WHO and the mental health of children

Philip Graham & John Orley

WHO’s work on child mental health began with John Bowlby’s classic on the subject, written for WHO in the early 1950s. In the mid-1970s the Division of Mental Health was created, and this led to major advances in establishing a sound epidemiological and scientific basis for child mental health services. Significant contributions were made to the establishment of “biobehavioural” interventions to tackle the major causes of childhood mortality and morbidity throughout the world, and to provide better care for children with mental disorders at primary level.

From its earliest years, WHO has seen the mental health of children as a priority. In 1948 the United Nations commissioned a study on the effects of homelessness on children, and WHO offered to consider the mental health aspects of this problem. With this in mind, in 1950, John Bowlby, a then relatively unknown British psychiatrist, was appointed as a WHO consultant. He visited several European countries and the United States to carry out a study on children living in institutions of different types. His conclusions were published in WHO’s monograph series (1). They stressed that care in a family is the most appropriate form of care for children, and was much to be preferred to care in an institution. This meant, for instance, that when parental care irrevocably broke down, adoption into another family should be arranged as soon as possible. Long-term family foster-care was seen as a less satisfactory arrangement, but better than care in a children’s home. Emotional deprivation and frequent separations were seen as a major contribution to delinquency and to psychiatric disorders. In passing, the practice of separating babies from their mothers at the time of birth in hospital was roundly condemned in this report.

The fact that his findings now seem rather banal is a tribute to the influence of Bowlby’s ideas on social and health policies concerning children whose parents are unable to provide adequate care, and on the welfare of children in hospital. They are now so widely accepted as to appear self-evident. The monograph is surely one of WHO’s most successful. It has sold over 450,000 copies and been translated into at least 12 languages. Possibly, he understated the importance of fathers, and perhaps slightly overstated the significance of separation, but by the standards of his day, Bowlby wrote a humane and scientifically excellent document. Sometimes his

---

Dr Graham is Emeritus Professor of Child Psychiatry at the Institute of Child Health, University of London, England. Dr Orley was Programme Manager, Programme on Mental Health, World Health Organization, 1211 Geneva 27, Switzerland, at the time of writing this article; correspondence should be addressed to the Programme.
ideas were misinterpreted and led to the unnecessary closure of day nurseries and to guilt in mothers who left their children with quite satisfactory substitutes in order to go out to work. But overall, Bowlby’s work led to great improvements in the care of children in hospitals and other institutions.

**Planning for the mental health of children**

After this excellent start, however, there was a long interlude during which WHO did very little in the field of child mental health. During that time, WHO’s focus on the major causes of childhood mortality throughout the world meant that children’s mental health received little attention. It was only with the creation of a Division of Mental Health in the mid-1970s that a new initiative began in this field. The new division was partly the result of growing awareness that the most effective way to fight disease is at the earliest stage possible in the development of its causes. At least since the time of the founding of the United Nations after the Second World War, it had been widely recognized that the major causes of death and disability on a worldwide scale were malnutrition and infection. But then it became increasingly clear that malnutrition and infection, in their turn, are not caused only by shortages of food and resources. They are also caused by mental and social problems such as poor child care, lack of education, misleading dietary beliefs, and reluctance to participate in immunization campaigns.

In 1976, WHO convened an expert committee on child mental health and psychosocial development. The findings of this committee (2) are widely regarded as a landmark in the identification of child mental health issues worldwide and in the planning of child mental health services, especially in countries where the relevant professional expertise is scarce. In keeping with Bowlby’s earlier findings, the Committee stressed the paramount importance of the continuity of parent-figures. Parents should, for example, have unlimited access to their children in hospital, and early adoption should occur when parents are unable to look after their children. Preventive care programmes are needed in this field. Governments should develop resources at the community level for such programmes, and for treatment. An epidemiological approach was encouraged, especially as by this time reliable measures existed for recognizing and defining “cases” of disorder (3). Governments were also encouraged to work out policies which promote the mental health of children, and not to leave this to the health department; such policies should be formulated in cooperation with those involved in juvenile justice, education and social welfare.

One of the new Division’s tasks was to promote the development within countries of plans for child mental health. It worked out a national case study format, with guidelines for the types and amounts of information to be collected. These included:

---

The battle against preventable child mortality must continue, but attention is now turning to ways of enhancing the physical and mental development of the majority of children who in fact survive infancy.
- frequency and types of child mental health problems in the country concerned;
- their main causes;
- children's reactions to stress and socio-cultural factors such as the role of women, average family size, child rearing beliefs and practices;
- legislation;
- existing approaches and services for prevention and treatment of children's mental disorders.

