a few days, is not the same as panic disorder. Mood fluctuations are a perfectly normal part of child and adolescent development. While most children will recover on their own, it is important to recognise where a child is located on the continuum and when they need additional supports, and at what point they need to be referred to a mental health professional.

Children require a broad spectrum of support, with the first line being provided by caregivers, extended family and peers. When a child begins to feel some stress, they do not require professional intervention or a diagnosis. Far from it, what they most need is to feel safe with and supported by caregivers. Even in the immediate aftermath of a trauma, the best thing to do is to help the child feel safe and warm and contained. Some children might require counselling if symptoms of difficulty emerge. If symptoms persist, and the functioning of a child at school or in their peer group appears to be threatened, then this is the time for more professional support or treatment. Understanding mental health as a continuum also highlights how there are always risk and protective factors at play – where protective factors promote children's mental health, well-being and resilience, and risk factors intensify mental distress and increase the chances of children developing a mental disorder. In other words, mental health is not simply located in the mind, it is shaped in powerful ways by children's relationships, life events and living conditions.

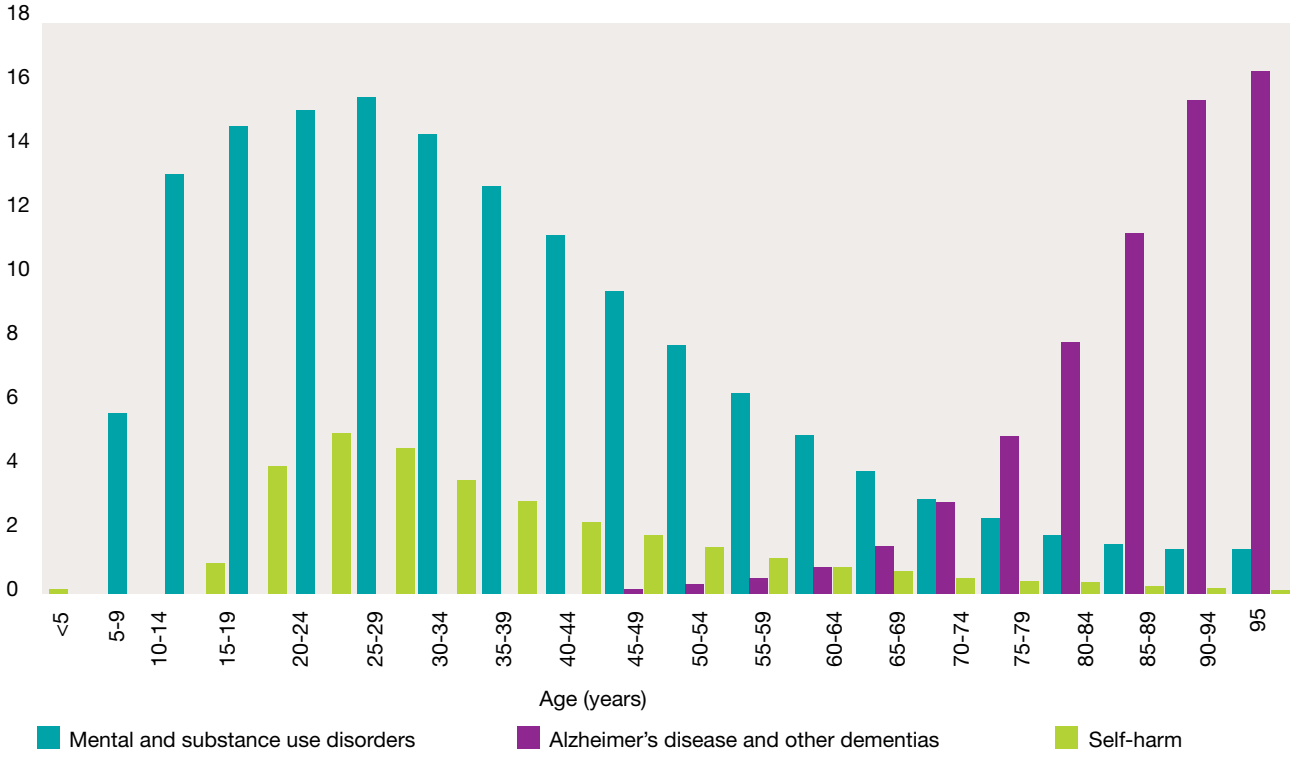
What are the current burden and long-term costs of child and adolescent mental disorders?

It is estimated that mental disorders account for 13% of the global burden of ill-health among 10 – 19-year-olds.[7] Depression, anxiety and behavioural disorders are particularly prevalent amongst adolescents. Approximately 20% of young adults have a disabling mental disorder,[8] and a systematic review of adolescent mental health problems in sub-Saharan Africa found a higher prevalence of mental disorders than in other low-to-middle-income countries.[9]

In the absence of a national prevalence study, data on the burden of child and adolescent mental disorders in South Africa are limited.[10] The 2009 South African Stress and Health study[11] did not include children and adolescents, and a somewhat dated expert consensus study estimated an overall annual prevalence rate of 17% for mental disorders occurring in childhood and adolescence in the Western Cape.[12] Yet, even without reliable prevalence data, it is clear that many children in South Africa are failing to thrive due to widespread violence, discrimination and poverty[13] and that our failure to prevent, promote and treat mental disorders will become increasingly costly.

