

**Les déterminants influant
sur la santé mentale des enfants :
l'intersectionnalité comme cadre pour le
renouvellement des soins de santé primaires**

Charmaine M. McPherson, Elizabeth A. McGibbon

La notion de renouvellement des soins de santé primaires (SSP) a été explicitement conçue pour traiter de la question des facteurs multidimensionnels ayant un impact sur la santé, notamment les déterminants sociaux. Ces déterminants sont d'importance capitale en matière d'élaboration de politiques intégrées, intersectorielles et intergouvernementales, comme c'est le cas pour les déterminants qui alimentent les modèles de soins de santé mentale partagés pour enfants. Toutefois, l'intégration de ces questions multidimensionnelles dans la conception de politiques comporte des défis théoriques complexes. La relation qui existe entre les déterminants sociaux de la santé et les éléments d'identité, tels la race, le sexe biologique, l'âge, la sexualité et l'appartenance à une classe sociale, lesquels s'inscrivent dans un contexte géographique donné, est un sujet rarement abordé et figure parmi ces questions. Cette étude met à contribution l'analyse intersectionnelle dans l'examen des liens complexes qui existent entre les facteurs influant sur la santé mentale des enfants et les défis inhérents au renouvellement des SSP dans la sphère des politiques. Selon les auteures, les décideurs doivent s'appuyer sur une solide compréhension des liens entre les déterminants sociaux de la santé, l'identité et la géographie, dans le cadre de leur démarche de renouvellement des SSP, entre autres dans leurs efforts pour s'attaquer aux inégalités en santé mentale infantile.

Mots clés : Déterminants de la santé, soins de santé primaires

Addressing the Determinants of Child Mental Health: Intersectionality as a Guide to Primary Health Care Renewal

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Primary health care (PHC) renewal was designed explicitly to attend to the multidimensional factors impacting on health, including the social determinants of health. These determinants are central considerations in the development of integrated, cross-sectoral, and multi-jurisdictional policies such as those that inform models of shared mental health care for children. However, there are complex theoretical challenges in translating these multidimensional issues into policy. One of these is the rarely discussed interrelationships among the social determinants of health and identities such as race, gender, age, sexuality, and social class within the added confluence of geographic contexts. An intersectionality lens is used to examine the complex interrelationships among the factors affecting child mental health and the associated policy challenges surrounding PHC renewal. The authors argue that an understanding of the intersections of social determinants of health, identity, and geography is pivotal in guiding policy-makers as they address child mental health inequities using a PHC renewal agenda.

Keywords: child health, determinants of health, health disparities, health policy, mental health/psychosocial, primary health care

A key aspect of primary health care (PHC) reform is the promotion and protection of the health of communities through public policy that tackles the systemic origins and outcomes of health inequity (World Health Organization [WHO], 2008b). Given the complexity of such policy challenges, especially with respect to vulnerable populations such as children, it is essential that decision-makers and practitioners be grounded in clear and appropriate frameworks to guide PHC renewal. There has been some discussion of PHC in Canadian nursing (DiCenso et al., 2007; Dracup, 2007) and in primary mental health and related fields (Hughes, 2006; Piat, Barker, & Goering, 2009). However, little attention has been paid to the complex issue of addressing child mental health inequities within PHC renewal. An intersectionality lens holds great promise for reducing mental health inequities because it explicitly attends to complex interactions among root causes, including the social determi-

nants of health (SDH) and other inequities such as those related to racism and sexism.

Child mental health is an urgent matter in Canada. Significantly, child mental health is seen as a *new morbidity* for Canadian children and youth, in addition to chronic childhood illnesses such as asthma, diabetes, and obesity (Canadian Paediatric Society [CPS], 2009). A policy report by the advisor to the federal Minister of Health on the health status of children and youth highlights mental health as one of three national health priorities for this population (Leitch, 2007). At any given time more than 1.2 million Canadian children and youth, or 15% of this population, are affected by mental illness (Leitch, 2007). Mental health problems among children and youth are expected to increase by 50% by the year 2020 (CPS, 2009). The mental health of our children is also a critical issue globally, with epidemiological data suggesting a 20% worldwide prevalence of child and adolescent mental disorders (WHO, 2003).

