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From New Delhi to Chicago: Transcending Barriers to Child Advocacy

As a general psychiatry resident in the United States, I have learned that despite living in the wealthiest nation on earth, many of our children struggle with the same obstacles as those in developing countries.

Shawn S. Sidhu, M.D.

In this John E. Schowalter, M.D. Resident Member to Council column, ***Shawn S. Sidhu, M.D.****, reflects upon his work with an AIDS orphanage in India and imparts his insight into the challenges of child advocacy in the United States.*
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The auto-rickshaw came to a lurching, dusty halt. It was midday, and the overhead shade offered little relief from New Delhi's piercing summer heat. The motorized box-on-wheels oscillated with the vibration of vehicles passing by as a pair of weather-beaten eyes peered at me through the rear-view mirror. "That'll be twenty rupees." While I pondered how the previously agreed upon fifteen rupees had now become twenty, I took in my surroundings with a sense of disbelief. "Are you sure this is the place? I'm volunteering at the NAZ AIDS Care Home." Before me stood a two-story stucco structure with metal rails for window shutters and an open door just paces from a congested throughway. A surrounding shantytown of sheds built with spare parts extended for blocks on either side. "Yeah, yeah, that's it," he replied, "twenty rupees." I stepped out of the rickshaw and paid, bracing myself for what was certain to be a grim scene. However, as I approached, I was startled by an unexpected sound. It was laughter! Not just giggling, but the roaring, full-bellied, riotous laughter, which reflexively brings a smile to even the most despondent face. I entered to observe two children tickling one another while a third began to sing his favorite hit song. The other two joined in a chorus and ran to greet me at the door.

Over the next four weeks I bonded deeply with these children. I was continually amazed at their resiliency. Despite losing both parents to AIDS, being cast out by society as "diseased" and "the product of sin," and having limited access to their basic needs, they remained hopeful and caring. Yet, the precocious criminal activity of their neighboring peers was a constant reminder that a child's resiliency can only go so far.

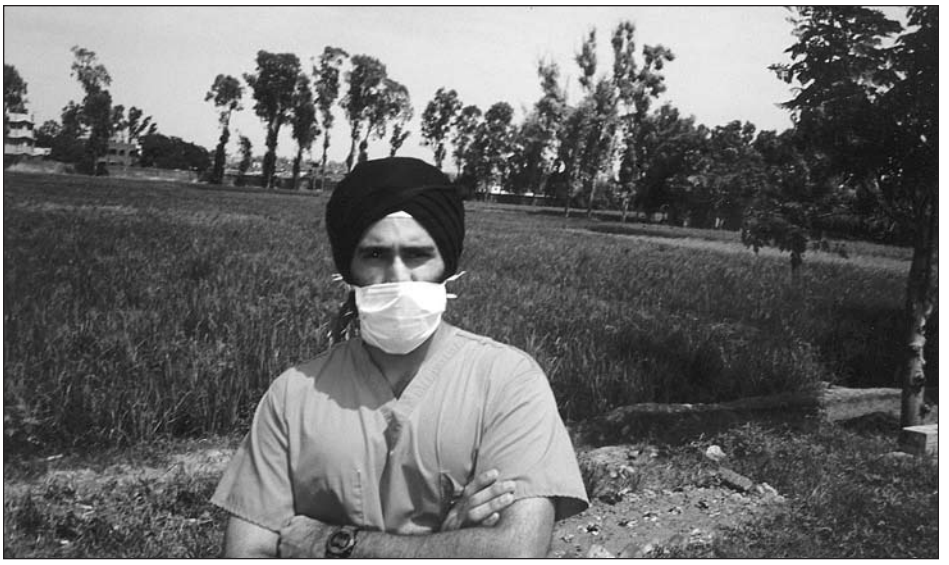
What was the difference between these children and their counterparts on the street, many of who would end up entangled in the city's web of gangs, drugs, prostitution, and ultimately destitution? The difference was that these kids had advocates. They had mentors, whether nuns, teachers, or volunteers, who kept them from despair by guiding them with unconditional love and support. As Mahatma Gandhi said, "You must be the change you wish to see in the world;" I was impressed by how the adults working tirelessly at the orphanage exemplified this.

