Promoting Resilience and Psychological Well-Being in Vulnerable Life Stages

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Mental health and emotional and psychological well-being are fundamental for all children, enabling them to meet their potential, to experience life as meaningful and to be active citizens.

Unfortunately, current estimates indicate that at least one out of every four to five young people in the general population will suffer from at least one mental disorder in any given year [1]. Similar data have been previously reported by WHO, showing that worldwide up to 20% of children and adolescents suffer from a mental illness with at least mild functional impairment: one adolescent in five has behavioural, cognitive and emotional difficulties and one adolescent in eight suffers from a mental disorder [2]. Comorbidity is very common and can occur at three levels: with other mental disorders, with substance abuse and with chronic diseases [1].

Developmental psychiatric disorders rarely have a spontaneous remission and may cause difficulties in social adaptation or mental disorders in adult life [3–12]. There is evidence that adult mental disorders usually begin during youth [13, 14], although they are often first detected later in life [1].

Besides personal suffering, stigma and discrimination, mental disorders may have a high social impact, in terms of treatment and support costs, reduced or lost productivity, and the expenditure of criminal justice (e.g. conduct and behavioural disorders) [15].

Despite these data, only a minority of vulnerable children and adolescents have access to mental health ser-

vices, even in high-income countries [16]; the majority of young people with mental health problems are still not getting the help they need. A major reason for this is the worldwide gaps in child and adolescent mental health policy and services well identified by the World Health Organization through its Atlas project [17]. The degree of coverage and quality of mental health services for the youths are generally worse compared with the ones provided for adults [18]. Little information is now available about health and social investment into child and adolescent mental well-being. However, as denounced in the Florence Declaration – developed during the 13th European Society for Child and Adolescent Psychiatry (ESCAP) Congress and signed by WHO and by EACAP (European Academy for Child and Adolescent Psychiatry) – as regards Europe, all indicators strongly suggest that child and adolescent mental health in most countries is receiving a relatively small proportion of funding, with, in turn, a typically low investment for general health, on average only 5.6% (see appendix). The median percentage of governments' health budget earmarked for mental health is as little as 1% in low income countries [19]. The gap is not limited to the quantity, as the quality of services is often extremely poor, even in high income countries [19].

Nevertheless, the mental well-being of children still remains a major public health priority and a prominent area of international debate. Scientists and researchers from all over the world are focusing on how to improve

children's mental health, how to ameliorate the accessibility and the quality of services, how to strengthen the effectiveness and the efficiency of treatments, and finally how to overcome stigma and protect children's rights (see appendix). The magnitude of children and adolescent mental disorders, taken with the limited investments and availability of services, argue for preventive and early treatment interventions capable of promoting healthy development and psychological well-being [20, 21], both by strengthening protective factors and reducing risk factors.

In fact, even though the etiology of developmental mental disorders is multifactorial, a large number of risk and protective factors have been identified. Trauma exposure, for example, is a significant risk factor for psychiatric impairment. In a recent epidemiological study, more than two thirds of children reported at least one traumatic event by sixteen years of age, suggesting that potentially traumatic events are fairly common in childhood and adolescence [22–25]. Other well-known risk factors include parental psychopathological disorders [26], domestic violence and bullying [27, 28], physical abuse [29], having a chronic paediatric illness [30], poverty and material hardship [31, 32]. Longitudinal studies have also shown that 'consistent and engaging parenting styles, parents and friends who model healthy behaviour, being in full-time education in a school with a zero-tolerance policy towards bullying and the promotion of a learning atmosphere where individual needs and interests are addressed, and involvement in community activities and religious observance are protective' [1, p 1305].

Preventive intervention should be consistent with these findings, evidence-based and possibly implemented by non-specialist health workers in primary health care settings [1, 33, 34]. However, what are the most promising examples of preventive interventions now available?

Preventive interventions have been classified as universal (targeting the entire population), selective (targeting a population at risk) and indicated (targeting sub-threshold symptoms) [35]. Several reviews and meta-analyses have demonstrated that prevention programs for children and adolescents produce significant benefit by reducing the rates of future social, behavioural and academic problems [21]. Durlak and Wells [36] reviewed 177 universal prevention studies, finding significant mean effects ranging from 0.24 to 0.93 according to program type and target population. Their findings showed that preventive interventions had the dual benefits of enhancing competencies (assertiveness, communication

skills, self-confidence and academic performance) and reducing internalizing and externalizing problems. One year later, the same authors found significant mean effects (0.50 on average) after reviewing 130 indicated prevention studies [37]. After the analysis of 130 universal, selective or indicated school-based programs, Greenberg et al. [38] concluded that multiyear programs are more likely to foster enduring benefits than short-term interventions, that the most effective programs are the ones focused on multiple domains (individual, school and family), and that the main goals of a program should be children's behaviour, teacher and family behaviour, home-school relationship and neighbourhood support for healthy, competent behaviour [39].

