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Building Resilience in Children - Moving from treatment to prevention

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Interest and concern about the mental health and emotional well-being of young people has increased exponentially. In Europe, the prevailing economic crisis has exacerbated the feelings of insecurity and anxiety among the younger generation. Mental health problems constitute the largest single source of world economic burden, with an estimated global cost of £1.6 trillion (or US$2.5 trillion) – greater than cardiovascular disease, chronic respiratory disease, cancer, and diabetes on their own (Insel, 2011). The World Health Organization (2013) estimates that, worldwide, 20% of adolescents in any given year may experience a mental health problem.

Children and adolescents are suffering from increasing levels of stress and anxiety. There is a large gap between the early onset of mental health problems and the point at which young adults find appropriate help. Unfortunately, young people tend to access services as a last resort. There exists an opportunity to support young people before the onset or at the early stages of mental health problems and thus prevent the need for costly medical/psychiatric interventions. Moreover, such preventive support programs can be optimized by involving young adults in the actual design, delivery and evaluation of programs that aim to increase their resilience. In this special issue, we will present the background to a European project aimed at Building Resilience in Children (BRIC). The BRIC idea has been developed using a bottom up approach by a consortium of like-minded European researchers. The aim of this special issue is introduce the ideas and concepts behind BRIC, and identity some of the key challenges in a selection of European countries.

Background and methodology

Student participation is the core of citizenship education (Holdsworth, 2002). Through active participation in discussion and policy development in topics that affect them directly, participatory research can provide opportunities for young people to develop the knowledge, skills and attitudes that will enable them to take an informed and active role in a democratic society (McLaughlin, 1992). Community-based participatory research can meaningfully involve youth in program design and improvement efforts. Participatory research and evaluation engages youth in the process of identifying the health needs of their peers, defining research questions, creating research instruments, and interpreting their findings to shape the more appropriate health interventions (Ballonoff, Suleiman, Soleimanpour, & London, 2016). Innovative ways to improve wellbeing and social inclusion are urgently required, as the growing demands on student counselling services exceed capacity. Previous research in a variety of different populations has shown that participatory arts projects may have beneficial effects on general wellbeing (Lomas, 2016).

The ultimate aim of the BRIC project will be to develop on-line accessible support services that are aimed at prevention and increasing resilience. Most

importantly, the developed services will be developed by young people for young people. The main objective of the proposed project is to engage young[1] people in the promotion of positive mental health and resilience among their peers. It is envisaged that the service will be delivered online to increase the reach and impact of the developed tool. Our target group will be 14-16 year-old children.

The overarching approach of the BRIC project will be rooted in action research. Action research differs from more traditional empirical research paradigms in that it conducts research with participants rather than on participants. Action research is an emergent inquiry process that engages in an unfolding story, where actions shift as a consequence of interventions and where is it not possible to predict or control what takes place (Coghlan & Shani, 2013). Action research involves five stages: (1) Problem identification, (2) Planning of action, (3) Implementation of action, (4) Evaluation, (5) Reflection. This framework can be further reduced to Look, Think, Act, and Repeat for use with young adults.

In action research, the content and process issues are equally important. Thus, we are interested in the outcomes of the research (content) and the way the children experience the research (process). The project will address the gap in terms of mental health issues in young children by putting the schools at the core of prevention, intervention and awareness activities. Few preventive resources are offered to young people so that they can identify, let alone manage, mental health issues. We have situations where whole communities of students are left helpless to do deal with critical events by themselves, like the death of a fellow student, and circumstances, like living with jobless parents.

The BRIC project will integrate three parallel but distinct areas of knowledge; health psychology, health promotion and student voice. Health promotion activities are increasingly putting an emphasis on actual user involvement in the design and delivery of services. Congruently, there is a movement within education towards greater involvement by students in the organization and planning of educational activities, referred to as 'student voice'. Finally, health psychology emphasizes the importance of self-regulation as a key to successful behaviour change initiatives. We have joined elements from these three bodies of knowledge to create a project that is evidence-based, practical and is located in key institution in every community; the school (Montgomery & Kehoe, 2016). The proposed project will facilitate young people to develop resources in terms of teaching material, training material, activities, exercises, awareness material, preventions and intervention strategies, case studies, success and failure stories that can be used to buffer the resilience of their peers in terms of their positive mental health. Additionally, the project will utilize tools from the social sciences and humanities to develop resilience strategies aimed at promoting functional coping strategies.

The project will create innovative material that can be applied (1) as courses embedded in the curriculum, (2) as long term workshops for students and teachers, (3) as short term workshops for students and teachers and (4) as a resource pool that students' mental health groups can draw ideas from and work with. In order to ensure the sustainability of the BRIC project, support networks will be created and run by students in the form of BRIC NGOs that will be managed by the students with the support of the university partner and school.

1 We have adopted the classification used by the Health Behaviour in School-aged Children Network http://www.hbsc.org/ , whereby children are classified as being between 11-13, and youths 14-16.

Ethical issues in BRIC

Involving children in the BRIC project means that we must devote special attention to protecting their wellbeing. Guidance or guidelines on conducting research with children is a relatively new (e.g., Greene & Hogan, 2005). Indeed, the interest in accessing the perspective of children has been prompted by the United Nations Declaration on the Rights of the Child. From a scientific perspective, 'we have much to learn about children from children' (Greene & Hogan, 2005). The newness of the field, suggests that it would be unhelpful to search for one 'definite' set of guidelines on doing research with children. Instead, we should attempt to bring a broad range of perspectives to the analysis and exploration of children's experience. Thus, in the following, we outline observations and guidance recommended when conducting research with children.

Morrow and Richards (1996) recommend the following when conducting research with school children; conceptualizing children as less competent is unhelpful and it is important to see it critically, because it can provide teachers and parents with powerful normative models for what children are (or should be) like. Moreover, the authors reflect that it is important to take children's ideas seriously. Thus, researchers and adults need to resist the urge to trivialise and devalue children's acts as a matter of course. Researchers should be wary of set themselves up as the understanders, interpreters and translators of children's behaviours. Rather researchers should see children's competencies as 'different' rather than lesser. The biggest ethical challenge is the disparities in power and status between adults and children.

Craig (2003) reviews children's participation in community development research observes that while evaluative practice has developed considerably, evaluation practice with children had tended not be develop in tandem. Furthermore, Craig (2003) advises that for researchers who are promoting the development of policy with children and young people, and its evaluation, also have to accept that the outcome of such work may not be simply that the aims or methods of certain interventions are challenged but that challenge extents also to the organisational context within which such interventions are made. Put simply, work with children may increasingly challenge the power of adults both about what is done and how it is done.

Moving from treatment to prevention

The BRIC Project represents an innovative way of empowering school children to cope with the mental health issues that arise as a natural consequence of growing up. The project will be both preventive - address problems at an early stage and longitudinal- imbue students with the appropriate coping strategies that will be useful as they progress to adulthood and their chosen careers.

The project will particularly focus on building positive mental health and resilience as a tool to navigate relationships, conflict with peers and psychosomatic problems. To date solutions for mental health problems have been mainly individual-focused and pathogenic (e.g., therapy, medication) and have not addressed the system-level factors that contribute to dysfunctional coping strategies. Furthermore, these solutions are also limited as a result of the budgetary cuts associated with the current economic crisis. As a result, there is a pressing need for us to involve school children in developing tools to enhance resilience, and by doing so take ownership of their own school journey. Moreover, schools have not properly utilized the potential of their students to

self-develop solutions that are easy to use, accessible and focus on the potential for social rather individualistic approaches.

This special issue is devoted to delineating the objectives, concepts and rationale of the BRIC project. In the first paper, Barnes and Montgomery introduce us to the conceptual and measurement issues involved in operationalizing resilience. The authors argue for a connected or social approach to resilience, whereby young people are empowered to engage the already existing networks around them. Following this, we have a series of articles that highlight the key challenges in addressing youth mental health in Bulgaria (Alexandrova-Karamanova & Todorova), Romania (Ciuca & Baban), Turkey (Dogan, Goregenli, & Karakus), Greece (Karagianni), and FYROM (Mijakoski et al.,). The aforementioned countries that are situated in the Balkan South European region are facing significant challenges as the impact of the economic crisis has resulted in critical cuts in funding and staffing levels. Matos, Carmen, and Cicognani (2016) present an integrative review of the challenges in Portugal, Spain and Italy. In particular, the authors highlight the fact that young people in disadvantaged contexts perceive their role in their community and participation in civic activities as diminished. We finish the special issue with a UK perspective, firstly with Chase et al. (2016) who delineate a picture of contracting services in UK and note a turn towards preventative solutions as a way to address the shortfall in services. Secondly, Kasteel and Barnes (2016) provide an insight in to how social media and creativity can successfully provide younger people with tools to explore mental health and wellbeing. Additionally, their paper represents a great example of how a child psychiatrist and media company can collaborate.

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original article

BRIC - Conceptualizing and measuring resilience

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In terms of the mental health needs of children and young people, it has become increasingly clear that services, in their current configuration, are unlikely to ever be able to fully address need and demand (Guardian, 2015). The scale of demand has meant a shift towards more preventative approaches (Mental Health Task Force, 2016), with greater emphasis on seeking ways to "turn off the tap", rather than continuing "mopping the floor". Underpinning much of this preventative work has been a wider interest in resilience, for both the individual and the wider community, seeking to help children and young people to find the necessary resources to manage difficulties, without becoming overwhelmed and subsequently developing a need for specialist support.

What do we mean by resilience?