Children and adolescents are vulnerable to a range of mental disorders. One of the leading causes of illness and disability during adolescence is depression[7, 14] and rates increase rapidly between early- and middle-adolescence, particularly in contexts of family depression[15]. Depression contributes directly to suicide, which is the fourth leading cause of death amongst 15 – 19-year-olds.[7] Anxiety disorders often co-occur with other disorders like depression and are associated with increased rates of anxiety and depression and adverse outcomes in adulthood.[16] Other disorders requiring attention include psychotic disorders, autism spectrum disorders, attention deficit hyperactivity disorder (ADHD),

Figure 2: The global burden of mental health conditions across the life course



Source: Global burden of disease health data (2016) Reproduced with permission from: Patel V, Saverna S, Lund C, et al. The Lancet Commission on Global Mental Health and Sustainable Development. *The Lancet*, 2018;392: 1553-1598.

post-traumatic stress disorder (PTSD), learning disorders and conduct disorder, among others. In addition, there is a high burden of substance abuse disorders in South Africa, where 20% – 49% of those admitted to drug treatment centres in the first six months of 2020 were 10 – 19-year-olds.[17]

Alcohol exposure can have devastating effects on children's development and mental health, with South Africa having the highest rate of Foetal Alcohol Spectrum Disorders in the world.[18] A South African Medical Research Council study found that a large percentage of adolescents in the Western Cape reported alcohol (60%) and cannabis (23%) use, with over half of the large sample being at medium to high risk for mental health problems.[19] A study of 1,034 young people in Cape Town found that those exposed to violence had much higher odds of having PTSD, with the likelihood increasing as the degree of exposure to violence increased.[13]

Early intervention matters

Half of all adult mental health problems have their origins prior to age 14, and 75% by age 24,[20] making early prevention and promotion essential. Figure 2 provides a stark portrayal of how the burden of mental disorders shifts with age and how most mental disorders have their origins in childhood and adolescence. Across the life course, mental and substance use disorders peak in late adolescence and young adulthood, as does self-harm.

As Desmond and colleagues have pointed out, when we fail an individual child, the lifetime and generational impact is felt at a societal level.[21] The costs of not intervening, of not strengthening families and support systems for vulnerable children and families, and of not improving platforms (such as schools and health facilities) to better support children and families, are huge.[21] Investing early is a moral imperative but investing early is also perhaps the best investment that can be made in the generational health of our society, in that it offers an opportunity to break the cycle of poverty, violence and mental ill health.

What are the key drivers of poor mental health?

The United Nations Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health argues that: 'Mental health and well-being cannot be defined by the absence of a mental health condition, but must be defined instead by the social, psychosocial, political, economic and physical environment that enables individuals and populations to live a life of dignity, with full enjoyment of their rights and in the equitable pursuit of their potential'.[22]

Case 1: Putting children's perspectives at the centre of our analysis

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Child well-being is often reported on using pre-determined objective indicators (statistics on social and living conditions, excluding self-perceptions and independent of personal evaluations) of children's living conditions, which are distilled from population-based surveys and administrative data (data collected from government institutions to facilitate the delivery of services and programmes). For example, over the past 28 years, the South African government has made significant progress in developing strategies to measure the extent of child poverty and children's access to education, health care, housing, water, and sanitation.

However, using objective indicators as the exclusive means of determining child well-being is limited. In recent years, a strong argument has been made for the inclusion of children's subjective perceptions, which are measured by asking children to evaluate their own lives and living conditions. While this subjective, or self-reported, stance on well-being is well-known in the adult literature, there has been less investment in empirical research with children and adolescents. Yet, there is sound scientific evidence that subjective and objective indicators of well-being are strongly associated and it is now well-established within the scientific literature that both objective and subjective indicators are important considerations in the assessment of the overall well-being of children.[96]

Asking children their opinions also highlights the importance of children's active and authentic participation in the decisions, processes, programmes, and policies that affect their lives. In South Africa, child participation is deeply enshrined in a range of legal and policy frameworks, including the Children's Act. As a general principle, it should guide the design and implementation of policies and programmes to ensure they give effect to children's 'best interests'. Similarly, child-centred approaches to research position children's subjective understandings or 'standpoints' at the centre of enquiry.[97]

What do we mean by subjective and psychological well-being?

The concept of well-being has its origins in the Greek philosophical concepts of 'hedonia' and 'eudaimonia', collectively referred to as self-reported well-being in research with children and adults. Figure 3 provides a visual representation. Hedonic well-being focuses on life satisfaction, happiness, and subjective well-being (SWB), denoted as 'feeling well', representing the good life, and concretised as experiencing happiness. [98, 99] SWB is a multifaceted expansive concept that comprises cognitive and affective components, including individuals' perceptions, experiences, reflections, and appraisals of their lives.[100, 101] The cognitive component refers to global and domain-based life satisfaction, while the affective component refers to positive and negative affect.[102] When we ask children about their SWB, we are asking them to which extent they are satisfied with their lives in general and with certain aspects of their lives (such as family life, friends, or school), and how they feel about their lives, both in terms of positive and negative emotions.[103]

By contrast, eudaimonic well-being focuses on the extent to which an individual is fully functioning in society. This includes having a sense of purpose and meaning in life, autonomy, life goals, opportunities for self-actualisation, and is often described as 'psychological well-being' (PWB).[104-107] The eudaimonic orientation of PWB reflects an historical shift of the conceptualisation of health advanced by the World Health Organisation in 1946, from a focus on risk and illness to an emphasis on well-being and factors that support human health,.[108] This paradigm shift aligns with a growing interest in positive psychology, and positive social science more generally. In the field of child research, the construct of children's PWB has not received much attention, largely as a result of a widely held belief that children lack the cognitive capacity to reflect meaningfully on their PWB. Recent studies provide contrary evidence, and have distilled valuable data on children's PWB.[109]

What do we know about child well-being in South Africa?