There is a promising universal intervention specifically designed to help children in the first years of school and to develop the necessary skills for life-long emotional well-being [40].

Others are directed at children at risk of developing specific mental disorders. Four conduct disorder preventive programs [41–44] produced significant results in randomised controlled trials. These programs are designed for children at risk in their early years (0–7 years) and use parent training or child social skills training (problem-solving skills, communication, friendship-building and self-control skills).

As to mood disorder prevention programs, a significant reduction of symptomatology and new cases of anxiety and depression was obtained in school-age children (10–13 years) by using universal cognitive-behavioural training (CBT) [45]. Significant benefits of cognitive-behavioural therapy (CBT) over the no-treatment control group were found at 6 and 24 months after the intervention [46, 47]. When parent training was combined with child group CBT, there were some additional benefits for the children [48]. Clarke et al. [49, 50] also used CBT in school-aged children. This intervention, which generally takes place in schools and is administered to students screened and selected from the general population, produced a significant decrease in major depressive episodes or dysthymia in the experimental condition compared to the controls. The CBT interventions included teaching children positive coping skills, such as problem solving and identifying and challenging distortions associated with the disorder.

Alleviating the negative (psychological distress) through psychological interventions is one target of efforts. Engendering the positive (through the promotion of psychological well-being) could be another way to reach the same goal, and may yield important protective

factors in the face of future challenges and adversity [51, 52]. In this direction, a specific psychotherapeutic strategy for enhancing well-being (well-being therapy; WBT) has been developed [53, 54] and tested in controlled trials, both alone [53] and in addition to cognitive-behavioral packages [55–59]. The results of these studies have documented its efficacy on the adult population. A protocol for the application of WBT in a school setting has been developed. A pilot study documented its feasibility and showed a significant improvement in symptoms and psychological well-being [60]. Further controlled studies with larger samples and follow-up of children are in progress and may disclose whether WBT has a role in the prevention of psychological distress and in increasing resilience to stressful life situations.

Taken together, the evidence surveyed in this article provides a substantial foundation for prevention programs which can have strong potential as part of the spectrum of mental health interventions for children and adolescents, particularly given the large numbers of children these programs may involve. However, despite the scientific support for prevention programs and scientists' efforts to develop this area of research, most of the children in the world outside research trials still have little access to these programs. Prevention is still not a sufficiently high priority for state or federal policy makers and funders. This is mainly because of a marked separation between research and practice. Ripple and Zingler [61] provide promising data concerning the benefits of prevention policy, and proposed several steps toward filling this gap. As also highlighted by the Florence Declaration, new investments in prevention are needed. As reviewed above, effective preventive strategies already exist, others are in progress and showed promising effects at a preliminary stage [60]. Let us now forge a link between evidence-based research and practice, and give every child in the world access to these programs and the chance to fulfill his/her full potential.

Appendix

Florence Declaration: Mental Well-Being of Children in Europe: Plans and Perspectives, 13th European Society for Child and Adolescent Psychiatry Congress, Florence, Italy, August 25–29, 2007

Preamble

This Declaration was developed during the 13th European Society for Child and Adolescent Psychiatry (ESCAP) congress (Florence, Italy, August 25–29, 2007), which was attended by the lead-

ing experts in the field. The conference discussed the current state of European child psychiatry, and put forward recommendations as how to improve children's mental health, how to strengthen the effectiveness and the efficiency of treatments, how to ameliorate the accessibility and the quality of services and, finally, how to overcome stigma and protect children human rights.

It is consistent with the UN Declaration of the Rights of the Child [62], the Geneva Declaration of the Rights of the Child [63], the UN Convention on the Rights of the Child [64], the WHO Mental Health Declaration For Europe [65] and Mental Health Action Plan for Europe [66], and the EC Green Paper on Mental Health [67]. By adopting these documents, Member States have committed themselves to promote the mental health of all children and adolescents, and ensure that mental health policies include as priorities the mental health and well-being of children and adolescents. Member States have committed themselves to develop and make available and accessible mental health services that are sensitive to the particular needs and human rights of children and adolescents, operating in close collaboration with families, schools, day care centres, neighbours, extended families and friends. They recognise the right of children with disabilities and/or mental health problems to enjoy a full and respectable life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community, as well as effective protection from abuse and neglect.