Multiple definitions of resilience exist. The original work on resilience aimed to understand what enabled some individuals to overcome difficult life circumstances and risk factors, viewing resilience as being successful adaptation, while hazards/difficulties relating to the individual or their environment increase the likelihood of a problem occurring (Rutter, 1987). Rutter, an early pioneer of the field, sought to locate the emotional and behavioral protective factors that could be useful for the whole population (Rutter, 1987).

Masten has defined resilience as "positive adaptation to adversity despite serious threats to adaptation or development" developing the phrase of "Ordinary Magic" (Masten, 2001) to assist our understanding of resilience, promoting the building of resilience as something "everyday" - such as a teacher checking in with a vulnerable student about their football match the night before.

Recently there has been a shift away from thinking about negative outcomes and damage caused by risk factors – with a greater interest in building on assets and strengths for both the individual and their surrounding communities – be they families, schools, youth clubs or the wider community environment.

The salutogenic model (Anthonovsky, 1987) possibly best exemplifies a model based on exploring strengths – encouraging the focus to be on the "sense of coherence" to determine whether the individual is impacted upon by the impact of hardship. But current research directions tend towards an emphasis on the socio-ecological context in which people experience risk factors and the identification of resources used for coping. This has been characterized by the Bronfenbrenner ecological model (Bronnfenbrenner, 1998) or Roisman (2002) who explored resilience as "an emergent property of a hierarchically organised set of protective systems that culminatively buffer the effects of adversity and therefore can rarely, if ever, be regarded as an intrinsic property of individuals". Hart el al, have perhaps refined this definition further, seeing resilience as "Beating the odds whilst also changing the odds" (Boing Boing, 2013)

Ungar (2011) has built upon this work allowing an understanding to be focused not just on the individual but to also think about those individuals

around the young person who might be needed to provide support, and thinking about the young person's place within their family and wider communities. Hence resilience is defined as:

I. The capacity of individuals to navigate their ways to resources that sustain well-being;

II. The capacity of individuals' physical and social ecologies to provide those resources

III. The capacity of individuals, their families and their communities to negotiate culturally meaningful ways to share resources (Ungar, 2011).

Connected resilience and relational mental health

The BRIC partnership have been looking to develop an understanding of resilience that acknowledges the social ecological perspective, whilst also supporting a framework that focuses more on strengths and assets, rather than deficits and difficulties. We are keen to move away from any paradigm that might seek to suggest resilience is something that you either have or you don't have, at an individualistic level.

Our aspiration has to be to focus on a more relational paradigm, building on the understanding of positive youth development within its relational context, enabling the needed support and scaffolding to be understood through relationships with oneself, with others and within our communities.

To develop this more relational approach we need to also consider a relational theory underlying the development of "self" (Ryle, 2002) – a theory which informs our emotional wellbeing and mental health. Understanding this relational model of development, and drawing on tools informed by Attachment Theory (Bowlby, 1971), we are then able to explore a relational approach to building resilience.

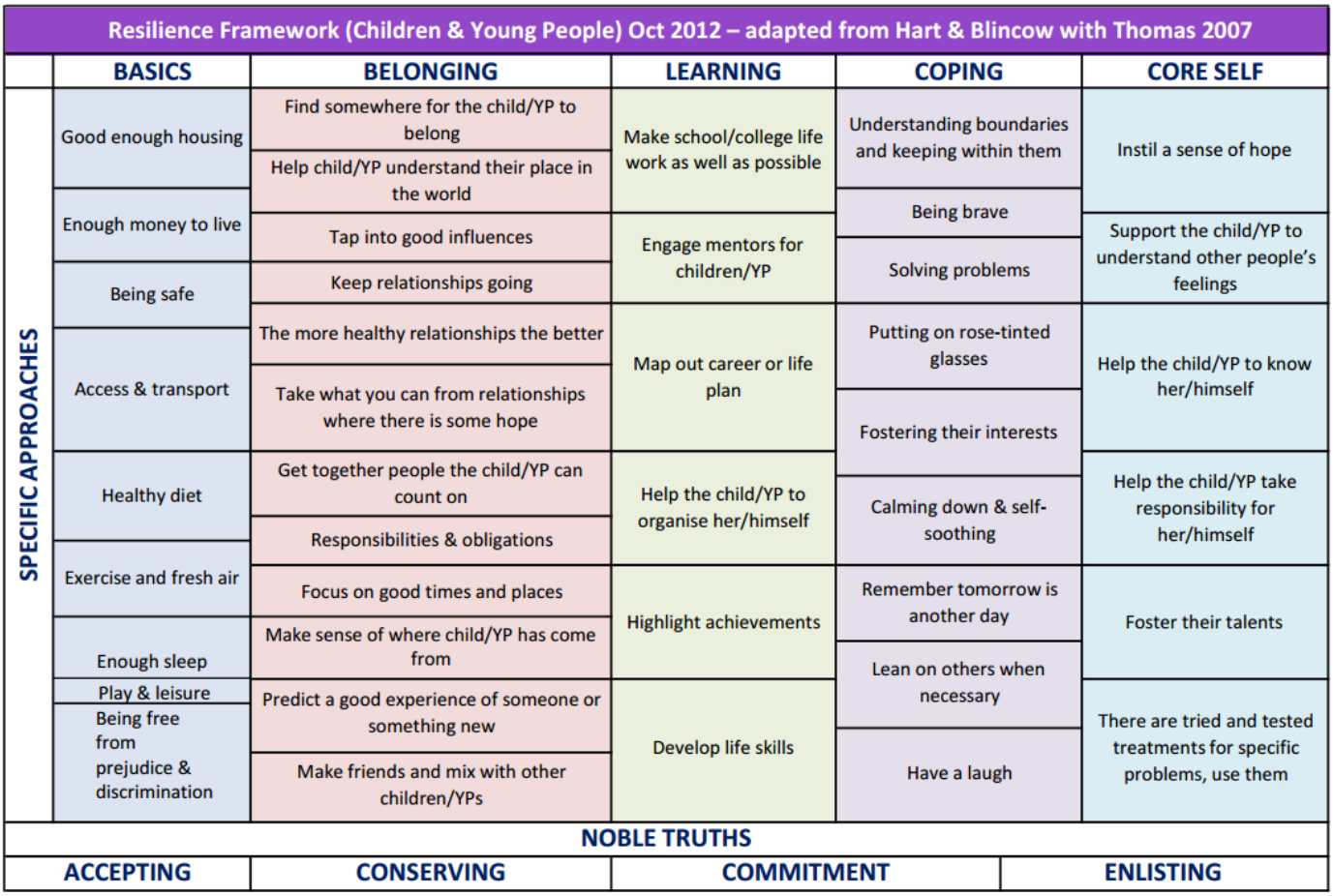
Connected Resilience is a model that focuses on building and sustaining connections/relationships – with parents, siblings, peers, schools, communities. Connections that enable a sense of belonging from which one can grow, explore and learn.

The resilience framework, developed by Hart et al, (Hart, 2012) outlines multiple approaches and interventions that can be considered for both the individual, and also across wider systems – to build resilience. The framework allows one to focus not only on the individual, but also on what the systems around the young person can do.

Many variations of the "Whole School Approach" to building resilience or addressing mental health exist (Cairns, 2006)often informed by attachment theory: working with a student within their Zone of Proximal Development (Berk, 1995) by starting where a young person is developmentally, and building on their potential and capacity to learn – educationally and developmentally.

Peer mentoring programmes often demonstrate this relational approach as there has been considerable evidence (Wheeler, 2010) that structured mentoring approaches using Positive Youth Development models result in increased levels of emotional resilience in both the mentor and mentee. Such models are structured around the development of the interpersonal relationship, as well as socio-emotional development and cognitive development. Many existing peer mentoring programmes (MBF, 2012) for young people focus on outcomes such as increased educational attainment or employment opportunities. But more recent developments (Brown, 2015) have been keen to utilize the relational focus of the work and look to build emotional resilience.

For cohorts where there are recognized vulnerabilities – such as being in the care of the local authority, or growing up in a family with parental mental health difficulties – then focused interventions allied with peer support are proven to have significant impact (Cooklin, 2013). Interventions such as the Kids Time Workshops



Resilience Framework (Children & Young People) Oct 2012 – adapted from Hart & Blincow with Thomas 2007					
	BASICS	BELONGING	LEARNING	COPING	CORE SELF
SPECIFIC APPROACHES	Good enough housing	Find somewhere for the child/YP to belong	Make school/college life work as well as possible	Understanding boundaries and keeping within them	Instil a sense of hope
		Help child/YP understand their place in the world			
	Enough money to live	Tap into good influences	Engage mentors for children/YP	Being brave	Support the child/YP to understand other people's feelings
	Being safe	Keep relationships going		Solving problems	
	Access & transport	The more healthy relationships the better	Map out career or life plan	Putting on rose-tinted glasses	Help the child/YP to know her/himself
		Take what you can from relationships where there is some hope		Fostering their interests	
	Healthy diet	Get together people the child/YP can count on	Help the child/YP to organise her/himself	Calming down & self-soothing	Help the child/YP take responsibility for her/himself
	Exercise and fresh air	Responsibilities & obligations			
	Enough sleep	Focus on good times and places	Highlight achievements	Remember tomorrow is another day	Foster their talents
	Play & leisure	Make sense of where child/YP has come from		Lean on others when necessary	
	Being free from prejudice & discrimination	Predict a good experience of someone or something new	Develop life skills	Have a laugh	There are tried and tested treatments for specific problems, use them
		Make friends and mix with other children/YPs			
NOBLE TRUTHS					
ACCEPTING		CONSERVING	COMMITMENT		ENLISTING

Figure 1. The Resilience Framework (Reprinted with the permission of Angie Hart)

allow for the children and young people to understand their parent's difficulties and distress, but also believe that there is a trusted adult available to support them if they feel overwhelmed.