There continues to be a dearth of information articulating child mental health outcomes and SDH. Analysis and synthesis of mental health outcomes related to the intersections of SDH identities such as racism, sexism, and geography have barely begun. The complexity of this concern requires a complex approach — we will not achieve justice in child mental health if we simplify or segment the causes and outcomes of these intersections. PHC, with its inherent emphasis on interprofessional and cross-sectoral partnerships striving towards health equity within a social justice frame, is foundational to child mental health outcomes and SDH.

Although intersectionality applies to all dimensions of nursing, such as practice, education, management, and research, the purpose of this theoretical article is to advance nursing knowledge about intersectionality as it relates to PHC renewal in *policy-making* on child mental health. We explicitly link child mental health and the concept of shared mental health care within the context of PHC renewal. We advance an intersectionality lens to support mental health within PHC renewal, to explore the impact of intersections of SDH on children, and to examine PHC renewal policy. We then use the four WHO (2008b) areas of PHC reform to guide the application of intersectionality.

Linking Child Mental Health to PHC Renewal

Governments have a responsibility to effectively promote child health and well-being through policy and programming. The complex nature of many childhood mental health issues requires the involvement of multiple professionals, sectors, and partners, including families, communities, and public services. However, our current system is not designed to

respond in an integrated, interprofessional, and cross-sectoral manner, as often dictated by child mental health needs (McPherson, 2008). Further, many inequities are driven by ineffective public policies, and the services that flow from these policies are essentially contributing to a worsening of mental health outcomes for children and their families (Bryant, 2009).

Health system strengthening through PHC renewal holds much promise (WHO, 2008b). Collaborative interprofessional and cross-sectoral partnerships, many of which involve the nursing profession, have been put forth as a key policy strategy in redesigning the health and public service systems to enhance health outcomes, especially for complex and vulnerable populations such as children (Romanow, 2002). Cross-sectoral teams are designed to mirror the undisputed links between SDH and child mental health outcomes.

The Context of PHC Renewal

Health systems have been undergoing necessary widespread reform globally, nationally, and provincially. Many stakeholders, including individuals, system leaders, and practitioners, recognize that PHC is the foundation of Canada's health-care system and that improving PHC is essential to widespread health system reform. There is robust theoretical and empirical evidence indicating an association between strong national PHC systems and improved health outcomes (Starfield, Shi, & Macinko, 2005; WHO & Public Health Agency of Canada, 2009).

Major policy initiatives have been undertaken globally to strengthen PHC since its introduction under the *Declaration of Alma-Ata* in 1978 (WHO, 1978). PHC represents the first point of contact that people usually have with the health-care system, including youth health centres, well-women's clinics, and community health centres. Collaborative PHC working arrangements are increasingly being recognized as a requirement for systemic change to address complex and contextually laden issues such as child mental health (McPherson, 2008).

The 2008 *World Health Report* outlines four key areas for PHC reform: public policy, universal coverage, service delivery, and leadership (WHO, 2008b). The report reiterates the 1978 focus on social justice and the right to better health for all by using evidence to address the politically, socially, and economically unacceptable health inequities faced by citizens globally. Such action requires a reorientation of the way in which public systems operate.

Shared Mental Health Care Within PHC Renewal

Many of the principles and values associated with PHC can be considered supports for the enhancement of policies for childhood primary mental health care, including interprofessional collaborative care deliv-

ered by the right provider at the right time in the right place. Primary mental health care, or *shared mental health care*, is a collaborative model that can help to shift the culture of general family practice from simple referral models to stronger models of interprofessional collaboration (Keleher, 2006), which is a cornerstone of PHC renewal.

Canada's Kirby Report on mental health (Kirby & Keon, 2006) identifies the need for departments and ministries of health, education, social services, and justice to work together at all levels to deliver integrated models of delivery and access to mental health services. Since at least 1997 there has been discussion regarding the shared mental health care model (Kates et al., 1997), including an explicit linking of PHC and the concept of shared care (Mazowita, 2004). Several Canadian shared mental health care models have been developed and tested (Hamilton Family Health Team, 2010; Shared Mental Health Care, 2010). There has also been recent activity by medical specialists in the United States regarding shared models focusing on children and adolescents (American Academy of Child and Adolescent Psychiatry, 2009). Some experts place the shared care model within PHC renewal, contending that mental health care is an ongoing PHC concern and that shared care and PHC renewal are inseparable. Meaningful participation by consumers and families in public decisions that affect their health is a fundamental principle of PHC (WHO, 2008b). However, one must become vigilant with regard to the evolving shared mental health care model to ensure that this PHC principle is respected; genuine and appropriate involvement of consumers and their families must be a priority. If the PHC renewal process is to be carried forward, it will have to widely adopt shared mental health care principles — just as the advocates of shared mental health care will have to adopt the principles of PHC.