Savahl and Adams[110] used a population-based sample of 10 – 12-year-old children to examine children's SWB and PWB, as part of the Children's Worlds: International Survey of Children's Well-Being. Unique to this study was the inclusion of children's perspectives in the development of the questionnaire. Scores on children's SWB and PWB are usually presented on a 100-point-scale, with scores typically ranging from 70 – 90 with a mean of 80. The results of the national survey showed a SWB mean score of

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86.10 and a PWB mean score of 85.90. This suggests that children across South Africa are presenting with scores above the expected mean. These scores place South Africa in the midpoint of the distribution in comparison with other countries participating in the global survey.

However, in relation to specific aspects of children's well-being there were varying results in comparison with other countries. South Africa scored higher than other countries in relation to children's 'satisfaction with their life as a student' and the 'things that they learned at school'. These findings point to the important role that school plays in children's lives and their experiences of well-being. Interestingly, South Africa's children also scored relatively well on 'body image' in comparison with the other countries. However, a comparative analysis of the scores across a range of other aspects of children's lives presented concerning results. For example, considering children's safety across contexts (home, school, and the neighbourhood), South African children presented with the lowest scores for feeling safe in comparison to other countries. More than 10% of children indicated feeling unsafe at home, more than 13% at school, and more than 30% in their neighbourhood and community.

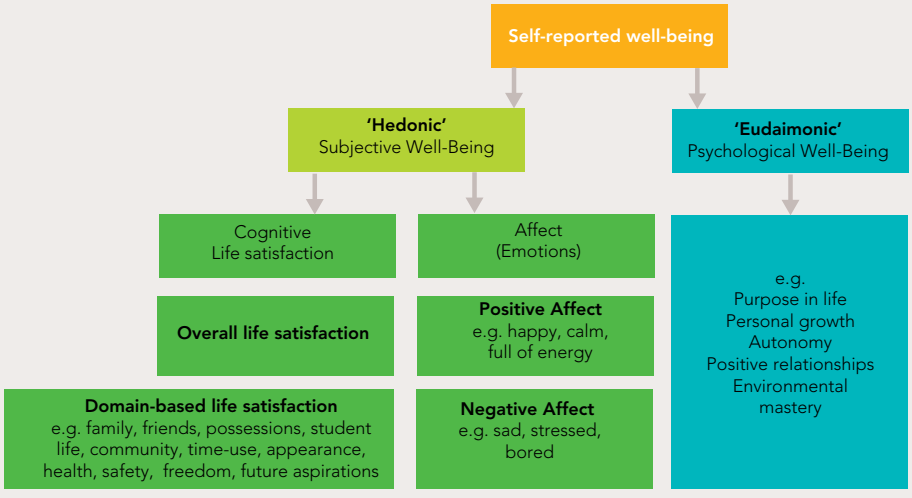
Further, it was found that bullying, victimisation and school violence were among the highest in comparison to the other countries, across all forms of bullying. Children from South Africa also indicated feeling 'least safe' 'traveling to and from school'. South African children also ranked relatively low on satisfaction with their family; the home where they live; relationships with classmates; and their perceptions about their future. The study further found that positive social relationships, access to safe spaces, spending time with family and friends, and lower levels of material deprivation were all associated with higher levels of well-being.

How can we enhance children's well-being?

Further research is needed to establish which factors contribute to higher or lower levels of SWB and PWB. A starting point for addressing this would be to consider UNICEF's multi-level framework of child well-being,[111] which illustrates how children's well-being and development is influenced by their interactions with their environment. This includes the immediate 'world of the child', the 'world around the child', and the 'world at large'.

The end-goal should be to develop child-friendly societies where the well-being of children is embedded in both the physical spaces and the social dynamics that shape social and community life. While national policies are critical in addressing the structural factors influencing families and communities, we suggest that a bottom-up approach, focusing on local policies and regulatory frameworks, would likely yield more impactful results. In both cases, these efforts need to start by (re)conceptualising children's position in society – from passive beings to active citizens and rights holders. This requires an acknowledgement of children's agency, not only as social actors engaging in different contexts, but also social agents affecting and shaping their social and physical environments, so that their views and experiences inform the design and delivery of services and support.[96]

Figure 3: Self-reported well-being



Adapted from: Rees, G., Goswami, H., Pople, L., Bradshaw, J., Keung, A., & Main, G. (2013). The Good Childhood Report. London: The Children's Society

The social ecological model

The social ecological model is perhaps the most widely used and well-known model in medicine and social science. Figure 4 shows how children are nested first and foremost within the family, and certainly for the infant and young child, the influence of the family is huge. But the social ecological model also highlights how even the most insular, and seemingly 'untouched' family, is embedded within communities (that may have high levels of violence and pollution), which in turn are embedded within broader political systems (where the rights of the child and their caregivers may not be protected). In addition, we are increasingly understanding the key role played by the commercial determinants of child and adolescent nutrition and mental health. Children and adolescents are bombarded from an especially young age by social media and advertising for junk food, alcohol, tobacco, gambling and an endless array of products that exploit their vulnerabilities and need for affirmation and belonging.[23]

Embodiment: Krieger uses the term 'embodiment' to illustrate how children's physical and mental health and well-being are shaped by – and embedded in – their environments.[24] In other words, our bodies (and our humanity) cannot be divorced from the social and material conditions of our existence. The socio-economic, political and environmental conditions in which we live become embodied in our bodies and psyches, giving rise to our experiences of health and/or disease at the individual, family, community, national and global levels – where societal patterns of disease reflect the biological consequences of how power and resources are distributed in society. These environmental impacts on our bodies and minds also shape individual power and agency, and the extent to which we are in a position to recognise the

Figure 4: The social ecological model

stories our bodies may tell, and if we are able to, allowed to, or choose to tell those stories.[24, 25] Embodiment therefore also speaks to the relative power of children and adolescents, their families and their communities to be physically and mentally well, and to act with agency to improve their circumstances.