Lastly building resilience within the community seeks to have a positive impact on all – individuals, parents, families, schools, businesses, housing estates etc. Much of this work has been focused on the concept of Social capital (Sanders, 2016) "the collective value of all social networks (who people know), and the inclinations that arise from these networks to do things for each other (norms of reciprocity)" - and how this enables the people to feel a sense of connectedness within their community. By developing a relationally informed approach to resilience, we are interested in exploring this perspective of "connectedness" – as there is clear evidence that community resilience can be built up and developed if those within the community feel more connected and engaged in community life (McKenzie, 2015).

How to measure – what to measure?

Attempting to operationalize the concept of Connected Resilience is challenging. However, there are multiple ways of showing that a young person feels connected with their peer group, their school, their family and their community. What can be more problematic is measuring change, being

difficult to determine causation and impact of interventions.

At an individual level there are many tools available to directly measure resilience, with the CYRM (Liebenberg, 2012) SRS (California Department for Education, 2004) and the RSCA (Prince-Embury, 2005) being some of the most frequently used measures. Not all of these tools are validated for showing change, but all offer a baseline perspective for resilience and connectedness.

One can also explore an indirect measure of resilience – through components that make up resilience. Tools such as Strengths and Difficulties questionnaires (Goodman, 1997) Wellbeing scales (Tennant 2007) or self-efficacy (Rosenberg, 1965) tools can all be correlated with a young person's Connected Resilience.

Building on the idea of connectedness, a focus on family and parent-child relationships can be helpful. The Family Functioning scale (Moos, 1994) explores relationships within a family whilst the Schools Organisation and Climate Scale (Hart, 2000) takes this model and applies this to a school setting, and the Social Support Index (McCubbin, Paterson, & Glynn, 1987) seeks to combine family and peer networks. Broadening this ecological perspective even further, the Health Promoting School Scale (Deschesnes, 2003) helps focus on a specific community and relationships within, with a focus on a sense of satisfaction, whilst the Social Capital Scale (Onyx, 2000) builds on the wider framework mentioned previously, allowing for a broader, more holistic sense community resilience.

Lastly, tools such as the WARM measure (Mguni & Bacon, 2010) are designed as a way of "Taking the Temperature of Local Communities" offers a good example of how to measure a community's overall connectedness and resilience.

Summary

Resilience needs to move from an individual to a socially connected model, that addresses the development of the self within a socially saturated world. Congruently, the word 'resilience' is evocative of a reaction rather an active/preventive strategy that identifies potential threats to well-being. A greater focus on salutogenic concepts will help to address this pathogenic bias.

There are a considerable number of measurement tools available. In this paper, we have developed the idea of connected resilience, and the challenge is to link this new concept to evidence suggesting that the effective mastery of social and emotional skills supports the achievement of positive life outcomes, including good health and social wellbeing, educational attainment and employment, and the avoidance of behavioural and social difficulties.

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original article

Youth mental health context in Bulgaria

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Social and legislative context in Bulgaria

The social changes in South Eastern Europe over the past quarter century have been co-ntradictory, dynamic, and multilevel in their relevance to health, and have been particularly important in exacerbating inequalities. These phenomena need to be addre-ssed in their psychosocial, economic, and cultural contexts. Some countries in this area of Europe, including Bulgaria, exhibited worsening health indicators during this period (Todorova, 2011). Even though this phenomenon of health decline has shown recent signs of improvement, it conti-nues to be of central interest both in terms of implications for the current health and well-being of the populations, and in terms of practical and theoretical lessons learned for the future. These changes are also relevant to mental health, including the mental health of young people in the region.

In Bulgaria, one of the policies of the general National Health Strategy 2014-2020 'Creating conditions for health for all through the lifespan' dedicated to mental health, is 'Protecting and improving mental health'. The focus of this mental health policy is on mental health promotion, starting from early childhood and continuing through the lifespan – an area that is currently evaluated to be unsatisfactorily addressed. Another aspect that is currently missing is the development of an effective community-based system for psychosocial rehabilitation. The National Health Strategy envisions the establishment of community-based mental health services with multidisciplinary teams of professionals for children and adolescents, which will bridge the gap between the existing medical and social services. The National Mental Health Programme 2014-2020 is still under development.

Prevalence of mental health problems in Bulgarian children

In general, among the 42 countries participating in the Health Behavior in School-aged Children (HBSC) 2014 study, Bulgarian children are among those that experience the highest multiple health complaints - for girls these numbers are 39% of 11 year olds, 50% of 13 year olds, 60% of 15-year-old girls (Inchley et al., 2016). According to this HBSC national representative survey in Bulgaria, 19.9% of the girls and 12.1% of the boys cluster in a group with poor mental health (Vasileva et al., 2015). Mental health symptoms that are most frequently reported are feeling nervous (36.8%) and being irritable/with bad temper (30.9%) every day or more than once a week. Bulgarian 13 and 15 year old youth also report some of the highest rates of alcohol consumption among the countries in the HBSC survey, including drinking alcohol at least once a week, and been drunk on two or more occasions (Inchleyet al., 2016). It has been estimated that 9% of the Bulgarian children require some sort of mental health care (Kovess et al., 2015). The suicide rate for adolescents aged 15-19

was 3.0 per 100 000 persons in 2010 (Eurostat: Causes of death). In 2014, 224.1 per 100 000 of children under 18 were hospitalized with mental and behavioural disorders (NCI & NCPHA, 2016).

Available services and unmet mental health care needs

According to the School Children Mental Health in Europe (SCMHE) study, 91% of Bulgarian children, who need care for mental health problems, have not received any mental health care consultation (Kovess et al., 2015). This proportion of unmet mental health care needs is the highest within this international dataset. According to the same study, Bulgarian children in need of psychiatric care had the lowest rate of consultation with a psychiatrist (4.4%). Children needing mental health care in Bulgaria usually visit general practitioners (70.7%) or paediatricians (43.8%).

In 2014 in Bulgaria there were 12 psychiatric hospitals with 2393 beds and 12 state mental health centres with 1506 beds (NCI & NCPHA, 2016), including specialized units for children and adolescents. In 2014 there were 0.7 psychiatrists per 10 000 citizens (NCI & NCPHA, 2016). Child psychiatrists in Bulgaria are greatly needed - their number is particularly low and they are unevenly distributed through the country. Indeed, within the Bulgarian Health system "Child psychiatry" didn't exist as a separate medical specialty until 2007.

Psychological services are not covered by the National Health Insurance Fund and have to be covered by parents. This is difficult for many families, given that the median wage in Bulgaria is the lowest in the EU and 21.0% of the population were at risk of poverty in 2013 (Eurostat: Income distribution statistics). In 2008 only 0.3% of Bulgarians aged 15-24 have consulted a psychologist during the last year (Eurostat: Mental health). From the children with mental health problems requiring non-psychiatric care only 7.3% have met with a psychologist/psychotherapist (Kovess et al., 2015). At present there are a small number of community-based centers for free mental health care services operated by NGOs.

In summary, it is clear that there is room for improvement of the mental health care for youth in Bulgaria, particularly by focusing on prevention. The current social and healthcare system context is complicated, as there are multidirectional and contradictory influences on youth. Since youth are those that best understand how the situation is affecting them, what are their main sources of difficulties, what are their challenges and resources - it would be most beneficial for the youth themselves to be actively involved in understanding these phenomena and developing preventive programs and approaches. This is the impetus of the BRIC project which proposes a Participatory Action Research framework and co-development of culturally relevant preventive approaches to protect youth mental health.

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original article

Youth mental health context in Romania

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Context

Adolescence is a crucial developmental period for promoting mental health and reducing risk factors for mental health problems. Youth mental health is influenced by a variety of factors, including socio-economic and cultural contexts, inequality, stigma and discrimination, a non-supportive environment as well as pressure to succeed. Several care systems (e.g. education, welfare, health) may underestimate both the vulnerability factors which are specific to different adolescent groups and the precise manifestations of mental health disorders in youths.

During the last 25 years, Romania's socio-political context has been challenged by the transition to democracy. Despite a rapidly growing economy, poverty remains an important issue for many Romanians. A 2013 UNICEF report shows that one in four children lives in a household with an income below the relative poverty line. According to the National Authority for Children's Rights and Adoption, in 2015, more than 80,000 children had parents working abroad. Non-governmental organisations argue that these official numbers don't represent the entire phenomenon and estimate that the number of children growing up alone is approximately 350,000. This vulnerable family context comes with high emotional costs for the children (Baban, Taut, Craciun, & Marcu, 2009; Baban & Taut, 2010). At the end of 2015 more than 20,000 children were officially in institutional care, a group exposed to higher risk of social exclusion, stigmatization, behavioural and mental health problems (Baban, Marcu, & Craciun, 2008; Baban & Taut, 2011; Taut, Damian, Lobonea, & Baban, 2011).

Financial cutbacks in several public sectors during the last years have been associated with reduced wages and lack of new employment in the health sector. This had a significant effect on a number of factors associated with mental health, such as employment, secure incomes, and social support (Nica, 2013). In spite of the Action Plan for Implementing the Mental Health Strategy in Romania (2006-2015) which aimed at: (1) developing the community services for mental health, (2) improving service quality in psychiatric institutions, (3) promoting the rights of persons with mental health problems, the economic context of the last years has slowed the development of mental health services for children and adolescents in Romania.