The Canadian Collaborative Mental Health Initiative (CCMHI) (2010) uses *collaborative care* terminology for the shared care model. This initiative describes collaborative care as “an interprofessional process of communication and decision making that allows the knowledge and skills of different health care providers, along with the client/consumer, to influence the care provided to that consumer” (Oandasan, 2003, p. ii). The CCMHI is one of many initiatives supported by Health Canada's Primary Health Care Transition Fund, and it has contributed to a broad action plan supporting PHC renewal and innovation in Canada. The Canadian Nurses Association has been one of 12 national organizational partners in this initiative, thus ensuring an interprofessional presence for nursing. The CCMHI reflects commitments made by Canada's First Ministers in 2001 to make adjustments to PHC delivery to maximize access and effectiveness while strengthening the preventive and health promotion aspects of the health-care system.

Mental health is an integral element in PHC because patients regularly turn to PHC providers for support, treatment, and access to specialized resources. The CCMHI has strived to develop policies that promote and advance collaborative mental health by engaging consumers, families, communities, primary care practitioners, and mental health care providers. In its planning, the CCMHI has targeted eight distinct populations, including children and adolescents.

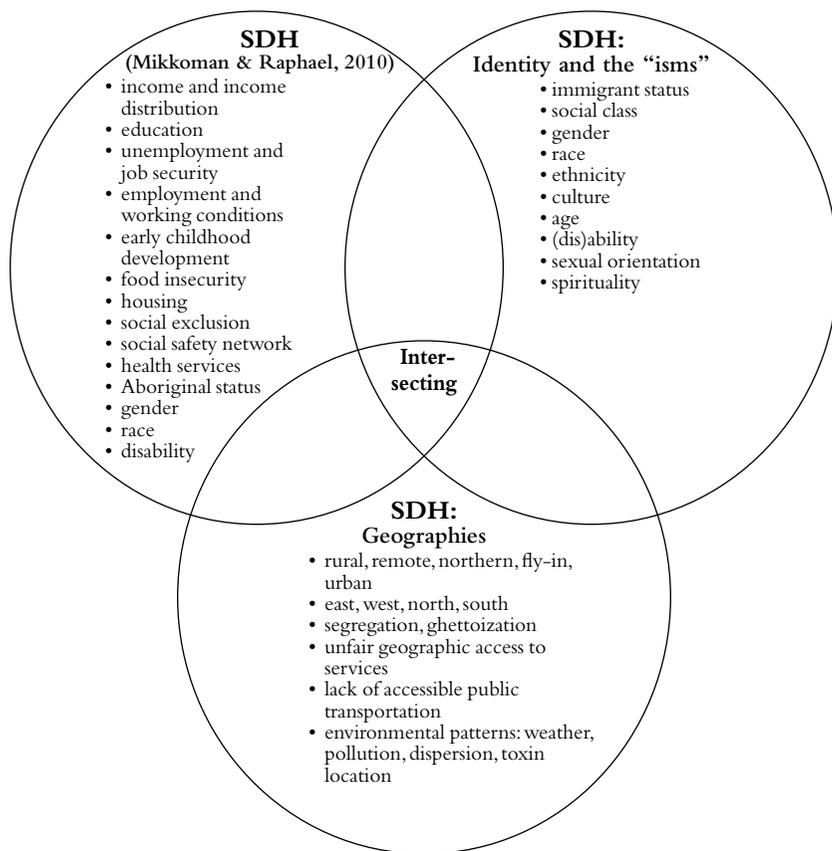
From a federal policy perspective, in 2007 the Canadian Advisor on Healthy Children and Youth, reporting to the Minister of Health, recommended five key actions regarding the role of the federal government (Leitch, 2007). Included among these was improvement of mental health services for children and youth. Leitch notes that Canada needs to build health human resources capacity in pediatric mental health. Specifically targeting implications for nursing and physician regulatory bodies, she links child mental health to PHC by recommending that capacity in PHC settings be augmented to effectively maximize the contribution of all health-care providers.