Inflammation: Another way of thinking about embodiment is by way of understanding inflammation. When the body detects a threat, experiences an environmental injury or is stressed and damaged, it mounts what is known as an inflammatory response.[26] Marya and Patel refer to this inflammatory response as our bodies' ancient mechanism of self-healing.[27] The response involves multiple cells and molecular messengers, whose aim is to restore balance. The way our body works is that when the injury is healed or the threat disappears, the inflammatory response is switched off.[27] This is how it is supposed to work. However, when the threat or trauma is chronic, when violence is repeated, the inflammatory system does not get 'switched off', resulting in a hyperinflammatory response.[26] Marya and Patel describe this as a 'smouldering fire'[27] that creates ongoing damage such as triggering diseases, most notably a number of psychiatric disorders.[26] There is increasing evidence of how trauma and PTSD are associated with inflammatory diseases,[28] which leave 'deep wounds, and the immune system keeps those stories alive in the body' (p69).[27] It is not only experiences of violence and environmental insult that result in increased inflammation. Racism and other forms of discrimination are associated with chronic inflammation in adulthood and these are mediated through stress.[29]

Violence: Children in South Africa are exposed to extremely high levels of violence, including all forms of abuse and exposure to intimate partner violence.[30] High levels of exposure to violence (85%) were found to increase the likelihood of experiencing depression, anxiety and PTSD,[13] while South African adolescents who reported sexual violence were two to three times more likely to report PTSD, anxiety or depression than those who had not.[31] Sexual violence, with a prevalence of 35% amongst adolescents in South Africa,[27] has a strong association with unintended pregnancy in girls and adolescents,[32] which can have detrimental mental health, physical health and socio-economic impacts for girls and the children they bear.

Economic hardship: The strain of living in poverty is a form of 'slow violence'[33] which steadily erodes the mental health and well-being of children, families and communities, and is often accompanied by problems such as food insecurity, violence, crime, illicit alcohol and drugs, crumbling infrastructure and poor access to basic services. Exposure to adverse economic events (such as a global recession or losing a job) can intensify stress within the family and precipitate an increase in mental health problems.[30] At the same time, economic hardship reduces families' ability to travel to and pay for mental health services, helping fuel a cycle of poverty and poor mental health (see Figure 9 on p45).

Treatment gap: An estimated 90% of children with mental disorders in South Africa are unable to access mental health care.[31] The unmet need for mental health care is associated with poorer performance at school, and risk-taking behaviours such as substance abuse and criminal activity, which then impacts on skills development, readiness for adult life roles, social and economic independence and ability to contribute to family economic security.[34] This is one of the strongest motivations for intersectoral collaboration to strengthen support systems and to address both the root causes of poor mental health, as well as to ensure better health promotion and prevention using different platforms (see the schools chapter).

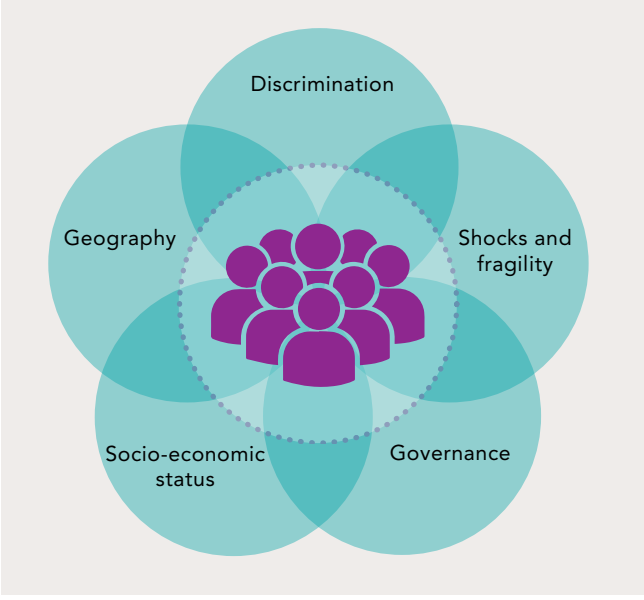
Discrimination and exclusion: Discrimination along the lines of race, ethnicity, gender and disability, for example, interface with income, education and geographical location to shape health inequalities. Discriminatory pathways include economic and social deprivation, excess exposure to toxins and hazardous conditions, social trauma, inadequate medical care and ecosystem degradation and alienation from land.[25] In the South African context, historical systems of slavery and the dispossession of indigenous people during the early colonisation of South Africa, coupled with systemic structural segregation during apartheid, and the failure to address the racial and ethnic polarisation still prevalent in the country[36, 37] has left the majority of young South Africans struggling with endemic post-apartheid poverty. This locks young people and their families within an intergenerational cycle of poverty and deepening income and health inequalities.[38]

Racism: Recent global events, such as the Black Lives Matter Movement, have also brought attention to the widespread negative impact of historical, institutional and socio-cultural patterns of race-based discrimination on the mental health and trauma of black, indigenous and other people of colour. Black, indigenous and other young people of colour are more likely to experience, for example, implicit and explicit exclusion and devaluation, differential access to societal resources, lack of safety, and increased risk of entering a correctional facility rather than be referred to mental health services.[35] Within mental health settings, language barriers and the impact of cultural factors on symptom expression may also impact on practitioner intervention choice for black, indigenous and other young people of colour.