Prevalence of mental health problems

The most commonly identified mental health problems among children and adolescents in Romania were anxiety disorders (13%), ADHD (5%), affective disorders (3.5%), conduct disorders (2%), and drug addiction. Additionally, approximately 1 in 500 children are diagnosed every year with autism spectrum disorders (Save the Children Organization, 2010). Approximately 9% of Romanian children require mental health care every year (Kovess et al., 2015).

Based on data from the Health Behaviour in School-aged Children (HBSC) national representa-

tive survey from 2014, 24% of girls and 11% of boys of 11-15 years old reported poor mental health. Moreover, 35% of girls and 25% of boys reported feeling sad in the week prior to the study. Other reported symptoms were: lack of energy (30%), irritability (25%), anxiousness (24%), and sleeping problems (20%), (Baban, 2016). Body image concerns and dissatisfaction were also risk factors for positive self-image, self-esteem, and emotional well-being. One in 3 girls of 15 years old perceived themselves as being overweight and had negative feelings about their body (Baban & Taut, 2014; Nanu & Baban, 2014; Nanu, Taut, & Baban, 2013; Nanu, Taut, & Baban, 2014). Bullying is another relevant risk factor for mental health problems among adolescents (Cosma, Balazsi, & Baban, 2015). Bullying, the expression of interpersonal power through aggression towards another, was a behaviour reported by 30% of boys and 19% of girls, at age 15. On the other hand, 17% of boys and 11% of girls reported being victims of bullying at school in the past couple of months (Cosma & Baban, 2013). Data from 2014 HBSC report shows that cyber bullying was experienced by 5% of boys and 3% of girls of 11 years old. This phenomenon seems to be decreasing to 3% of boys and 2% of girls at the age of 15 years old.

Data from a national survey on adverse childhood experience showed that more than 25% of youth were exposed to physical and emotional abuse inside the family in the first 18 years of life. Sexual abuse was reported by 9% of the participants, with girls reporting significantly higher levels of sexual abuse than boys (Baban, Balazsi, Cosma, Sethi & Olsawski, 2013). Abuse in childhood was associated with additional health risk factors later in the life (Bellis et al., 2014).

According to Eurostat, the suicide death rate in Romania for adolescents aged 15 to 19 decreased from 6.6 per 100,000 persons in 2011 to 5.8 in 2012 and to 5.4 in 2013. However, research indicates that (Sarbu, Bunaciu, & Maris, 2014), more than a third (37.8%) of adolescents admitted to know someone with suicidal thoughts, 15.8% had suicidal thoughts themselves, 13.5% wanted to commit suicide and 5.6% had at least one suicide attempt.

Available mental health services

Children needing mental health care mainly visit general practitioners (85.1%) or paediatricians (38.6%). That being said, approximately 75% of children do not receive any mental health services (Kovess et al., 2015). Services for children and adolescents are insufficient and unequally distributed across the country (i.e. urban vs. rural areas). Clinical psychology, psychotherapy, counselling, outpatient support, psychosocial interventions and rehabilitation services for adolescents are undoubtedly insufficient. To date, the most accessible therapeutic services are pharmacological treatments (Carral Bielsa et al., 2009). In fact, mental health services for children and adolescents in Romania are currently offered in 15 major psychiatric clinics and 20 Mental Health Centres (Save the Children Organization, 2010). Psychiatry services are also in great need of development: Romania has one of the lowest numbers of professionals working in mental health in Europe, with 4.7 psychiatrists and 22.4 nurses per 100,000 inhabitants (World Health Organization, 2008). The public mental healthcare system for children still focuses more on curative actions than on the preventive side (Baban, Craciun, Balazsi, Ghenea, & Olsawsky, 2008). So far, there has been a limited number of awareness campaigns promoting the rights and needs of children with mental disorders, or encouraging their social inclusion and prevent discrimination (Baban, 2009; Baban & Craciun, 2010; Zlati, Oh, & Baban, 2011). Therefore, it becomes evident that more action is needed to promote prevention programmes.

Conclusions

In dealing with the challenges of growing up and become active adults, appropriate mental health services are crucial for children and adolescents. Mental health services can help achieve and maintain optimal psychological, social, physical functioning and well-being.

In developing mental health preventive services for children and adolescents, Romania faces several challenges. Firstly, more professionals trained in mental health are needed in all public institutions which involve young people. Secondly, professionals need to be able to rely on a coherent national public policy that efficiently integrates all services and social actors involved in youth mental health. Thirdly, public policy must guarantee that youth and professionals have access to relevant resources, and provide a framework for all social actors (e.g., schools, NGOs, public/private institutions) to easily get involved in mental health preventive measures. It is necessary to make youth voices heard, to better identify their needs and design prevention programs that successfully address these needs. This can be achieved by empowering young people to become active in designing and carrying out programs to increase awareness towards mental health prevention, and wellbeing.

Successful preventive health services and programs need to be effective in promoting healthy lifestyle choices and behaviours. Professionals in health, social, and educational systems need to become active in reaching out and providing support. Moreover, young people need to be empowered to seek information, support, and treatment when needed, without the fear of stigma.

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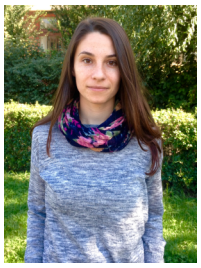

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original article

Youth mental health context in Turkey

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According to the census of 2015, the population of Turkey is approximately 79 million, with children (ages 0-18) and young adults (19-24) constituting 40.2 % of the entire population (Turkish Statistical Institute, 2015). Eleven percent of these children and adolescents suffer from various types of mental health problems (United Nations International Children's Emergency Fund, 2012). However, there are high numbers of untreated emotional, psychological, and psychiatric problems among children and adolescents due to the limited number of mental health professionals and shortage of mental health services in Turkey (Coskun, Zoroglu, & Ghaziuddin, 2012).

The current 'National Mental Health Action Plan' in Turkey is based on the mental health policy of the Ministry of Health. This action plan covers the activities that are being implemented between 2011-2023. The main activities include the establishment of community-based mental health services, the use of patient-centered approaches, the promotion of preventive intervention services, and the integration of mental health services in other health-related services both in the rural parts of the country and in the city centers (The Ministry of Health of Turkey, 2011).

According to a Ministry of Health of Turkey report (2011), there are 206 child and adolescent psychiatrists (0.28 per 100.000) working in hospitals or in private practice. This number is very low compared to European countries where there are 1.5 child and adolescent psychiatrists per 100.000 inhabitants (World Health Organisation, 2008). There are also 1.370 psychologists (2.20 per 100.000) working in the mental health field in Turkey. As compared to other European countries, this ratio is also considered very low. For example, there are 47 psychologists in Finland, 30 in the Netherlands, 14 in Greece and 10 in Denmark per 100.000 people (World Health Organisation, 2008). As the data shows, the number of mental health professionals working with children and adolescents are sparse in Turkey.

Over the past years, alcohol, drug and substance use have become one of the major problems affecting adolescents' life negatively in most societies. Despite the fact that there is a noticeable increase in drug use especially among adolescents in Turkey the prevalence of drug use in the young adult population is still far below the rates reported for most European Union countries and the United States (Ayvasık & Sümer, 2010). Ögel, Taner, and Eke (2006) showed that the life time prevalence was 37% for cigarette use and 51% for alcohol use among adolescents. Inhalants (5.9%), marijuana (5.8%) and flunitrazepam (4.4%) and ecstacy (3.1%) were the most commonly used substances among adolescents. According to Isıklı and Irak's comprehensive report (2002) the mean age of onset was reported as 12.83 years old for smoking and 13 years old for alcohol use. In a study including a large number of adolescents and using the Health Behavior in School-aged Children Survey (HBSC 2009/2010), Cavdar et al. (2016) found that 34% of the adolescents reported they experimented with smoking and 6.6% of them did so before the age of 11. In addition, 15% of the adolescents reported that they smoked regularly

and 18% of them got drunk within the last month. Furthermore, 13.3% of the youth reported that they bullied their peers at least two times and 12% of the youth reported that they were the victims of bullying.

Similar to many countries, suicide is the 4th leading cause of death among youth aged between 15-19 in Turkey (Turkish Statistical Institute, 2014). Eskin, Ertekin, Dereboy, and Demirkıran (2007) found that 23% of the high school students (aged 13-18) reported that they had thought of killing themselves at least once in their lives and 2.5% of them had attempted to kill themselves. Previous research also shows that women are at higher risk for suicide. The risk factors for young women, especially those living in the rural areas include forced marriages at early ages, domestic violence, sexual abuse, and lack of social support (Coskun et al., 2012).

Turkey is currently undergoing rapid social change that has been strongly affected by social factors at the personal, family, community, and national health system levels. These social determinants that affect adolescents' health are crucial for the health and the social development of the whole society. More cross-national and cross-cultural research is needed to determine how age, gender, developmental, family, and socio-political based community factors may mediate the strength and nature of social change, and to understand what type of interventions are the most effective in a variety of settings and cultural contexts.