Using an Intersectionality Lens to Support Mental Health Within PHC Renewal

Health system strengthening through PHC renewal and shared mental health care offers a clear policy opportunity to address inequities in the social determinants of child mental health. The nature of these inequities is underscored by the inherent need for a cross-sectoral policy focus in PHC. The concept of intersectionality has much to offer in terms of support for system strengthening and decreasing the material deprivation that underpins and exacerbates the mental health struggles of children. Although the particulars of service development and evaluation require further scholarly examination within the nursing community, this discussion focuses on *policy practice*. We emphasize how an understanding of the intersections of SDH, identity, and geography can enhance PHC policy development to reduce inequities. This perspective, known as *intersectionality* (Hankivsky & Christoffersen, 2008; McGibbon, 2009), is entirely consistent with the cross-sectoral underpinnings of PHC renewal and is central to addressing inequities in child mental health outcomes.

This discussion is necessarily complex, because three crucial SDH areas must be integrated: (1) SDH as laid out by Mikkoman and Raphael (2010); (2) identity and its related forms of oppression, referred to herein as the “isms” (e.g., racism, classism, sexism, ageism), as an SDH; and (3) geography as an SDH. Figure 1 illustrates these three areas. It is important to note that *all three areas* are now considered SDH. The examples that follow demonstrate how intersectionality can be used to under-

Figure 1 *SDH Intersectionality Lens for Addressing Health Inequities*



Source: Adapted from McGibbon (2009), p. 322.

stand the context of child mental health and the related complexity within the PHC policy context.

Intersectionality lenses have been used to describe the interwoven influences of identities such as gender, sexual orientation, race, ethnicity, (dis)ability, and age on experiences of injustice (James, 2003). For example, feminist intersectionality frameworks emphasize “an understanding of the many circumstances that combine with discriminatory social practices to produce and sustain inequity and exclusion . . . can impact the combination of a person’s social or economic status, race, class, gender, and sexuality” (Canadian Research Institute for the Advancement of Women, 2006, p. 7). In this context, discrimination is action or inac-

tion based on prejudice, such as provision of inadequate emergency care for Aboriginal families. Oppression is discrimination backed up by institutional power (health, education, or legal system), such as occurs when a hospital does not intervene to halt discriminatory practices (McGibbon & Etowa, 2009).

Intersectionality theory emphasizes the interaction of various forms of oppression related to the “isms” and the links among the oppression and systemic power (Collins, 2000). These forms of discrimination, and hence oppression, do not operate independently of each other. They interact in complex ways that intensify oppression. The following example may serve to illustrate. Stress within a family is often increased when a child experiences a serious mental health concern. If this is a low-income family, consider the potential increase in stress due to the burden of worry about the family’s ability to provide the necessities of life (i.e., SDH as outlined by Mikkoman and Raphael [2010]). Now, consider the interaction of the stress caused by low income with that caused by one of the “isms,” such as racism. Finally, if this family lives in a rural area, then it is not difficult to see how the three areas of SDH (i.e., Mikkoman and Raphael, “isms,” and geography) indeed interact in a complex way to intensify the experience of oppression.

Intersections of SDH: Impact on Children

Although SDH have long been recognized as determinants of mental health, the interrelationships or *intersections* among SDH themselves (e.g., early childhood development, income, food security) are much less understood. Four longstanding factors continue to explain a large proportion of the differences in health among Canadians: gender, Aboriginal status, age, and socio-economic status (Canadian Institute for Health Information, 2009). Supporting this finding are the solid links between childhood health status (physical and mental) and SDH (Raphael, 2009b; WHO, 2008a). While there are many conceptualizations of SDH, a recent publication on the topic (Mikkoman & Raphael, 2010) outlines the following determinants: income and income distribution, education, unemployment and job security, employment and working conditions, early childhood development, food insecurity, housing, social exclusion, social safety network, health services, Aboriginal status, gender, race, and disability. Notably, health disparities among Canadian children remain linked primarily to differences in family socio-economic status (Lemstra & Neudorf, 2008), and poverty remains the strongest determinant of health (Raphael, 2009a).