As a general psychiatry resident in the United States, I have learned that despite living in the wealthiest nation on earth, many of our children struggle with the same obstacles as those in developing countries. Limited access to consistent, present, and conscientious advocates is among the most crippling. This problem is far too complex to be solved by one party. Families, schools, health systems, and providers all face unique challenges and opportunities for improvement.

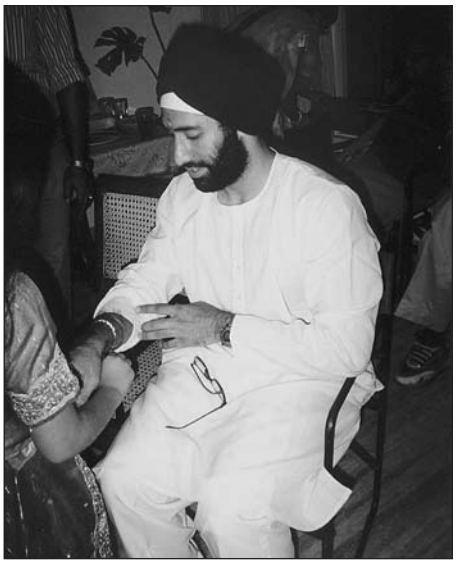
Even though most children are part of a family unit, consistent, reliable, and emotionally available advocates are not necessarily available to them. Parents may struggle with the challenge of caring for themselves due to a variety of psychosocial stressors, leaving them with less time and energy for their children. The demands are even greater for caretakers of children with mental illness. Many families would benefit from assistance, however, the difficulty lies in finding the means to educate guardians; educating them about services that are available and ensuring that those services are accessible.

Schools offer tremendous opportunities for child advocacy. However, structural challenges such as overcrowding, underfunding, and teacher burnout leave local school districts with minimal reserves. Under these constraints schools must focus exclusively on maintaining test scores and graduation rates. Advocating for a child requires attention and time, luxuries that many educators cannot afford.

In the United States, much of the responsibility of caring for youth rests with families and schools. Conditions for children are not likely to improve



Dr. Sidhu at TB clinic



Dr. Sidhu at NAZ AIDS Care Home

until our health systems recognize child advocacy as a legitimate priority. Overwhelmed and underfunded, state and city departments of child services share the burden of schools in trying to advocate for the rights and protection of children with dwindling resources. Child and family services are often among those most adversely affected by political and financial trends. Because they are only able to work with a limited percentage of referred cases, child advocacy organizations cannot attend to many children who are enduring situations of abuse and neglect. At the end of the day, there is little if any room for mentorship efforts in government bodies that are designed to alleviate human suffering. Government leaders must be effectively informed about the importance of funding education and other programs for children. After all, children are our future, and healthier children mean a healthier nation.

Child and adolescent psychiatrists are well positioned to advocate for their patients despite the challenges that could impede progress in child advocacy efforts. One barrier is that of 15 million children with psychiatric disorders with only 7,000 child and adolescent psychiatrists available to evaluate and treat them. There are also the pressures that individual clinicians face in negotiating what they want to do with what they are able to do in promoting child and adolescent mental health. With increasing medical school loans and dwindling physician reimbursement, some psychiatrists are not able to accommodate those who are unfunded. Physicians are often reluctant to work in the public sector because of a perception that the caseloads in such settings would be insurmountably challenging and their autonomy forfeited. Consequently, children who require the most intensive treatment receive suboptimal care. While loan repayment programs do exist, they are often few and far between and offer minimal compensation. Also, providers need a working environment that is collaborative, supportive, and empowering to combat fatigue and burnout.

Despite the aforementioned challenges, there is room for hope. Many caretakers are highly responsive and eager to contribute to the wellbeing of their children. Parents challenge public schools to provide the best possible education for youth in their communities. The federal government works toward improving mental health policy. Although legislative reforms have directly impacted children's mental health, many of our representatives in government strive to increase funding for education and social programs. The American Academy of Child and Adolescent Psychiatry works tirelessly to advocate for child and adolescent mental health. Individuals and charitable organizations volunteer hours of labor to improve community response to psychiatric illness in children and adolescents. As long as we are able to identify efforts toward intervention, we have reason to believe that we can make a difference. At the end of the day, while kids will always be amazingly resilient, there is no substitute for a supportive presence to help guide them along life's journey. ■

Dr. Sidhu is a second year resident in the General Psychiatry Residency Program at the Feinberg School of Medicine of Northwestern University.