Gender: Gender is a key determinant of mental health across the life course. Sex differences in the prevalence of mental disorders in children and adolescents are common with males having significantly higher prevalence rates of ADHD, autism spectrum disorder, oppositional defiant disorder (ODD) and conduct disorder.[40] Towards the end of adolescence, adolescent females are more likely to be diagnosed with anxiety and mood disorders.[36] In adulthood, depression is diagnosed twice as often in women than in men. Increasingly, there is also the recognition of how diversity in gender identity is associated with poor mental health in children and young people.[40]

Disability: Children with neurodevelopmental disorders, such as intellectual disability, autism spectrum disorder, ADHD and specific learning disorders experience a higher prevalence of mental health problems than the general population, yet services and expertise to address their mental health problems are underdeveloped in the South African context. For young people with co-occurring mental disorders and intellectual disability, for example, accurate understanding and diagnosis of stress or mental health problems are challenging as these conditions may present atypically, with behaviour such as aggression or self-injury, as well as developmental regression and loss of communication skills.[41] In a context where clinical skills training in working with people with intellectual disability is lacking, and patients struggle to communicate their experiences, mental health problems or disorders may go undetected and untreated in people with intellectual and developmental disability.[42, 43]

Figure 5: What does it mean to leave no-one behind?



Source: United Nations Development Programme. *What does it mean to leave no one behind? A UNDP discussion paper and framework for implementation.* New York: UNDP. 2018.

Intersectionality: Over the past 30 years there has been a growing recognition that experiences of discrimination along the lines of age, race, class, gender, ability and other individual characteristics are not isolated and distinct, but rather 'intersect' with one another in complex, cumulative and often mutually reinforcing ways that serve to marginalise, silence or exclude certain individuals or groups, and to perpetuate the play of power and privilege in society. For example, whilst adolescent girls may share much in common due to their age and gender, their experiences also diverge and are shaped in different ways by their 'race', 'age', 'class' and 'sexuality'. Adopting an intersectional lens can help mental health professionals, policy makers and programmers become more attuned to how social norms and the play of power in society shape the unique lived experiences of individuals and communities, and encourage them to partner more intentionally with individuals, groups, communities and children to challenge discrimination and develop strategies that promote mental health, well-being and inclusion across a range of settings including families, schools and health facilities.

Figure 5 captures the ways in which certain groups of children are subject to multiple and compounding experiences of deprivation and exclusion, including: children living below the poverty line, children living in rural areas or informal settlements who have poorer access to services and economic opportunities, and children who experience discrimination, including children with disabilities, adolescent mothers and children of immigrants, refugees and asylum seekers. It also draws attention to how these patterns of disadvantage may be intensified by shocks such as economic recession and climate change, and/or poor governance, where corrupt or unaccountable or unresponsive officials fail to deliver services.

It is children at the intersection of these five circles who are most likely to be silenced, rendered invisible and left behind in our pursuit of the Sustainable Development Goals, and who need to be actively included and prioritised if we are to move beyond the rhetoric and realise the vision of the Constitution and the National Development Plan.

COVID-19: Humanitarian crises and shocks such as conflict, climate change and pandemics tend to intensify inequalities and highlight the fragility of our support systems in ways that leave children particularly vulnerable. For example, the COVID-19 pandemic and associated lockdown measures severely stretched the capacity of families to maintain