Despite the well-documented links between poverty and child health, and despite a unanimous 1989 House of Commons resolution to eliminate child poverty in Canada by the year 2000, the situation has grown

progressively worse. More than one million Canadian children, or one child in ten, are still living in poverty — an actual increase of over 20% since 1989 (Campaign 2000, 2009). Furthermore, poverty intersects with racism such that children from racialized groups experience higher than average levels of poverty. Social exclusion and the racialization of poverty mean that 51% of Aboriginal children and 42.7% of visible minority children in Canada are likely to be poor, compared to the already unacceptable national average of 23.4% of children living in poverty (Canadian Council on Social Development, 2009). Our great national shame is that one in every four children in First Nations communities is growing up in poverty (Campaign 2000, 2009).

In a recent series of papers, Raphael (2010a, 2010b) focuses on the health of Canada's children. He concludes that Canada's performance ranks poorly among developed countries on several key indicators of child health. And he notes that there is little evidence of recent improvements. Raphael (2010a) ties low health status scores to SDH, such as income and family socio-economic status, seen broadly as the living conditions to which children are exposed. He analyzes the mechanisms and pathways by which children's health, including their mental health, is either supported or threatened. Consistent with our arguments here, Raphael concludes that life-course explanations focus on how Canadian children experience systematically different life circumstances that translate into health differences. Further, the extent of inequality in living conditions and the health-related experiences of children and their families are heavily influenced by public policy.

An environment of poverty is characterized by exposure to cumulative adverse physical and social stressors (Evans & English, 2002). Of particular concern is the robust relationship between poverty or low socio-economic status and childhood stress (Evans & Kim, 2007). This stress has been documented as producing a wide range of physiological and socio-emotional difficulties in children, including chronic dysregulation of the cardiovascular system, disruption of the body's stress-regulation system (Evans & Kim, 2007), depression, and low achievement (Alaimo, Olsen, & Frongillo, 2002). The scope and depth of the impact of childhood poverty on long-term mental health are further evidenced by the inverse relationship between poverty and working memory in young adults (Evans & Schamberg, 2009). The term working memory refers to a brain system that provides temporary storage and manipulation of the information necessary for such complex cognitive tasks as language comprehension, learning, and reasoning (Baddeley, 2003).

The intersectional impacts of deprivation related to SDH remain a central and under-recognized factor in the mental health struggles of children. For example, food insecurity related to unemployment plays a

central role in shaping childhood mental health outcomes. Young people aged 15 and 16 from homes where there is not always enough to eat are five times more likely to attempt suicide than well-fed adolescents; they are also four times more likely to suffer from chronic low-grade depression, which is a high-risk factor for major depression, and almost twice as likely to be suspended from school; in addition, they have more problems getting along with their peers (Alaimo et al., 2002). Children aged 6 to 11 who live in families without enough food are twice as likely to see a psychologist and 1.4 times as likely to repeat a grade and to have significantly lower mathematics scores (Alaimo et al., 2002).

The geographic and spatial contexts of oppression introduce yet another layer of complexity, including lack of access to services in rural, remote, and northern areas (Ministerial Advisory Committee on Rural Health [MACRH], 2002). Infant mortality rates in rural Canada are 30% higher than the national average. Further, over 50% of the country's indigenous peoples live in rural, remote, and northern regions. The health status of rural indigenous families follows the same pattern of decreased life expectancy and increased morbidity as Canada's indigenous families as a whole (MACRH, 2002). What the geographic contexts of oppression, SDH, and the "isms" have created, ultimately, are intersections of intersections. Collectively, the three areas — SDH, identity and the "isms," and geography — form a powerful synergy of oppression that is difficult to disentangle in terms of its policy base and its impact on everyday life. Collectively, the three intersecting areas have built a complex and deeply embedded system of disadvantage for many Canadian children that public policies are largely ill-equipped to handle.