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original article

Youth mental health context in Greece

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The context in Greece

In 2015, Greece entered its seventh year of recession and has been operating within severely constricted fiscal limits. The Greek healthcare system is falling apart after years of austerity and is dealing with major problems that have resulted from the economic crisis. Not surprisingly, this sector has suffered the most due to austerity. Public hospitals have had to reduce budgets (on average) by 50% during this time. Basic supplies in materials such as gloves, syringes and cotton wool have long been in short supply. The numbers of doctors and nurses is critically low (Chrisafis, 2015). While nurses greatly outnumber physicians in most OECD countries, the opposite is true in Greece, where there are twice as many doctors as nurses (Organisation for Economic Co-operation and Development, 2016).

In Greece public and non-profit mental health service providers have scaled back operations, shut down, or reduced staff; plans for development of child psychiatric services have been abandoned; and state funding for mental health decreased by 20% between 2010 and 2011, and by a further 55% between 2011 and 2012 (Anagnostopoulos & Soumaki, 2013).

The Greek Ministry of Health and Social Solidarity is in charge of allocating budgets for Mental Health and the national budget for Child and Adolescent Mental Health does not compose a separate budget, but is incorporated in the overall Mental Health budget (Puras, Tsiantis, & Kolaitis, 2010).

The gap in service provision is being filled by non-governmental organisations (NGOs), who plan and put into practice mental health projects and services. Most of the services tend to be oriented towards relief even-though some are working towards developing progressive services. Overall, the Government gives less funding for Mental Health services in relation to General Health and, not surprisingly Child and Adolescent Mental Health receive even less funding (Puras et al., 2010).

Greece lacks appropriate policies for child and adolescent mental health. Consequently, services do not form part of an overall system, and as a result they are quite limited and have to deal with barriers when there is a need to integrate new knowledge in a systematic way.

Prevalence of mental health problems in Greek children

Recent changes in the Greek educational system has resulted in more stress and anxiety among adolescents; the new system in the Lyceum where students have to be examined in four basic courses instead of 6 for their entrance in the university has caused anxiety to students where besides their everyday attendance to school the majority of them also attend extra private educational institutions (called frontistiria). Frontistiria teach the same exam material as schools and the majority of students along with their everyday attendance at school they spend on average 4-5 hours in these institutions. Entrance to higher education depends on performance in the exams and thus attendance at these schools is seen as obligatory. These results

in longer hours for students and an extra financial burden for less affluent families (Sianou-Kyrgiou, 2008).

The fear of school's exams results has caused higher levels of psychological distress. The number of adolescents, who look for psychological help, in order to be able to handle the anxiety of the exams, has risen considerably in the last year. Moreover, the number of hospital admissions due to suicide attempts or constant and severe non-organic somatic symptoms (abdominal pain, recurrent severe headaches, conversion symptoms, etc.) has noticeably increased (Giannopoulou & Tsobanoglou, 2014).

The available evidence points to a substantial deterioration in mental health status. Findings from population surveys suggest a 2.5 times increased prevalence of major depression, from 3·3% in 2008 to 8·2% in 2011, with economic hardship being a major risk factor (Economou, Madianos, Peppou, Patelakis, & Stefanis, 2013). Greek families are less able to provide a supportive framework for children and adolescents.

With regard to the provision of mental health services for children and adolescents the National Action Plan Psychargos, examining the period between 2000-2009, reported that only 30% of the planned mental health services for children and adolescents have been created (Loukidou et al., 2013). In addition, those services are not equally distributed across Greece, and as a result most of them are functioning only in the bigger cities (Athens, Thessaloniki) while other prefectures do not have mental health services for children at all. Not surprisingly, the demand for mental health services is increasing, with research indicating a 39.8% increase in new cases in public outpatient services for children and 25.5% for adolescents (Anagnostopoulos & Soumaki, 2012).

Furthermore, economic difficulties mean that less people are able to access private health care, which is increasing the pressure on the public sector especially in terms of waiting lists and the waiting times (Christodoulou, Ploumpidis, Christodoulou, & Anagnostopoulos, 2012).

Data from adolescent inpatient units showed an admission increase of up to 84 %, with diagnoses on admission of borderline conditions, severe behavioural disorders, acute psychotic crises, self-harm behaviours, and other similar conditions constituting 78% of the total cases in 2011, compared to only 48 % in 2007. Borderline states are now more common, and generalised substance abuse has spread throughout the majority of schools, along with bullying and racist behaviours. Acting out behaviour is commonly the main mechanism for the expression of adolescent psychopathology, both at an individual and a social level.

Available services and unmet mental health care needs

The existing National Healthcare System CAMHS, which is the core of the service provision system, now functions with 10–40 % less employees, who are not paid on a regular basis and whose salaries have been reduced by 40%. A significant portion of the more qualified personnel (i.e, those with years of experience) has been forced to retire. Furthermore, the number of new incidents has increased, and the need for supportive work within the community (as a result of the collapse of social services) and schools (due to a lack of psychological services) has also increased. In reality, child psychiatric services now have to substitute and cover the work of other services (Anagnostopoulos & Soumaki, 2013).

Several large-scale programmes have been established in Greece relating to child and adolescent mental health such as: parenting and community training, Help-lines for children and adolescents, The Daphne II Programme, Needs assessment and awareness-raising interventions on

bullying in Schools, Programme to Reduce Stigma and Discrimination due to Schizophrenia. The lack of infrastructure and as a result lack of funding leads to actions being implemented without being monitored or evaluated. Although Greece has ratified the "Convention on the Rights of the Child", the Greek state does not deliver on certain standards (Puras et al., 2010). For example the pre-natal, labour and post-natal care for women illegally entering Greece is not adequate. In addition, children and families, living in remote, rural areas have limited access to services, goods and resources due to geographical reasons and other adversities.

Out of the 54 prefectures, 20 prefectures are without Mental Health services for children and adolescents while the rest of them do not have adequate staff numbers. Significant staff reductions (40% for some services) threaten many current services. Ironically, some of these services (i.e., day centres, hostels for adolescents with Mental Health difficulties, services for autistic children etc.) had recently started to gain ground in Greece. Apart from the funding cuts, the collaboration and co-ordination between ministries, government organisations, and NGOs is rudimentary and has many gaps, which is a major issue (Puras et al., 2010).

Conclusion

In Greece there are many challenges involved in trying to introduce preventative mental health programs and interventions in Greek Schools. The bureaucracy that is present in all public settings is a significant barrier to changes to be accomplished. Civil society organizations are trying to fill the gap and organisations like A Child's Smile (To xamogelo tou paidiou) offer help to children in need. Schools offer the prime area through which teenagers can develop appropriate behaviours in relation to their psychological and physical health. The school has the potential to play an important role in helping to ameliorate the problems associated with economic hardship, such as the stress on family relationships and loss of social capital. Mental health can be a taboo subject for all individuals, also the teachers who are not trained to deal with these issues and in many cases can be prejudiced and incapable of offering appropriate help. In order for a change to be accomplished all these issues need to be addressed and also children's voices need to be heard. Schools, especially public schools, represent the centre of a community and as such are well placed to be vehicles for preventative strategies aimed at building positive mental health and resilience among young people.

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original article

Youth mental health context in R. Macedonia

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Socio-economic challenges

The socio-economic circumstances in the R. Macedonia are a function of a prolonged process of transition and global crisis, accompanied by the EU accession requests. They also reflect the changes in the national health care system such as reforms, new legislation and financing mechanisms, and privatization of health care institutions. Therefore, the system faced and still faces multiple challenges in improving access, quality, and efficiency within continuous health care reforms (Karadzinska-Bislimovska et al., 2013). To improve the quality of care in general and, particularly, mental health care, there is still a need for programmatic and social policies with on adequate emphasis on stress prevention and improvement in the mental health status of young people. According to the World Bank Group (World Bank Group, 2016), in 2004 the proportion of the population under the age of 15 years in R. Macedonia was 21%.

Legislation context

In R. Macedonia, health care for persons with mental health problems is provided on three levels. Primary health care physicians have to detect the problem and refer patients to higher levels of health care. Secondary health care is provided by the neuropsychiatry specialist-consultative outpatient services that functions within Health Centres throughout the country, as well as by the Institutes for Children and Youth in Skopje and Bitola. Neuropsychiatry departments within General Hospitals provide inpatient secondary care. The tertiary level is represented by psychiatric hospitals that are mainly providing care for patients with mental health problems. Additional tertiary inpatient mental health care is provided by the University Clinic of Psychiatry and Neuropsychiatry department within the General Hospital in Skopje (World Health Organization, 2009). Concerning the financing of mental health services, 3% of health care expenditures are directed towards mental health (World Health Organization, 2009).

The National Mental Health Committee and the Coordinator for mental health, both appointed by the Minister of Health, provide advice to the Government on mental health policy and legislation. Mental health policy from 2005 includes several pillars: developing community mental health services, downsizing large mental health hospitals, developing mental health services within primary health care, strengthening human resources, involvement of users and families, advocacy and promotion, human rights protection of users, equity of access to mental health services across different groups, financing, quality improvement, and monitoring system (World Health Organization, 2009). The Mental Health Law, adopted in 2006 and its changes from 2015 regulate the basic principles of mental health protection and promotion, as well as rights and

responsibilities of persons with mental illness (Mental Health Law, 2006). The improvement of mental health as well as the improvement of health services for persons with mental health problems was also included in the Strategic Plan of the Ministry of Health (Ministry of Health, 2012). The prevention and control of mental health problems were incorporated within National Strategy of R. Macedonia for prevention and control of non-communicable diseases (Ministry of Health, 2009). Additionally, the Government of the R. Macedonia in 2014 adopted the Program for active health care of mothers and children for 2015 aimed at continuous improvement of the health status of children and women in the reproductive period.