The use made of the study format and guidelines was inevitably variable, but in some countries, such as Greece and Sri Lanka, they had a considerable impact.

Promoting health in early childhood

The last two or three decades have seen significant achievements in child health worldwide, as shown by indicators such as infant mortality, but major problems remain. Immunization against six vaccine-preventable diseases (diphtheria, tetanus, pertussis, measles, tuberculosis and poliomyelitis), undertaken with intensive support from WHO, UNICEF and the international community, saves millions of children annually from death and disability. The battle against preventable child mortality must continue, but attention is now turning to ways of enhancing the physical and mental development of the majority of children who in fact survive infancy. As Meyers has eloquently put it, one in 13 children die, but "the 12 who survive" also need care (4).

In parallel with progress in preventing mortality, other major international initiatives have influenced child health, such as the 1989 Convention on the Rights of the Child. By the end of 1995, 179 countries had ratified the Convention, committing themselves to "ensure that all children have the right to develop physically and mentally to their full potential, to express their opinions freely, and to be protected against all forms of abuse and exploitation".

Poverty is closely associated with child mortality and problems of child development, but there are great variations in child health even where economic conditions are about the same. Such variations have many causes. Governments vary in their commitment to child health, maternal education, health promotion and care delivery. Even in parts of a given country where food is equally available, some young children will become malnourished and others will not. Children whose parents are isolated, depressed, uninformed or misinformed about health and nutrition, or unskilled in child care, are obviously at much greater risk. "Biobehavioural" factors of this kind have been the focus of several WHO programmes undertaken in collaboration with UNICEF to find underlying causes and remedies for major childhood diseases. Some of these activities have been carried out within WHO’s programme on psychosocial and behavioural factors in human health and development, which has been an important part of the Mental Health Programme since it was founded.

In the area of early childhood, WHO and the health sector in general have put most
of their effort into promoting and maintaining the physical health of children, emphasizing safe delivery, breastfeeding, immunization and nutrition. There has been little response to the challenge expressed in the Convention on the Rights of the Child of “ensuring that children have the right to develop mentally to their full potential”. The mental, emotional and social growth of children has been largely left to other sectors, although it is health workers who tend to have the most contact with mothers and babies during the first year of life.

The importance of interaction

The mother is the most important person in a baby’s life for its physical and psychosocial care, and the psychosocial interaction between baby and mother is as important as the physical feeding and contact. Babies become positively distressed when their mothers do not respond to their signals. In most cases such “conversations” happen naturally, because mothers and babies are biologically conditioned for them, just as they are for breastfeeding. There are, however, occasions when this communication does not adequately occur, and the relationship suffers. For example, a mother may not find enough time to give to her baby, perhaps because she has too many children too closely spaced, or too many other tasks, with insufficient support. Some mothers are uncertain about how to respond to their children despite biological prompting; they may need help, just as some need help with breastfeeding. Advice and guidance to a young mother from her own mother or other experienced women are often not available with the breakdown of traditional family and social patterns. There might also be aspects of the child’s condition that inhibit interaction. A low-birth-weight baby in an incubator, for instance, cannot interact easily with its mother. Sensory defects such as those of sight or hearing, often undetected during the first months of life, also naturally impair communication.

In orphanages or other institutions the biological promptings of parenthood are largely absent, and the staff often need help in learning how to respond appropriately to children. It is all too easy for the carer in such institutions to be like a gardener, tending children as plants to be watered, fed and treated for diseases, rather than as people who need human interaction. Day care for babies should never be seen merely as a way of parking them, like cars in a garage. Even very young infants need to interact with those looking after them in order to develop well. To help carers provide good psychosocial as well as physical care, the WHO Mental Health Programme published a checklist of items for them to be aware of in their daily work (5).

It used to be thought that the mental health of children was better protected in the traditional extended family than in a modern nuclear one, but now this is questioned. Studies have revealed little difference in the prevalence of psychiatric disorders in children living in these two situations (6). In the infant and young child, feeding and sleeping problems are common. Physical and emotional abuse, as
well as non-organic failure to thrive also occur. In school-aged children, learning difficulties may become more evident. In adolescents, in many countries, violence, attempted suicide, homicide and road traffic accidents are major reasons for contact with health services, hospital admissions and death.

Throughout childhood and adolescence, medically undiagnosed physical symptomatology is a frequent reason for attending primary and secondary health care facilities. In developing and industrialized countries alike, about a third of those seeking care present with non-organically determined physical symptoms (7). There are still relatively few doctors, nurses and other primary health care workers who have learnt to assess and treat these very common symptoms for which no physical cause can be identified. Training in this area therefore continues to be a high priority.

References


