3.9 RESILIENCE-BASED MENTAL HEALTH INTERVENTION FOR STREET CHILDREN IN DEVELOPING COUNTRIES

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INTRODUCTION

"Street children" are an underprivileged group that is visible in public places of urban areas in developing countries. These children engage in informal economic activities to make a living for themselves and their families. They are found in every corner of the globe, but are more visible in developing countries in Africa, South Asia, and parts of Latin America (Thomas de Benítez, 2011). There is debate about the size of this population, with estimates ranging anywhere between several million and 100 million. Part of the difficulty in determining the exact number is the lack of a universally accepted definition of street children[1] (Thomas de Benítez, 2011).

These challenges aside, the question remains: Why do these children leave their homes for the complex hardships of street life? Research from developing countries tends to view children's movement to the street through two lenses: poverty and family dysfunction. Chronic poverty often creates unbearable conditions at home for young children and exerts pressure on family members to find economic means for survival (Ballet, Bhukuth, & Radja, 2013). In this situation, children migrate to the streets voluntarily or involuntarily to support their families. From the family dysfunction perspective, family environments that feature conflict, violence, abandonment, and authoritarian behaviour weaken or disintegrate ties among family members, prompting the child's eventual departure from the home (Ballet et al., 2013). Moreover, population growth, urbanization, war, and HIV epidemics affect the stability of economic and social institutions in developing countries; when these institutions are unstable, families and individuals migrate to urban centres that are themselves economically depressed and thus offer limited opportunities. Some families disintegrate under these conditions and children are forced to take to the streets for survival (Kombarakaran, 2004).

[1] UNICEF and other organizations identify two types of street children: Children on the street are those who use the street for economic activities and return to their family home. Children of the street, on the other hand, are homeless and live and sleep on the streets. This pair of definitions excludes many of the children who do not fit either category. There are children who use the streets as a transitional habitat that allows them to move between a state of independent living on the street and their family home. These children are both "of" and "on" the street. Since we haven't agreed how we define this population, it is difficult to determine how many street children there are globally.

While the reasons for street migration vary, one thing is clear: these children struggle against insurmountable odds. Literature from developing countries paints a grim picture of the fight to survive and of victimhood and lost childhood (Aptekar & Stoecklin, 2014). The most common experience among these children is systematic exclusion. They are excluded from basic rights to food, shelter, school, health care, and sanitation, and are denied the social and physical protection that most people enjoy. In addition, structural barriers block them from social and political participation and the pathways to becoming productive citizens (United Nations Children's Fund, 2006).

Given this chronic deprivation and multiple stressors, street children are at particularly high risk of physical and mental health problems in countries where the health needs of the general child population already receive little attention. The World Health Organization (2017) has estimated that 20% of children and adolescents worldwide experience mental health problems. Many factors contribute to poor child mental health in developing countries. For example, in 2015, about 174 million children in Africa and Asia were at risk of stunting due to malnutrition, which hinders cognitive and social-emotional development and educational performance, and increases the risk of mental illness and chronic physical disease (Lu, Black, & Richter, 2016).

Limited research exists on child and adolescent mental health in developing countries (Patel, Fisher, Nikapota, & Malhotra, 2008).The absence of any large-scale global studies makes it difficult to determine the worldwide prevalence of mental health problems among street children. What studies are available are country specific and based mostly on non-standardized protocols and convenience samples, using diagnostic tools that have not been validated (Cumber & Tsoka-Gwegweni, 2016). Despite the scarcity of research, there is consensus among researchers and practitioners that street children experience much higher rates of mental health disorders compared with children in the general population.

This chapter reviews research on the mental health of street children in developing countries. It proposes a model of mental health intervention that fits with programming being delivered by agencies that serve developing countries, and describes organizational and programmatic considerations in implementing this model.