Using an Intersectionality Lens to Examine PHC Renewal Policy

Intersectionality theory and PHC renewal are related in several ways. Both are grounded in an inherent focus on the intersections of areas of practical and theoretical knowledge. In the case of PHC renewal, the emphasis is on shared mental health care, the need for collaborative inter-professional and cross-sectoral partnerships, and universal access to services to reduce health inequities. Indeed the concepts of interprofessional partnerships and cross-sectoral partnerships were introduced to form a bridge between the traditional health sector and sectors such as social services, education, and justice (McPherson, 2008). For example, ameliorating the stress experienced by children who live in poverty requires a cohesive and combined effort by senior policy-makers not only in the mental health sector but also in the social services, education, and justice sectors. Here, the use of an intersectionality lens makes intuitive sense,

since child mental health is deeply embedded in SDH. Policies and programs need to be put in place to address the root causes of SDH-related mental health symptoms.

Appendix 1 applies an intersectionality lens to the four key areas of PHC reform outlined in the 2008 *World Health Report* (WHO, 2008b). We place the emphasis on the first area of reform — public policy — since it is pivotal to reforms undertaken in the other three areas.

Conclusions

Certain key public policies and practices have a major impact on the mental health of Canada's children. Public and system leaders must be held accountable for their priority-setting and strategic initiatives within PHC renewal, and within primary mental health services for children in particular. An intersectionality lens can be used to assess leadership accountability and as a "checkpoint" guide for public leaders in all phases of the policy cycle, including issue assessment and policy design, implementation, and evaluation. The nursing profession should seize the opportunity offered by health system strengthening through PHC renewal to advance care reforms aimed at diminishing exclusion and social disparities (International Congress of Nurses, 2008). Nursing can do so through children's mental health services and system redesign that takes into account the lack of access based on the "isms." It is imperative that future research explore how these barriers might be analyzed and addressed in the context of inequities related to SDH, identity as an SDH, and geography as an SDH. Further work is needed to move this intersectionality thinking from the policy imperative through to service design, delivery, and evaluation. The global focus on health system strengthening through PHC renewal affords the perfect opportunity to advance this thinking in many domains of practice.

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Appendix 1 *Application of Intersectionality Lens to the Four Areas of PHC Reform (WHO, 2008)*

1. Public policy reforms to promote and protect the health of communities

- Strengthening of the mental health care system through PHC would benefit from the use of an intersectionality lens as a “checkpoint” for issue assessment and for policy design, implementation, and evaluation.
- Use of an intersectionality lens supports the integration of public health actions with PHC and the pursuit of healthy public policies across sectors. This frame provides a lens through which to examine policies, with the goal of healthier communities.
- People expect their governments to have public policies in place to address health challenges such as discrimination against persons with

mental illness. An intersectionality lens for policy design and reform would further support PHC principles.

2. Universal coverage reforms to improve health equity

- Strengthening of the mental health care system in order to diminish exclusion and social disparities must include an accounting of lack of access based on the “isms” (e.g., racism, sexism, ageism, homophobia).
- These barriers must be analyzed and addressed in the context of inequities related to SDH and geography as an SDH. This will serve to address the spatial and geographic barriers (e.g., lack of access to pediatric specialist services in rural and remote areas) to the achievement of mental health equity.
- In global terms, public spending on health care benefits the rich more than the poor (World Bank, 2004). Use of an intersectionality lens supports an inversion of care, whereby those with the least means and the poorest health eventually become the greater consumers.

3. Service delivery reforms to make health systems patient-centred

- Strengthening of mental health care systems requires a reorientation, to transform conventional care into accessible patient-centred PHC. An intersectionality lens supports policy decisions and services that are relevant for disenfranchised communities and addresses inequities arising from intersections of SDH, identity, and geography.
- An intersectionality lens would force a reorganization of health-policy decision-making and services around people’s needs and expectations. This would optimize the effectiveness of all services at all levels and make them more socially relevant and responsive.

4. Leadership reforms to make health authorities more reliable

- Policy-makers and leaders at the local, national, and global level must be held accountable. Leaders can use an intersectionality lens to work with system-based decision-makers and practitioners to systematically assess progress towards PHC renewal.
- Leaders in all public sectors need to work collectively to mitigate any adverse health effects and make the most of any health benefits arising from other sectors. An intersectionality lens would demonstrate to multiple sectors the cross-sectoral complexity and implications arising from the intersections of SDH, identity, and geography within their own and other sectors.
- The complexity of health system strengthening through PHC requires inclusive and participatory leadership. Community participation must address barriers to participation in society, including those arising from the intersection of SDH, “isms,” and geography. Inclusive and participatory leadership can foster the involvement of consumers and families in shared mental health care.