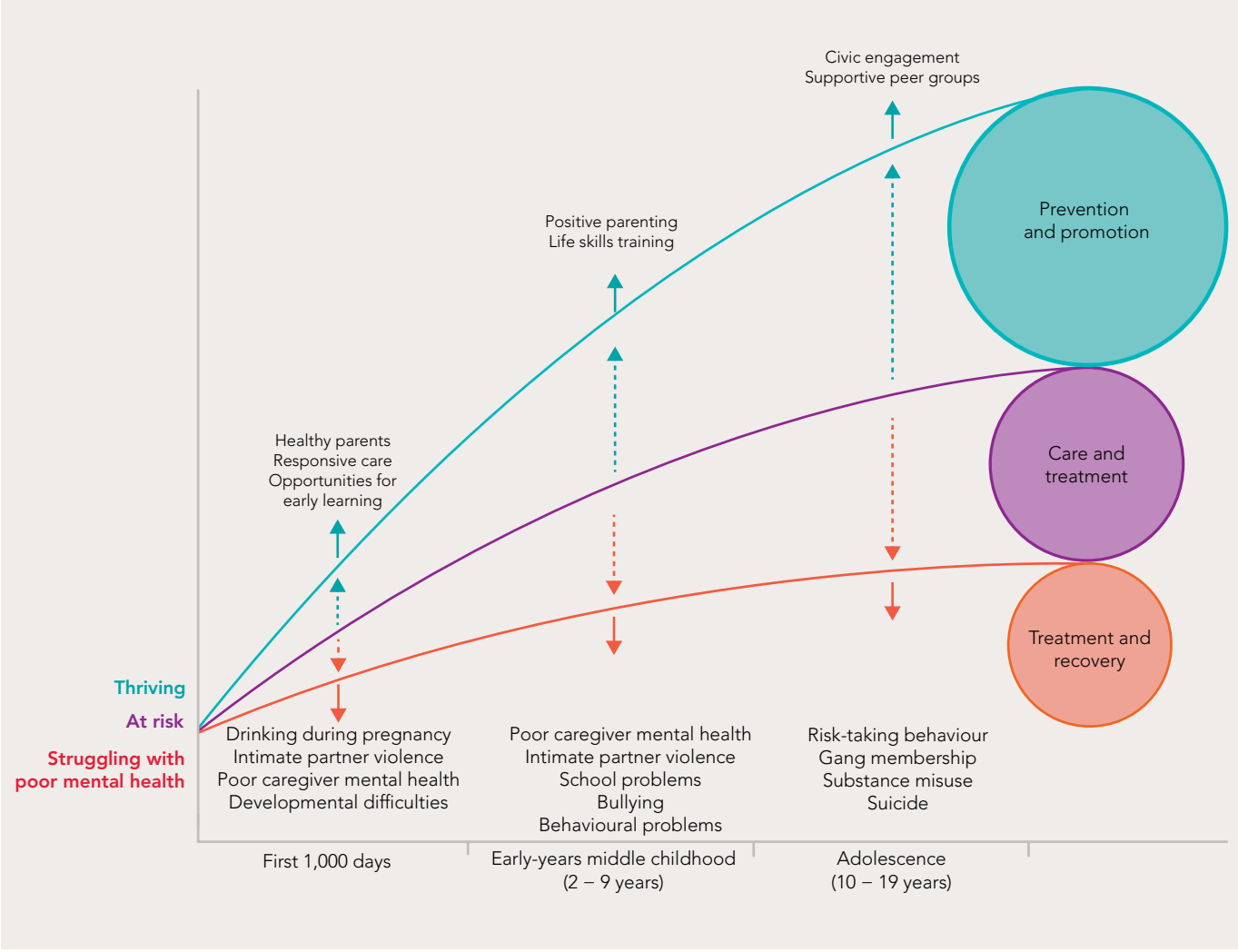
their sense of well-being and mental health, and disrupted access to social and environmental supports, including food, income and other essentials. It has reduced opportunities to attend school and to work, threatening the security of homes and reducing the mental health and capacity of parents and other supporters to maintain a stable, emotionally regulated and secure environment. The human need for relationships, contact with family, friends and neighbourhood support was disrupted, and many families are still grappling with the loss of both loved ones and livelihoods.[44, 45]

Climate breakdown: Rising temperatures and extreme weather events such as floods, fire and droughts, are threatening food and water security, destabilising communities and increasing stress and the propensity for aggression.[46, 47] It is therefore not surprising that climate breakdown is impacting on child and adolescent mental health and giving rise to anxiety, depressed mood and trauma from exposure to natural disasters and resultant displacement, as well as young people's growing awareness of the existential threat to their future (see Case 34 on p153). In addition, the environmental, social and health impacts of climate change are likely to intensify existing inequalities, with the effects concentrated more intensely on already marginalised communities[48] and children whose developing bodies and brains are particularly sensitive to environmental exposures[49].

Enabling environments

All of these social and environmental determinants have a profound impact on children's mental health and well-being. Yet, their impacts are also mediated in significant ways by the immediate world of children's families, friends and communities. Secure attachment, self-regulation, self-

Figure 6: Protective factors and risk factors in the early life course



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Case 2: Resilience – A multisystemic, contextually responsive process

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Across the world, child and adolescent health and well-being are threatened by significant shocks and stressors, many of which appear to be relentless, such as armed conflict and other forms of violence, the threats of climate change, and multidimensional poverty. Given this harsh and apparently intractable reality, multiple researchers are committed to understanding – and mobilising – the factors and processes that support young people's resilience or capacity to function adaptively (i.e., to be/do okay), despite significant risks to their health and well-being.[84] Positive outcomes associated with child and adolescent resilience in South Africa include minimal symptoms of psychological distress, continued school engagement, and young people's positive contributions to their household, family, and/or community.[85]

Resilience is misrepresented when positive outcomes are solely or mostly attributed to young people's personal strengths. While earlier studies did attribute positive outcomes to young people's personal strengths, current resilience science emphasises how human resilience is facilitated by promotive and protective factors and processes across multiple systems, both within the individual person and outside of them.[86, 87] Put differently, resilience draws on biological, psychological, social, institutional and environmental resources that work together to produce positive outcomes. These resources can promote positive outcomes when exposure to risk is low and/or protect children and facilitate positive outcomes when exposure to risk is high. For example, a systematic review of 61 South African studies of child and adolescent resilience showed that young people's positive outcomes were shaped by a combination of resources from multiple systems.[85] These included:

- physical health,
- psychological strength (e.g., being goal-directed or making hopeful meaning),
- social support (from family members, peers, community members, teachers, and/or service providers),
- financial resources (e.g., prospects for employment),
- quality schooling,
- facilities in the immediate built environment (e.g., recreational centre, library, or safe spaces to play), and/or
- opportunities to engage in enabling religious or cultural activities.