MENTAL HEALTH & SUBSTANCE USE AMONG STREET CHILDREN IN DEVELOPING COUNTRIES

Studies from developing countries reveal a high incidence of mental health problems among street children. These issues include anxiety, depression, low self-esteem, posttraumatic stress disorder (PTSD), and suicidal ideation. A study in Ghana found that 87% of street children exhibited moderate to severe psychological symptoms such as self-stigma, violent behaviour, and suicidal ideation (Asante, Myer-Weitz, & Petersen, 2015). Similarly, in a Brazilian study, 89% of street children were diagnosed with a psychiatric disorder, and 40% with a substance abuse disorder (Scivoletto, da Silva, & Rosenheck, 2011).

HOPELESSNESS, SELF-HARM, & SUICIDE

A sense of hopelessness is common among children who are homeless. Woan, Lin, and Auerswald (2012) found high levels of hopelessness, social alienation, and depression among street children in Asia and Latin America. Hopelessness stems from an insecure life, abuse, and cultural and social exclusion, which many of these children face every day. Those who have lived on the streets for a long time and have few ties with family members and other street children are more likely to experience hopelessness and low self-esteem. Being physically abused or learning that their peers experience such abuse also contributes to a sense of hopelessness. A Turkish study found that abuse in a police station significantly increased the sense of hopelessness (Duyan, 2005).

Studies have found a link between hopelessness and suicidal ideation and self-harm. For example, a study of 150 street youth in India aged 10–16 found that 13% had seriously contemplated suicide and 3% had attempted it at least once since they began living on the street (Khurana, Sharma, Jena, Saha, & Ingle, 2004). There is also evidence that poor psychological functioning (e.g., emotional problems, peer relationships problems) is directly linked to suicidal ideation (Asante et. al., 2015). Suicidal ideation is more common among females than males, perhaps because girls' street life is more stigmatized and involves more sexual violence than that of boys (Cumber & Tsoka-Gwegweni, 2016). A study in Pakistan found that about 40% of street youth inflicted self-injury by cutting themselves, with a median of 10 times. This self-injury was most prevalent among current drug users (Sherman, Plitt, ul Hassan, Cheng, & Zafar, 2005).

TRAUMA & ABUSE

Street children experience high rates of trauma and abuse prior to their street migration. In fact, abuse in the family is a critical catalyst for children's movement to the street (Conticini, 2005; Reza, 2016). Once they are on the street, children encounter multiple forms of abuse, including physical, emotional, and sexual. This abuse comes mostly from people in their social surroundings (e.g., employers, service clientele, police, older youth). A randomized study in Egypt found that 93% of street youth had experienced some form of violence or abuse. Physical abuse was reported by 45% and sexual abuse by 12% (Nada & Suliman el., 2010). Similarly high rates of physical and emotional abuse have been reported among street children in India (Mathur, Rathore, & Mathur, 2009). The pattern of abuse tends to be gendered, with girls more likely to experience sexual abuse and boys more likely to experience physical abuse. Studies in Africa and Latin America have consistently found that sexual violence among street children is more common among girls than boys (Lalor, 2000). In a Nigerian study of girls engaged in street vending, 70% had been sexually abused, with 17% having had penetrative sexual intercourse (Lalor, 2000). This gender difference, however, does not mean that males do not experience sexual abuse. A study in Ethiopia reported that 29% of male street children were victims of some form of sexual abuse (Tadele, 2009). Children in this study also ranked sexual abuse as the most frightening threat of street life. Having a physical disability also increases the risk of abuse. A study from Bangladesh found that in addition to experiencing physical, emotional, and sexual abuses, street children with disabilities are exploited for economic reasons. Some are sent by their families to beg on the streets, and others are rented or even sold to organized rings that force them to beg on the streets and in public places (Sayem, 2011).