Prevalence of mental health problems

The Institute of Public Health of RM, Skopje, reported about 6951 persons treated in mental health facilities in the country (in 2014) and 3.5% of them were children and adolescents aged below 19 years (Institute of Public Health of R. M., 2015). According to the World Health Organization data about the burden of mental disorders in R. Macedonia (in 2014, per 100,000 population), disability-adjusted life years were estimated at 3441 and the suicide rate was 6.7 (World Health Organization, 2015).

In a survey of adverse childhood experiences in 1277 students aged 18 and above from a representative sample of high schools and universities in RM (Raleva, Jordanova Peshevska, & Sethi, 2013), a high self-reported rate of physical (21%), emotional (10.8%), and sexual abuse (12.7%) was identified, as well as physical (20%) and emotional neglect (30.6%). Household dysfunction was also common: 10% witnessed violent treatment of their mother, 3.7% lived with someone who abused drugs, 10.7% lived with an alcoholic, in 6.9% a household member had a mental illness, and in 5% a household member had been incarcerated, and 3.8% had experienced parental separation. This survey (Raleva et al., 2013) showed that adverse childhood experiences were linked to health-risk behaviours, implying an association with long-term poor health outcomes. Emotional abuse doubled the likelihood of drug abuse, tripled the likelihood of attempted suicide, and increased the likelihood of early pregnancy by a factor of 3.5. Additionally, physical abuse increased the likelihood of early pregnancy 8.3 times and doubled the likelihood of attempted suicide. The rate of current alcohol use by students was about 28% and the rate of lifetime drug use was 5.4%. Overall, suicide attempts were reported by 2.8% of respondents.

Available services and unmet mental health care needs

In R. Macedonia there are 19 mental health outpatient facilities (World Health Organization, 2015) as well as six mental health day treatment facilities (three provide treatment for children and adolescents only) (World Health Organization, 2009). There are also four mental hospitals and 12 psychiatric units in general hospitals, including specialized units for children and adolescents (1% of beds in mental hospitals reserved for children and adolescents only) (World Health Organization, 2009; 2015). Of all outpatient mental health facilities available in the country, about 14% are specialized for children and adolescents (World Health Organization, 2009). Only 6% of all users treated in mental health outpatient facilities were children or adolescents (World Health Organization, 2009).

The percentage of mental health facility users that are children and/or adolescents varied substantially from facility to facility. The proportion of

children users was highest in mental health outpatient facilities (6%) followed by mental hospitals (i.e. 4%). The lowest proportion of children and adolescents treated was in community inpatient units (1%) (World Health Organization, 2009).

Data obtained from the "Mental health atlas - country profile 2014" (World Health Organization, 2015) show that availability and status of mental health reporting in the country is weak, indicating that mental health data are compiled only for general health statistics. Data for some core mental health indicators are available, including those related to mental health policy and law, and workforce availability. It is important that mental health policy and law are fully in line with human rights covenants. Unfortunately, there is a considerably lower quality of data for other indicators, such as items related to mental health spending, social support for persons with mental disorders, service coverage as well as continuity of care for persons with severe mental disorders. The number of NGOs in the country involved in individual assistance activities such as counselling, housing, or support groups is also unknown (World Health Organization, 2009).

Additionally, only 5% of the training for medical doctors and nurses was devoted to mental health and only 3% for primary health care physicians. Nurses and non-doctor/non-nurse primary health care workers have received at least two days of refresher training in mental health. Moreover, such training modules were insufficient and did not cover identified needs for education (World Health Organization, 2009).

The percentage of psychiatrists and nurses with at least two days of refresher training in child/adolescent mental health issues was only 8% and 2%, respectively (World Health Organization, 2009).

In terms of support for child and adolescent health, 44% of primary and secondary schools had either a part-time or full-time mental health professional, but few primary and secondary schools have school-based activities to promote mental health and prevent mental disorders (World Health Organization, 2009).

As a conclusion, mental health care for children and youth in R. Macedonia is not satisfactory. Programs for the promotion and prevention of mental health problems for vulnerable groups are neither sufficient, nor comprehensive. Community mental health services for children and youth are still underdeveloped. There is also a lack of professional staff in the country dealing with mental health problems in children (child and adolescent psychiatrists, child and adolescent psychologists and social workers), although nowadays there is separate medical specialization in Child and Adolescent Psychiatry with a total duration of 60 months.

Child and adolescent mental health issues are of particular interest for occupational medicine specialists. Within work ability assessment, there are two specific procedures, identified as professional orientation and professional selection. Namely, professional orientation involves work ability assessment in students finishing their primary or high school education in order to choose their future career that will best suit their physiological and psychological characteristics. On the other hand, professional selection puts an emphasis on the selection of the most capable and fit persons for workplace activities. Additionally, psychological aspects of the work include psychological adaptation of the worker to the workplace activities through training and education, as well as adaptation of the work to the mental needs and capacities of the worker (Karadzinska-Bislimovska, 2011).

It is obvious that there are many unmet mental health care needs for children and youth in R. Macedonia. The most important challenges in introducing mental health preventive programs for young people in schools in the country arise from the opportunities to support young people before

the onset or at the early stages of mental health problems. Population level preventive programs that involve young adults in all stages (design, delivery and evaluation) have specific advantages over strategies that focus exclusively on the individual. Since they target a much broader audience, they have the potential to produce widespread effects at the population level, especially in circumstances characterized by underdeveloped community mental health services for children and youth. Mental health prevention in schools is particularly important within the process of further professional orientation and psychological adaptation of the student to the workplace activities.

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original article

Youth mental health in Portugal, Italy and Spain: Key challenges for improving well-being

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The economic recession revitalized the concept of alienation (Seeman, 1959) as witnessed by individuals with reduced power, little meaning in their lives, living in a scenario with changing social norms, and with little future expectations. Congruently, a sense of "belonging", a sense of coherence, a sense of personal competence, social participation and engagement, trust and hope all dovetail with mental health. Why is it that we are more habituated to talking about alienation and pathology instead of social engagement and well-being?

Several studies have confirmed the relationship between socio-economic status and mental health (Reiss, 2013), and the relationship between social capital and well-being (Elgar, Trites, & Boyce, 2010) identifying certain neighbourhood social cohesion characteristics such as mutual help, reciprocal norms and trust among families that are important in precarious situations.

Especially under deprivation conditions mental health care must be central issue in public health policy. Interventions should preferably identify individual and community assets, and allow for personal and community participation while greater engagement should also be an important goal for public policy makers (Matos, 2015).

Key indicators and challenges in Portugal

In 2015, Portugal entered its seventh year of recession and mental health services providers have scaled back operations, shut down services, and/or reduced staff.

More than one in every five persons had a mental disorder in the last 12 months; anxiety disorders showed the highest prevalence (16.5%), children and adolescents are vulnerable groups for major depressive disorder and anxiety (females), and for impulse control disorder and substance use disorders (males). The middle-low education group presented higher prevalence in both impulse control disorder and substance use disorders than the higher education group (Caldas de Almeida & Xavier, 2009).

There are mental health services for children and adolescents in the bigger cities (Lisbon, Oporto and Coimbra) and following the National Mental Health Plan 2007-2016 (National Mental Health Plan, 2012) new child and adolescent mental health services were created.

In Portugal in 2008, 712 admissions of children and adolescents under the age of 18 years were recorded; of which 41 were due to depressive disorders, 33 due to eating disorders and 25 due to anxiety disorders. Data from children and adolescent outpatient departments showed an increase in consultations by 29% between 2005 (63.538) and 2011 (89.726) (National Mental Health Plan, 2012), and by 21% between 2011 (89.726) and 2013 (113.985) (ACSS, 2015). The National Mental Health Plan 2007-2016 has guidelines for mental health services for children

and adolescents, and, since 2010 the Psychologists Union (OPP at www.ordemdospsicologos.pt/) has been lobbying for public policies that increase access to preventive programs and mental health care.

According to the 2014 HBSC study (the first post crisis) in Portugal (Matos et al., 2015), that encompass five waves of data mental health data; adolescents showed signs of mental distress with an increase in psychological symptoms, an increase in self-harm, and an increase in feelings of hopelessness and despair that include less positive expectations towards the future, less intention to go to college, and less attraction to school. Across the 5 waves, boys, younger adolescents and adolescents with a higher Social Economic Status (SES) more frequently report good perceptions of life satisfaction, while girls, older adolescents, and adolescents with a low SES more frequently reported psychological symptoms (feeling depressed or low, feeling irritability, bad temper, feeling nervous) (Matos et al., 2015).

Key indicators and challenges in Spain

Spain (as well as Portugal and Italy) is a country with an aging population and increased unemployment rate (Encuesta de Población Activa, 2016).

There is no clear reference study that evaluates the prevalence of mental health problems. In minors, the available research established the rate of depression in children and adolescents to be between 6 and 14 percent (Carrasco, del Barrio, & Rodríguez-Testal, 2000), which varies depending on age and gender. The Health Behaviour in School-aged Children study (Moreno et al., 2016) included more than 30 thousand adolescents between the ages of 11 and 18, who were enrolled in Spanish schools in 2014. The results indicated that psychosomatic symptoms (headaches, stomach or back pains, dizziness, low emotional state, irritability, nervousness and difficulty in sleeping) were reported almost every week over the past 6 months, 72.8 percent of girls reported that they had felt one of the symptoms almost every week, compared to 58.6 percent of boys. Higher percentages of psychosomatic discomfort were found in the older age groups. Regarding life satisfaction, boys and girls showed similar values at 11 to 12 years old, but from 13 onwards life satisfaction levels were slightly higher in boys.