Although some resources (e.g., warm caregivers) recur across studies of resilience,[84] there is increasing interest in how some resources have greater impact on positive outcomes than others, with some sense that social and ecological resources may matter more than personal ones in places where there is higher risk and adversity.[88] The usefulness of resources – and even what form they take – could relate to young people's stage of development,[89] the severity of the risks they are exposed to,[88] and/or their socio-cultural context.[90] For example, a study with a sample of Australian Aboriginal adolescents found that high self-esteem supported positive mental health outcomes for adolescents in families with low or high levels of adversity, whereas peer support only enabled resilience for adolescents exposed to high levels of family adversity.[91] However, a South African study showed that peer support did not enable the mental health resilience of adolescents with experiences of domestic and other forms of violence.[92] Similarly, supportive peers did not facilitate school engagement over time for a sample of South African adolescents living in a stressed community. Instead, warm parents predicted the school engagement of adolescents younger than 16, and warm parents and competent teachers predicted the school engagement of adolescents older than 16.[93] African resilience studies have shown that warm parents are not necessarily biological parents; they can be relatives (e.g., grandmothers or siblings) or non-relatives who take on a parent role (e.g., caring teachers; supportive social workers); and this more flexible understanding fits with the traditional African valuing of interdependence that is not limited to biological kin.[94]

These variations mean policymakers and practitioners should take care not to make assumptions about what is needed to best support the resilience of children and adolescents. Optimally supporting young people to be/do okay when their health and well-being is threatened, needs to be rooted in understanding 'which promotive and protective factors or processes are best for which people in which contexts at what level of risk exposure and for which outcomes'.[95] This understanding then needs to be translated into developmentally and contextually responsive interventions that facilitate and sustain these resources across multiple systems to build resilience and champion young people's health and well-being.

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esteem, self-efficacy, problem-solving skills, attributions, engagements and connections with others are all protective factors that promote resilience and positive development.[50] We also know that caregivers and families are foundational to ensuring optimal child development and to creating enabling environments that build resilience in children and adolescents.

A developmental life-course approach

Understanding child and adolescent development as a life-course enterprise allows us to examine the onset of health problems and understand how health disparities develop, are amplified, mitigated or reproduced across generations, to enable more effective interventions.[51] Specifically, this perspective helps us understand how social risks and opportunities create vulnerability or resilience at each life stage, and how they accumulate, or are reduced across lives and generations.[51] A life-course perspective shifts our understanding from simple, linear, and mechanistic explanations to a perspective that acknowledges that mental health is complex, interactive, holistic and adaptive.[52] Perhaps most importantly, it gives us a way of showing how both ordinary and extraordinary experiences may 'get under the skin'.[53]

Poverty, violence and substance use, coupled with limited access to sexual and reproductive health services, increase the risk of unwanted pregnancies and are associated with an increased likelihood of a woman drinking during pregnancy. This may compromise the health and nutrition of mother and her developing child and result in foetal alcohol syndrome. Food insecurity and domestic violence are also associated with maternal depression, which further compromises the mother's capacity to provide responsive and nurturing care in ways that may give rise to stunting and developmental delays. These children are then more likely to struggle at school and to exhibit behavioural problems that in adolescence make them more susceptible to risk-taking behaviours that may lead to truancy, school dropout, substance use, violence and adolescent pregnancy, which may in turn compromise the health and education outcomes of the next generation of children.

On the other hand, outcomes may be different where a mother is in a supportive relationship and can rely on a group of friends and a network of familial support. Where the household is food secure, and she is able to receive six months of paid maternity leave, she is able to be present for her infant and to exclusively breastfeed for six months. The presence of a supportive and responsive caregiver helps infants and children calm down and cope with adverse experiences when they occur.[54] It is important to state that in both scenarios, nothing is cast in stone (see Figure 6). Even in the worst-case scenario, there are numerous points on the poor mental health pathway for early intervention, referral and support. Optimal early life experiences may help children cope with turmoil later in life, but they are not an inoculation.

How can a human rights approach enhance child and adolescent mental health?

In November 2021, during the COVID-19 pandemic, the United Nations Human Rights Council hosted a consultation to strengthen a human rights-based approach to mental health laws, policies and practices. This includes a global effort to promote and protect the rights of persons with mental health problems or psychosocial disabilities within mental health systems, and to address the broader social, economic and environmental determinants of mental health.

The United Nations Convention on the Rights to the Child (UNCRC),[55] United Nations Convention of the Rights of Persons with Disability (UNCRPD),[56] African Charter on the Rights and Welfare of the Child (African Charter)[52] and the Bill of Rights in the South African Constitution together outline the State's obligations to promote children's optimal health and development by providing access to resources to meet their physical, psychological and social needs, protecting them from harm, and supporting their active participation in society.

Provision: Access to resources to meet basic needs

The UNCRC and African Charter recognise the right of children to the highest attainable standard of health, and to facilities for the treatment of illness and rehabilitation of health,[53, 54] as does the UNCRPD for those with disabilities[59]. This includes 'timely and appropriate prevention, health promotion, curative, rehabilitative and palliative services',[60] which should be available, accessible to all without discrimination, acceptable and of good quality.[61] But children's right to health extends beyond the provision of health care services and includes the 'right to grow and develop to their full potential and live in conditions that enable them to attain the highest standard of health'.[60] While parents and families have the primary obligation to care for children and provide the conditions needed to support their health, well-being and development, states have an obligation to assist in case of need[62] and to provide for the socio-economic rights of children, including their rights to basic education, health care services, social services, social security, housing and shelter.

Case 3: Promoting participation - Child monitors as advisors

Steps have been taken in realising children's right to participation. For example, the Western Cape appointed a Child Commissioner in 2020, tasked with independently protecting and promoting the rights, needs and interests of children in the areas of education, health, social development, cultural affairs and sport. The Office of the Child Commissioner actively engages children in governance, programme development and ad hoc project implementation. Children recommended by organisations working with children have been selected as Child Government Monitors who provide advice and recommendations to the Commissioner in fulfilling her monitoring and research duties.