Violent victimization in childhood and adolescence has far-reaching implications for short- and long-term psychological functioning and overall social development. In the short term, victims of physical and sexual abuse have an increased prevalence of post-victimization stress, hopelessness, and anxiety. Victims of non-familial violence tend to have a higher risk of PTSD and are more likely to report feelings of sadness (Boney-McCoy & Finkelhor, 1995; Macmillan, 2001). In the long term, victims of sexual abuse are much more likely to suffer from depression, drug dependence, or phobic disorders. Physical abuse in childhood dramatically increases the risk of later experiencing a depressive episode or PTSD (Macmillan, 2001). Given the high prevalence of histories of physical and sexual abuse among youth living on the street, these youth are at higher risk of developing depression, PTSD, and drug dependence. Nanda and Mondal (2012) found

that sexually abused street children in India had higher rates of anxiety and depression than street children who had not been abused. A study in Iran found that more than half of street children, of whom a large portion was sexually abused, met criteria for depression (Ahmadkhaniha, Shariat, Torkaman-nejad, & Moghadam, 2007). Similar findings were reported in Ecuador and Brazil, where street children had higher rates of PTSD and depression compared with the general child population (Pluck, Banda-Cruz, Andrade-Guimaraes, Ricaurte-Diaz, & Borja-Alvarez, 2015; Silva, Cunha, & Scivoletto, 2010). The Brazilian study reported that the rate of depression was more than 30 times higher than that found among children living with their families (Silva et al., 2010).

However, not all studies of this population have reported similarly high rates of depression and PTSD. In India, Khurana et al. (2004) found that only 8% of children in their study met criteria for depression, even though many of them were physically and sexually abused. An Iraqi study found that 10% of this population had depression but also found a higher prevalence of anxiety disorders (57%) (Taib & Ahmad, 2014). In a separate study from the same region, Taib and Ahmad (2015) found that male street children had significantly higher rates of anxiety and depression than did school children (59% and 21% vs. 26% and 5%). They also found that street children had higher rates of other mental health issues, including disruptive disorders such as attention-deficit/hyperactivity disorder, conduct disorder, and tics, although the differences were not statistically significant. The authors caution that the lack of significant differences in disruptive disorders does not mean street children are not at risk of developing them; rather, genetic and environmental factors play an important role, and research has found that latent genetic factors can interact with environmental risk factors to trigger symptoms later in life (Taib & Ahmed, 2015; Thapter, Lagley, Asherson, & Gill, 2006). This may explain why children who stay longer on the street are more likely to develop mental illness (Taib & Ahmad, 2014).

SUBSTANCE USE PROBLEMS

Substance use among street children is widespread, and many studies from developing countries have examined this issue (Kudrat, Plummer, & Yousif, 2008; Mahmud, Ahsan, & Claeson, 2011; Sardana, 2015; Sherman et al., 2005). A literature review by Woan et al. (2012) found varying rates of substance use across countries, ranging from 35% to 100%. It also found that some street children begin substance use at a relatively young age (as young as 10), and that rates of use are higher among boys than girls. This gender

difference may reflect cultural practices and norms in some countries (e.g., Bangladesh, India, Pakistan) and the greater difficulties girls may have accessing drugs (Mahmud et al., 2011). The nature of substance use varies, depending on availability and location, but children generally use substances that are cheap and widely available, such as alcohol, cigarettes, inhalants, paint thinner, heroin, and marijuana.

Substance use has proven to be detrimental to children's physical and psychological functioning. In addition to experiencing immediate health risks (e.g., cardiotoxicity, DNA damage, pathological changes in the liver), street children who use substances are more likely to have mental health issues such as depression, stress, and anxiety (Edidin et al., 2012; Nyamathi et al., 2010). A study from Ghana (Asante et al., 2015) reported that substance use correlated with children's heightened anxiety and other emotional problems. In a Pakistani study, Sherman et al. (2005) found a relationship between drug use and self-inflicted wounds. However, the relationships between substance use and mental health problems could be bidirectional. Anxiety, depression, and hopelessness make children vulnerable and street children may use substances to medicate these conditions and counter life stressors. Sardana (2015) found that mental health is a significant predictor of substance use and that degrees of substance abuse can be predicted by the state of mental health. Conversely, substance use can worsen psychological functioning, thus increasing vulnerability to substance abuse (Elkoussi & Bakheet, 2011).