Although since 2007, national and regional strategies for mental health started to be implemented in Spain (Ministerio de Sanidad y Consumo, 2007), there still is some mismatch between youth needs and available mental health services (Rocha, Graeff-Martins, Kieling, & Rohde, 2015). Spain faces many future challenges when confronting the mental health of its youth (Cátedra de Psiquiatría de la Fundación Alicia Koplowitz, 2014; Honorato et al., 2009).

Spain needs better mental health epidemiological studies (Hidalgo-Vega, 2009). Detection and prevention services in schools must be improved and are a central key to address the mental health needs of children and adolescents (Mariño, 2012). Such services should include pedagogues, psychologists, psycho-pedagogues, and professionals in speech therapy and therapeutic pedagogy. Mental health services for children and young people in Spain consists of three type of services: mental health units for children and young people, short-term inpatient units and day inpatient units. The available resources for mental health in Spain do not properly respond to the prevalence of mental health diseases. For example mental health diseases affect 25% of the Spanish population, while specific resources allocated to services to address them does not reach 5% of public expenditure (Hidalgo-Vega, 2009). Integrated plans of action must be established highlighting the role that families and schools have

in promoting healthy lifestyles (Salvador & Suelves, 2009) and life skills (Springer et al., 2004). Community work with families and current steps towards promoting positive parenting very early in a child's life are good points of reference in this direction (Rodrigo, Almeida, Spiel, & Koops, 2012).

Key indicators and challenges in Italy

Available epidemiological sources for the age range between 11 and 34 years old (HBSC study and PASSI) target a variety of indicators of (mental and physical) health; including perception of health and wellbeing, perceived symptoms, depression, medicine consumption, and health behaviours.

Drawing from the HBSC study, the most recent report from Italy in 2016 (Cavallo et al., 2016) indicated that, on the one hand, most Italian adolescents (11-15yrs old) feel healthy and are satisfied with their life (80%), with lower scores among females and youth from the South of Italy. Reported symptoms indicate, however, an increase in the use of medicines and of health services in the last years, often associated with problems at school (e.g. bullying and relationships with peers in general) suggesting an association between stress and psychosomatic symptoms (at 11 yrs. old, 28% of males and 35% of females reported at least one of the symptoms – psychological and somatic - measured by the HBSC study, a percentage that increases up to 50% among 15yr old females). Around one fourth of adolescents have consumed more medicines in the last month. In the period 2010-2015, perceived health showed a slight decline and adolescents reported an increase in symptoms. Especially critical is the increase in consumption of medicines (over 50% of 15yr old males and about 70% of females), independently from reported symptoms. Data on risk behaviours (smoking, drinking, substance use, etc.) are in line with international evidence, showing an increase throughout adolescence and higher percentages among males and a basic stability across time. A new issue that shows a consistent increase is gambling (around 60% of 15yr old males have had one of such experiences).

Epidemiological evidence from the system of surveillance PASSI (http://www.epicentro.iss.it) on the age range 18-34 yrs., include as indicators health related quality of life (perception of health status) and depression (depressed mood). Most recent data indicate that 87% of the sample feels in good health; perceived health is higher among males, highly educated, foreigners vs nationals, who perceive lower SES differences and who live in Northern regions. Symptoms of depressions are reported by 5% of the sample, and show similar trends according to sociodemographic variables. The age range 18-24yrs report high alcohol consumption (34% a risky pattern of consumption and 14% binge drinking), which increases with level of education and economic well-being, and among males. Psychological well-being is lower among unemployed youth and percentages have further declined since 2005. The impact of the recent economic crisis, coupled with the high percentage of youth who remain in education for a longer time and high unemployment rate, contributes to the lowering of general well-being and psychological health in this population.

In sum

The trends reported in Spain, Portugal and Italy are consistent with research suggesting that young people in disadvantaged contexts perceive their role in their community and participation in civic activities as diminished (Marmot, 2013) and that restricted access to resources may lead to decreased health and social exclusion (Uphoff, Pickett, Cabieses, Small, & Wright, 2013). Moreover, young

people are not only affected by problems like unemployment and socio-economic inequality, but are also excluded from decisions regarding their own lives. Interventions with youths that promote civic involvement and social participation are essential for their well-being, and crucial for the development of a healthy and productive adult population (Viner, Ozer, Denny, Marmot, & Currie, 2012).

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original article

Young people's mental health in the UK: A 'preventative turn' emerging from crisis

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A national crisis?

A "national crisis" in the UK has been reported in recent years regarding care and support for children and young people's (YP) mental health and emotional wellbeing (Collishaw, Maughan, Natarajan, & Pickles, 2010; Cooper, 2014). Statistics show that 10% of children and YP aged between 5 and 16 have a diagnosable mental health problem including: conduct disorder (6% of the YP population), anxiety disorder (3%), hyperactivity disorder (e.g., ADHD; 2%) and depression (2%) (Mental Health Taskforce (MHT), 2016; ONS, 2004). As many as one in 12 YP are recorded to have self-harmed with 38,000 to the point of being hospitalised in 2015 (Mental Health Foundation, 2006; Young Minds, 2015) and the vast majority of the 1.5 million people estimated to have eating disorders in the UK are likely to have presented symptoms before their 20th birthday (Beat, 2015).

Other social and demographic factors are associated with increased risk of mental ill-health in YP. For example, children and YP from areas of socio-economic deprivation are three times more likely to present symptoms of mental ill health than those from more affluent areas (MHT, 2016). 95% of imprisoned young offenders have a mental health disorder and are far more likely to experience Autistic Spectrum Difficulties compared to the general population (15% compared to 0.6-1.2% respectively). More generally, YP diagnosed with conduct disorder (e.g., disruptive and aggressive behaviour) are significantly more likely to leave school without qualifications, three times more likely to become a teenage parent, and up to four times more likely to become 'drug dependent' (MHT, 2016).

This "national crisis" not only reflects increasing and highly complex mental health needs among YP but also the inadequacies of a system ill-equipped to support YP and their families. In fact the majority of children and YP who have a diagnosable mental health problem are unlikely to receive any support, and those who do will typically wait up to 32 weeks for routine appointments for psychological therapy (MHT, 2016). Moreover, YP requiring acute inpatient psychiatric/ psychological support are likely to need to travel long distances to specialist health facilities in neighbouring cities or further afield (MHT, 2016).

Whilst inadequate mental health provision plays a crucial role in the "national crisis", there are other important contributing factors. The stigma associated with mental illness creates a major barrier to accessing services and support. The "Talking Taboo" report (Young Minds, 2012) demonstrated that only 10% of YP felt comfortable seeking advice from a GP, teacher or parent about the issue of self-harm; a finding compounded by the admission of approximately 1/3 of parents who indicated they would not seek professional help in the face of their child self-harming because of concerns about how the problem reflected on them as parents. A further challenge, and one likely to be exacerbated by stigma, is the failure to identify and respond appropriately to early signs of mental ill health. The report "Nobody Made the Connection" (Hughes, Williams, Chitsabesan,

Davies, & Mounce, 2012), demonstrates the negative impact of failing to identify and address YP's mental health needs at an early stage, particularly neurodevelopmental conditions (such as ADHD, Autistic Spectrum Disorders or Speech and Language Difficulties). If we add into the mix the reported profound inequalities within the UK in acknowledging and meeting the culturally diverse mental health needs of different communities combined with the dramatic regional variation in service commissioning priorities and resourcing, we can begin to appreciate the gaping holes in children and YP's mental health provision (Wilkinson & Pickett, 2009; Friedli, 2009).

A 'preventative turn'

In the UK there is broad consensus on how the "national crisis" has evolved; a culmination of increasingly complex and significant needs (Collishaw, Maughan, Natarajan, & Pickles, 2010; Mental Health Taskforce, 2016) and woefully insufficient past expenditure on mental health services (Fonay, 2014). Being able to generate a cross party political consensus on the need for increased funding for YP's mental health during the 2015 general election (Young Minds, 2014), despite campaigning within the economic paradigm of "austerity", goes some way to illustrate the extent to which the "crisis" is acknowledged. At the same time, there is a collective understanding about the need to intervene earlier and in a more preventative manner (O'Keeffe, O'Reilly, O'Brien, Buckley, & Illback, 2015) if we are to reduce morbidity (and mortality) associated with mental health in the young. However, services are stretched beyond capacity and consequently face severe challenges to adequately support children and YP.

One major challenge for Child and Adolescent Mental Health Services in the UK is YP 'failing to engage' with services and being prematurely discharged as a result (Roy & Gillett, 2008). Campaigns such as Time-to-Change (http://www.time-to-change.org.uk) are creating opportunities to challenge public stigma surrounding mental health, but providers also need to ensure they offer YP and their families services which are sufficiently meaningful, inclusive and non-stigmatising. Recognising that the contexts within which we seek to meet the mental health and emotional needs of children and YP are as much political and economic as they are social and psychological suggests a move towards a perspective of practice that is more embedded within "community". Moreover, we need to conceptualise community in its widest sense. For example, for many YP, community is not just about their local surroundings and links through family and friends, but it is also constituted online and via social media. Prevention and support initiatives must therefore be firmly embedded within the online and social media community.