In discussions held by Child Monitors at schools in August 2021, for example, children noted their concern about underfunding of mental health in schools, their need for equal access to counselling and support in public schools, the importance of education and awareness about mental health and the need to break down stigma associated with mental health concerns at schools.[82, 83]

While the state is obliged to progressively realise everyone's right to have access to health care services, sufficient food and water, and social security within its available resources, Section 28 of the Constitution guarantees children a direct and unqualified right to basic health services, basic nutrition, shelter and social services, which should be prioritised in the allocation of state resources. In addition, the United Nations Committee on the Rights of the Child has stated that even in an economic crisis, governments may only introduce regressive measures as a last resort, after considering all other options and ensuring that children are the last to be affected.[63]

Protection: Ensuring that children and adolescents are safe from harm

Children also have the right to be protected from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation,[60-62] economic exploitation[67-69] and harmful traditional, social and cultural practices[57, 70]. This includes the right of child victims of neglect, exploitation, abuse and any form of inhumane treatment to psychological recovery and social reintegration,[71, 72] and the right of children who are placed in care to have periodic treatment reviews.[73] The Children's Act specifies that the Department of Social Development should assist children in need of care and protection, including those with disabilities. This includes children who have been abandoned or orphaned without any support, live and work on the streets, are addicted to substances and without support to access treatment, live in or are exposed to circumstances that are harmful to their well-being, or are neglected, maltreated, abused or degraded by a parent or caregiver. The Act provides for prevention and early intervention programmes, including parenting programmes, counselling and mediation, to help children and families resolve conflicts and improve caregiving practices. It mandates social services and the courts to ensure that children in need of care and protection can access therapeutic services and alternative care and describes the role of social workers and psychologists in custody, adoption and parenting plans.

Children also have the right to play, rest, leisure and recreation, and the right to education that develops children's personality, talents and mental and physical abilities to their fullest potential and instils a respect for human rights and the natural environment.[73] Finally, children have a right to an environment that is not harmful to their health, and sustainable development that protects the environment for the benefit of present and future generations.[74]

Figure 7: Children's rights to mental health are interdependent and indivisible

Participation: Involving children and adolescents

Article 12 of the UNCRC asserts the right of all children to express their views in all matters that affect them (including judicial and administrative proceedings) and for their views to be given due weight in accordance with their age and maturity. The UNCRPD raises the need for assistance to realise this right for children with disabilities,[75] and obliges states to consult with and involve children with disabilities when developing legislation and policies[76]. Section 10 of the Children's Act[77] affirms children's right to participate in matters concerning them in the South African setting and provides clear guidance on children's consent to medical treatment, while the Mental Health Care Act[78] regulates consent to treatment by children with mental disorders.

In addition, children have the right to parental guidance consistent with their evolving capacities;[79] information which promotes their social, spiritual and moral well-being, and physical and mental health;[80] and health information that enables them to make informed decisions and take responsibility for their own health in ways that are age-appropriate and accessible to children (see Case 3).[81]

Non-discrimination and equality

These rights and freedoms are universal and apply to all children and states must put in place measures to protect children from discrimination. The South African Constitution is founded on the values of human dignity, equality and freedom, and Article 9 expressly prohibits discrimination on the grounds of 'race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth'. This extends beyond equal opportunity and includes measures such as affirmative action and reasonable accommodations to level the playing field and ensure substantive equality – or equal outcomes.

Finally, Section 28 of the Constitution asserts that child's best interests are of paramount importance in every matter affecting a child or group of children. This best interest standard should guide all decisions, actions and proceedings regarding the health, care, protection and well-being of the child – from custody disputes to the design and delivery of health care services.

Children's rights place a legal obligation on the state to put in place laws, policies, programmes and services – and the necessary human and financial resources – to give effect to these rights. Yet, despite developing a suite of ambitious laws, policies and programmes that aim to promote children's optimal health, development and well-being, poor implementation continues to compromise children's mental health, and violate their human rights. It is therefore essential to recognise that children's rights are also a powerful advocacy tool for transformation that can be used by health workers, teachers, social workers, policy makers, families and children themselves to challenge these limitations, hold government accountable, and actively champion children's best interests from their homes, schools and communities to the corridors of power.

Conclusion

Children and adolescents in South Africa are facing an uncertain future, so it is vital that we find ways to promote children's mental health and resilience, and ensure they are equipped to cope with life's challenges. These solutions need to extend beyond medical treatment and the health care system to address social and environmental drivers of ill health, and to create supportive environments that enable children to thrive. In our search for solutions, we need to radically re-orient our way of thinking about how we include children and adolescents in decisions about their future. This must include a strong focus on equity, and approaches that ensure the inclusion of all children – and particularly the most vulnerable such as children with disabilities who live in poverty – to ensure that no-one is left behind.

In this 16th edition of the *South African Child Gauge*, we have compiled a set of 10 chapters that examine current challenges and identify critical points of intervention to promote children's mental health and well-being across the life course, and across a range of settings. This includes a deeper examination of the social, economic and environmental determinants of child and adolescent mental health, and how positive and negative life events impact on children's development across the life course in ways that either enhance or undermine their mental health. We then consider how to create a more enabling and supportive environment by strengthening the role of families, educational facilities, health care services and digital platforms in promoting children's mental health, as well as the need for intersectoral collaboration to address complex challenges such as violence and disability. The final concluding chapter calls for a whole-of-society, life-course approach that places children – and child mental health and well-being – at the centre of all policies to create an enabling environment in which our children and the planet can thrive.

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