A RESILIENCE-FOCUSED MENTAL HEALTH MODEL FOR STREET CHILDREN

The dismal mental health conditions of street children in developing countries has led to calls for immediate policy and program intervention by governments, service providers, and international agencies. The national governments of these countries face serious challenges to creating effective practice models or policies. They lack infrastructure and resources, as well as a basic understanding of the mental health needs of street children (Earls, Raviola, & Carlson, 2008). In the absence of government policies and services, it is imperative that non-governmental organizations doing work with street populations promote mental health by developing policies and programs that address individual and group needs.

RISK & PROTECTIVE FACTORS

Building mental health interventions within a resilience framework is a promising approach to working with street children. Resilience refers to "the capacity, processes, or outcomes of successful adaptation in the context of significant threats to function or development" (Masten, Best, & Garmezy, 1990, p. 426). It involves two core assumptions: that individuals and groups are prone to risk or adversity, and that protective factors help individuals and groups deal with such threats (Harvey & Delfabbro, 2004). Risk processes involve an episode or a series of environmental conditions or circumstances that challenge the normal functioning of individuals and groups. For street children, these domains of risk are economic, social, and environmental, and are manifested through poverty, hunger, lack of shelter, physical and mental health problems, and traumatic life experiences. Each of these risk factors alone increases the risk of negative outcomes and any combination of these factors increases the risk even more. This cumulative risk has profound effects on mental health (Monn et al., 2013).

Protective processes involve assets or resources that help modify or minimize the effects of risk factors. Protective factors may neutralize the effects of the risk, or they may activate other protective factors to enhance positive outcomes (Fleming & Ledogar, 2008). For street children, protective processes can emerge from three domains: the individual, the family, and the external environment. Individual factors include social competence, problem-solving skills, intelligence, and sociability (Garmezy & Rutter, 1983). Street children demonstrate these strengths through everyday survival activities. Family factors include socio-economic resources, child–parent relationships, and parental harmony. Children on the street who have family connections may activate these protective factors. Protective factors in the external environment also include resources available in the larger community, such as services from an agency or informal support networks (Smith & Carlson, 1997).

DEVELOPING RESILIENCE-FOCUSED INTERVENTIONS

Resilience-focused interventions that recognize risk and protective factors among street children can improve mental health outcomes. Interventions should conceptualize mental health in positive terms and emphasize health-promoting and preventative objectives. Health-promoting activities aim to enhance mental health, whereas prevention-focused activities aim to reduce the incidence, prevalence, or seriousness of mental health problems

(Barry, 2001; Patel et al., 2008). An Iranian study found evidence for the effectiveness of resilience-focused mental health interventions for street children. Children received 15 sessions of resilience training that covered topics such as stress, negative thoughts, positive social relationships, self-confidence, and positive inner speech. At the end of the program, children showed improvements in self-acceptance, relationships, environmental mastery, sense of purpose in life, and personal growth (Dousti, Pourmohamadreza-Tajrishi, & Ghobari bonab, 2014).

Because mental health does not exist in isolation, mental health programs for street children must consider the synergy of environmental, physical, and psychological factors. Agencies should embrace both promotional and preventative objectives and introduce holistic interventions that address basic physical needs and promote physical and mental health.

Two kinds of interventions have the potential to foster resilience among street children: those that focus on reducing risk factors and those that focus on boosting protective factors.

INTERVENTIONS THAT FOCUS ON RISK FACTORS

Central to interventions that focus on reducing risk factors inherent in the situation of street children is meeting physical needs. Many service agencies in developing countries offer services through centres that provide food, space for recreation, help with personal hygiene, and other essential services. Research has shown that subsistence services that provide food, shelter, clothing, and other basic necessities are most in demand among street children and the continuation of these services comes from integration with other types of services (Thompson, McManus, Lantry, Windsor, & Flynn, 2006). In some instances, agencies work with communities to reduce stressors from the environment. Some agencies in Bangladesh, for example, work with community members, including law enforcement agencies, business groups, and government officials, to create a safe community environment for street children (Aparajeyo-Bangladesh, n.d.). This form of intervention helps reduce rates of harassment and abuse among street children.