In the face of current failings in mental health support and services for YP, and in the realisation that an effective response to growing needs is unlikely to ever be sustainable through crisis reactive models of practice and provision alone, there is a 'preventative turn' beginning to emerge in the UK (e.g., MHT, 2016). A growing body of participatory and innovative initiatives are being piloted and implemented which aim to address mental health prevention and support in engaging, timely and flexible ways (e.g., HeadStart, YoungMinds, CUES-Ed, & Bounce Back). CUES-Ed (http://cues-ed.co.uk/), for example, is a class-room based initiative targeted at primary school children who are introduced to 'emotional resilience' and 'efficacy building' through age adapted forms of CBT. 'Young Minds vs' series of campaigns (http://www.youngmindsvs.org.uk), on the other hand, are aimed at 'resilience building' initiatives for older children in relation to important challenges faced at school and beyond; including bullying, sex and relationships, school

stress, employment and access to services. Moreover, outside of the classroom, and in the wider conceptualisation of prevention and 'community', more exclusive online resources are being implemented through the development of engaging digital tools. For example, APPs are emerging to include:

- doctor consultations (http://www.docready.org)
- information about medications (http://www.headmeds.org.uk)
- talking about feelings and mood (https://moodbug.me)
- counselling (https://www.kooth.com)

as well as accessible, anonymous and 'safe' online peer support (e.g., http://www.silentsecret.com).

Early indication is that YP are engaging with online and other preventative resources and 'communities', and that learning and skills development is evident (Hart & Heaver, 2015). However, a stronger evidence-base is undoubtedly needed. For example, while YP may be engaging with online 'resilience building' initiatives, which ones are the most effective, and what impact do they have on longer term mental health difficulties and the uptake of secondary mental health resources (Hart & Heaver, 2015)? Moreover, as Friedli (2009) and others have argued, there is a need to elevate 'resilience' and 'efficacy building' from an 'individual focus' to one that embraces the wider economic, health and social which contextualise 'mental health', 'agency' and 'resilience' e.g., 'building resilience' should not excuse our collective duty to improve the social, educational and economic determinants which are likely to exacerbate poor mental health and wellbeing. Nevertheless the emergent 'turn' from a predominant and inadequate crisis-resolution mental health provision, to one which is more equipped and focussed on prevention and engagement in YP appears to be an important opportunity which has surfaced from "crisis".

Conclusion: From crisis to opportunity

A recent independent review (Mental Health Taskforce, 2016) highlighted many of the weaknesses in current mental health services for YP and their families and offered a clear framework for transformation of services over the next 5 years. The concern remains that whilst we are seeking to address a chronically underfunded area of need, as well as improve what is actually on offer, funding cuts to much-needed services and support undermine their ability to function productively. We have discussed a 'preventative turn' in the UK where a number of innovative interventions designed to build 'emotional resilience' are emergent out of the "crisis"; albeit with 'individualistic' focus. Building on the opportunity this affords, we propose evidenced-based 'community' and participatory preventative strategies will go a long way to address the gaping shortfalls that exist in Children and YP mental health services in the UK.

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original article

Using Media and creativity to explore mental health and wellbeing with young people

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Introduction – Addressing unmet needs

Now more than ever, both in the UK and globally, it is essential to create safe spaces for children and young people to have a dialogue about mental health. It is estimated (Young Minds, 2015) that three children in every classroom have a diagnosable mental health condition and one in ten young people have self-harmed and even these figures are thought to be significantly underestimated. The World Health Organisation recently recognised that suicide is the primary cause of death for teenage girls, which is a shocking statistic (World Health Organization, 2014) that illustrates clearly that young people are experiencing significant levels of distress and need. In a climate of economic "austerity" however, it is unlikely that Children and Young People's Mental Health (CYPMH) services will meet the demand.

Looking to address this, we find significant barriers that prevent children, young people and families from engaging with what is on offer. A lot is written about how mental health stigma prevents young people from engaging with services, fearful this might imply that they are seen as "mad", have a vulnerability, or weakness and they are therefore inhibited from accessing support early. When they do present, they are often experiencing significant distress, that is harder to address and those that do access services, may experience a mismatch between their expectations and an understanding of their difficulties.

Consequently, there is a significant group, unwilling, or unable, to access the support available. Our work has focused on finding ways of helping young people engage with a dialogue around mental health and access support that is meaningful and has positive impact.

Background – Finding common ground

It is generally acknowledged that regardless of age, interests, or ability, one of the most effective ways to motivate young people, is through practical projects on subjects that interest them and that, in essence, is why Individio Media Ltd (IML) was established 30 years ago. To understand our goals and values, it will be instructive to start with the story of how the two authors came together to collaborate.

Working for the Inner London Education Authority (ILEA) to develop and manage a media resources facility in London Docklands, the first author, Dominic, used video across the whole community and realised how effectively it motivated young people. Tapping into their interest and understanding of film, television and media made many young people want to try it for themselves. The potential to develop this work further, particularly with disengaged young people, drove Dominic to set up IML, expressly to work on educational, youth development and social value projects.

Nick is a young people's psychiatrist who has worked within the NHS for many years, through an outreach service, with young people with significant mental health needs, such as psychosis,

severe depression, or suicidal behaviour. As a community practitioner, Nick is highly aware of the gaps that young people are falling through, often resulting in isolation, detachment and disengagement and believes that they need support and services that are more creative and individually tailored.

A young intern introduced Nick and Dominic to each other, seeing that both were trying to engage young people in "opportunities for change": Dominic, from an educational background, with professional media skills and Nick, informed by a psychiatric, psychological and developmental perspective, of the support needed for young people. From this has come an approach that works with young people and addresses their mental health needs, tailored to where they "are at", at their pace and working towards goals important to them.

Walk the Talk – Addressing need at the cutting edge

In January 2011 a 14-year-old student was fatally injured, following an altercation with a man carrying a knife. Many of his friends were present and the loss was profound, affecting the whole school, his family and the community. A core group of friends remained profoundly traumatised and at significant risk of harm, refusing multiple services and interventions and becoming increasingly isolated and detached. As a more creative way of approaching support, Nick developed an intervention (the K.Dot project) in partnership with IML, the school and the Kiyan Prince Foundation mentoring programme.

With grant funding, the group made a tribute film, helping them feel that their friend was appreciated, valued and remembered. It also offered a dialogue and narrative about trauma, grief and loss that was profoundly moving and powerful, bringing a packed school auditorium to tears and giving these young people "permission" to move forward and get their lives back on track.

Talk About Tottenham offered a similar opportunity for young people at a Tuition Centre, who were marginalised and excluded from mainstream education (and society), often because of underlying emotional and mental health needs. The narrative film they made about living in Tottenham, was based on interviews with elders in the community and the process enabled them be involved and create something of their own, learn new skills and feel proud that their parents and peers appreciated how much they had invested into their work.

Shift towards early help and prevention – Mental health is everyone's business

Both Talk About Tottenham and K.Dot involved young people with significant needs and were aimed at helping them through their recovery. But given the demand for Children and Young People's Mental Health services, we need to offer support for young people earlier, reducing the need to access specialised services. Rather than see mental health as an arena for "professional experts", we need to work alongside young people to find solutions.

Time 2 Talk (T2T) emerged from work around K.Dot, with the focus on the whole school community, rather than those with specific need. Commissioned by Haringey Council department for Public Health as part of their mental health stigma campaign, it aimed to offer an evidence based "Whole school approach", raising awareness about emotional wellbeing and mental health and challenging mental health stigma.

The project evolved over two years, starting with narratives of young people's experiences of

significant mental health need, which were introduced to pupils. From this a forum theatre piece was developed for school assemblies and turned into a film that informed a module of three lessons about mental health, now embedded into the school curriculum. Students were also invited to train as peer mentors, offering support to the students as well as guidance to teachers and parents about young people's mental health - facilitating a dialogue across the whole school community.

T2T empowered young people, creating changes that allow for greater awareness about mental health and overcoming some of the barriers that prevent young people from accessing support. Creativity was key to engaging them and ensuring that they felt sufficiently skilled-up to bring about change within their wider "system", and the strength of this work was being able to offer a "bottom up" model, giving the students agency over their opportunities for change and generating a dialogue that states: "Mental health is everyone's business".

Providing the tools for change

The use of film and other creative media enables young people get on board, feel comfortable with the tools and be aware of what is "good" and what can be "valued". Many young people, who repeatedly experience exclusion, can find the feeling of being valued, or appreciated, frightening – fearful this may trigger further humiliation or trauma. Film-making and creative media enables them produce something of value and to have a sense of achievement, as happened with K.Dot and Talk About Tottenham. When able to be proud of what they produced, without fear of being under attack, then the potential to learn from this experience is available.

Most importantly, this work is about relationships and agency. Young people need to feel able to trust those they work with, as change comes through trust, and hence the focus on relationships. But they also need a sense of agency in the process of change. If the work is done "to" them, rather than "with", they will not translate this experience to other areas of their lives. So the tools for change must involve young people at all stages, allowing ownership and a vested interest in making the project succeed.

So, what's it all about?

In summary, these projects succeed because of four over-arching principles:

1. Enabling a sense of Agency by ensuring young people feel involved and have agency within the project at all times
2. Providing Creativity by working creatively with young people through media/tools they understand and feel comfortable using
3. Thinking Developmentally by working where young people are at – rather than where others/services want them to be at
4. Working Relationally by constantly focusing on the relationships around the young person, in order to foster Trust , because without Trust there will be no Change

This work is therefore about a relational approach to mental health and the building of resilience. The key features that work for these projects should be what we seek to offer through established CYPMH services. The difference is the setting, the creativity and the flexibility. But if we are determined to have an impact on the current level of need, we must ensure that mental health is not something only for the specialist, rather, it is viewed from a salutogenic rather than a pathogenic perspective.

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