INTERVENTIONS THAT FOCUS ON PROTECTIVE FACTORS

A second kind of resilience-based intervention focuses on enhancing protective factors for street children. This can be achieved in two ways: first, by providing mental health services to help manage mental health issues; and second, by strengthening children's individual and group resources to prevent mental health crises.

Enhancing protective factors through mental health services

Interventions that focus on providing mental health services can be delivered on a residential or outpatient basis, or through community outreach. Residential programs are generally very narrowly focused and only people who are living in a shelter or receiving other forms of support are eligible for residential mental health care. Counselling services for shelter residents in developing countries are an example of such an intervention. This model of mental health services in which children are provided services in shelter has some potential. Research in developing and developed countries has found that counselling in residential settings reduces psychological distress and substance use and improves sleep. Key to the success of such interventions is participant interest and trusting therapeutic relationships (Altena, Brilleslijper-Kater, & Wolf, 2010). Drop-in centres may be a useful resource for street children who do not want or trust residential services. They can be particularly appropriate for this population, whose families often depend on their child's economic contribution, making it difficult for these youth to commit to their own mental health needs. Drop-in services could be tailored to meet the unique needs of these youth. Mental health services can also be delivered through community outreach. This allows agencies to extend mental health services to the broader community of street children.

Agencies may adopt a hybrid model that incorporates any combination of inpatient, outpatient, and community outreach services. For example, Salaam Baalak Trust (n.d.), an Indian agency serving street children, runs a mental health program that includes community outreach and inpatient care. A team of mental health outreach workers does informal mental health screening among youth on the street. A child identified as having a possible mental health disorder is referred to the mental health team for formal screening and treatment. This type of hybrid model allows agencies to expand their mental health services. For example, agencies can reach out to children who would not otherwise access their services and bring them into a program that focuses on building resilience and promoting mental health, such as an open air school.[2]

[2] Open air or mobile schools are programs for street children set up in public areas such as train stations or marketplaces where street children gather. In this informal, interactive setting, outreach workers teach various topics, including life skills, health and hygiene, safety, and resolving conflict.

Enhancing protective factors by leveraging existing resources

Street children may have individual and group resources, such as positive social relationships, that can mediate the negative effects of street stressors. Research shows that positive social relationships promote the development of psychosocial processes needed to cope with life's stressors and protect against ill health (House, 1981). Social support networks have been shown to be critical to street children's physical and emotional well-being (Davies, 2008). Through these networks, children gain knowledge and skills that help them access crucial resources such as food and shelter and that promote a sense of security (Aptekar, 1988; Felsman, 1989; Mizen & Ofosu-Kusi, 2010; Reza, 2014). Friendships on the street are a source of practical and emotional support. Friends can offer sympathy, solidarity, practical assistance, and protection to peers in crisis or facing abuse. Sometimes, youth also mobilize group members to protest in public against abuse and exploitation (Reza, 2014). Most importantly, street children indicate that love, sympathy, and cooperation are the most important assets in street life. Peer groups are central to improving the quality of their individual and collective survival on the streets (Conticini, 2005).

IMPLEMENTATION CONSIDERATIONS

Implementing a resilience-focused intervention for street children requires an agency culture that emphasizes resilience. This might require change in how agencies develop and implement interventions. Building a resilience framework begins with acknowledging, understanding, and defining mental health needs. This might be explored with simple questions: What are the mental health needs in the organization's catchment area? What services are required to address these needs?

Needs assessment surveys and consultation with outreach workers can help to answer these questions. Identifying demographic factors such as age, gender, and length of time on the street is important in order to tailor interventions to the unique needs of various groups. For example, gender might be an important consideration in developing a mental health intervention because girls are more likely to experience sexual abuse and to internalize the trauma, whereas boys are more likely to experience physical abuse and to externalize symptoms (Aptekar & Stoeklin, 2014). Cultural and religious factors are also important considerations in developing and providing mental health interventions. In some cultures, behavioural manifestations of a mental health disorder may not correspond to standard Westernized diagnostic categories. For example, in some Islamic countries,

signs of spirit possession are not considered to be symptoms of mental illness; rather, they are considered to be a genuine religious phenomenon in which an alien spirit enters the body to alter the person's identity and actions and cause harm (Khalifa & Hardie, 2005). This type of belief runs deep among Bangladeshi street children. Awareness of such culture-bound syndromes is important for proper diagnosis and treatment.

Agencies should select interventions that best fit their needs and abilities, considering factors such as available resources, service infrastructure, service delivery system, and, above all, program scope. In a resilience-focused mental health intervention, the scope could be promotional or preventative. Interventions that provide both require more logistics. Agencies that decide to focus on prevention need to determine what approach is most appropriate and effective. There is no universally appropriate intervention. For example, pharmacological interventions to treat severe psychiatric illness may be more accessible in resource-rich countries, and some interventions, such as brief motivational therapy, cognitive-behavioural therapy, peer-based intervention, and harm reduction interventions, have been evaluated mostly in resource-rich countries (Altena et al., 2010). Agencies in developing countries can adapt these interventions to make them more accessible and appropriate for the people they serve. For example, one Egyptian agency implemented an environmental behavioural modification intervention that used entertainment, role play, theatre, and other positive activities to improve self-esteem and social skills among street children (Hosny, Moloukhia, Abd Elsalam, & Abd Elatif, 2007). An evaluation of the program found a significant improvement in some aspects of behaviour. It is such innovation in developing culturally appropriate interventions that best addresses local needs.

Collaboration with other service agencies, government, and academic centres can reduce program overlap and costs, extend the reach of programs, and improve the quality of services. For example, the Equilibrium Project was developed by the Institute of Psychiatry at the University of Sao Paulo in Brazil in partnership with services for street children run by the city and other agencies. The collaboration involved determining clinical needs as perceived by street children and led to the development of services to meet those needs (Scivoletto et al., 2011).

Careful planning allows for more strategic street outreach. It improves access to services and helps agencies continually assess whether needs are being adequately addressed. Planning can also lead to necessary modification in service options (e.g., adding evidenced-

based interventions) and service delivery systems. Agencies should carefully evaluate their service delivery strategies. Research reveals that low service use is an issue, and that barriers stem from individual and structural issues. Individual-level barriers include lack of awareness of services, poor communication skills, fear, and mental and emotional stability. Structural barriers include program structure, availability, social stigma, and communication skills of program staff (Kurtz, Surratt, Kiley, & Inciardi, 2005). Program success requires removing these barriers and creating a positive service use environment. Although many agencies in developing countries offer basic services for survival on the streets, many children remain beyond their reach. Relying on traditional models of service delivery, in which clients initiate contact, is unlikely to succeed with this population because many street children do not recognize they have mental health issues that can be treated and mistrust of institutions is common (Slesnick, Dashora, Letcher, Erdem, & Serovich, 2009). This means that service agencies must find innovative ways to reach out to children, build trust, and encourage them to access services. One innovative approach to outreach is to recruit boys and girls form peer groups of street children and train them to connect peers who need help with services.

CONCLUSION

Poverty, abuse, and family dysfunction are some of the many factors that precipitate children's perilous journey to the streets in developing countries. In an environment that features chronic multiple stressors, the chances of leading a healthy life dwindle. Some children demonstrate resilience in the face of these challenges, but the vast majority become victims of systemic deprivation, abuse, and exclusion. Research provides overwhelming evidence that most street children experience mental health disorders. Thus, the need for mental health services is great. Yet developing countries often struggle to meet this need, given the lack of government support. Non-profit agencies assume most of the responsibility, but have scarce resources. A resilience-based mental health model is a good starting point for these agencies. By focusing on preventative and promotional aspects of mental health, it harnesses children's own resources while providing external support. Moreover, a resilience-based model can be integrated into existing programs. Finally, by collaborating with international development agencies, local agencies can expand the reach of resilience-based interventions to improve health outcomes among street children in developing countries.

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