Roots of Child and Adolescent Psychiatry in Europe

European child psychiatry arises from a dynamic coexistence of different theoretical models and approaches. A common basis is the culture of human rights; child and adolescent psychiatry in Europe is inspired by the deep respect of children's rights. By valuing these approaches and building on their strengths, while sharing a strong commitment to a shared value system, it is possible to develop a versatile model of child psychiatry, able to provide the means to prevent and cope with psychological and psychiatric difficulties by offering interactive and holistic interventions at community, family and individual levels. The European tradition also involves the social and public field, aiming at creating networks of many agencies which all contribute to the support of young people on the basis of their real needs only, by ignoring their age, gender, social or cultural background. In Europe, child psychiatrists respect individual differences, not only in the therapeutic realm, but also in the areas of public mental health addressing promotion and prevention. Child and adolescent psychiatry is strongly linked to other neighboring disciplines such as pediatrics, neurology, psychiatry and psychology, and to many other activities targeted at the child's physical and mental health, such as pedagogy, rehabilitation, speech therapy and physiotherapy. This interdisciplinary work is fundamental for prevention, treatment and research in the field of developmental age. The 3rd Millennium Europe wants to be more and more open to new and different cultures. Migration from neighboring as well as from more distant countries requires our systems to be more flexible in order to respond to new cultures and habits. The aim of European child psychiatry is to harmoniously integrate these populations and to enrich their cultures.

The Scale of the Problem

Europe is facing massive challenges in child and adolescent mental health. Fortunately, most people in Europe enjoy a high

quality of life: according to the World Health Organization [12], 80% of young people report good psychological well-being. However, 1 adolescent out of 5 has cognitive, emotional and behavioral difficulties and 1 adolescent out of 8 suffers from a diagnosable mental disorder, and the prevalence is increasing decade by decade. Suicide associated with depression, substance abuse, eating disorders, conduct disorders, attention deficit hyperactivity disorders and post-traumatic stress disorder in children are all deserving concerted action. Developmental psychiatric disorders rarely have a spontaneous remission, and may cause difficult social adaptation or mental disorder in adult life if not diagnosed and treated early. Child mental health is important in its own right, but it has also to be considered in the context of a lifespan approach; most adult mental disorders find their origin in childhood and adolescence and require early intervention and treatment. Mental disorders prevented in childhood are mental disorders prevented for life.

The Treatment Gap

The availability of mental health services and the number of child psychiatrists varies widely across European countries, ranging from 1 per 5,300 people under the age of 20 to 1 per 51,800 for the same population group. Countries of the European Union strongly differ in the organization of children and adolescent mental health services and in the content and organization of child psychiatry training. Little information is available about health and social investment into child and adolescent mental well-being, but all indicators strongly suggest that child and adolescent mental health in most European countries is receiving a relatively small proportion of funding within mental health, which in turn receives a low investment from general health investment, on average only 5.6%. Investing in the mental health of children and adolescents is the most cost-effective intervention, aiming at preventing the burden of mental health problems in all age groups, and lowering the personal suffering and loss of productivity at the individual, family and population levels throughout life.

Developing Responses

Recognizing the needs of children, adolescents, families and communities of Europe, and backed up by the evidence developed by European experts, the signatories of this declaration believe that European countries, regions and municipalities, supported and advised by intergovernmental agencies such as the Council of Europe, the European Commission and the World Health Organization, in partnership with NGOs including ESCAP, should all endorse the following actions that will assure the optimal mental well-being of young people:

Services and Pathways to Care

The core of our commitment is a reduction of the institutional approaches of care, which engender social exclusion. On the contrary, it is essential to improve the quality of life of people with mental problems or disability through social inclusion and the protection of their rights and dignity. The availability of services, mostly at the community-based level, helps patients and their families by providing an immediate and individualized answer to their needs. We believe that social and medical systems need to integrate their specific fields of action, with individual well-being as their central objective. This requires:

- Planning adequate community mental health services for all ages, adequately staffed by well-trained professionals working in multidisciplinary teams and integrated in primary health care.
- Developing community mental health services for the whole lifespan ensuring comprehensiveness and continuity of care, especially for the severely mentally ill, which monitors the patient's transition from child psychiatric care to adult psychiatric care.
- Monitoring and evaluating the utilization, the quality and the effectiveness of existing services.

Interventions

We want to offer effective and timely interventions, accessible to everyone on the basis of his/her need, balanced by the investment of evidence-based primary and secondary prevention by:

- Applying interventions, both preventive and therapeutic, grounded on reliable and valid evidence; research findings should be implemented in clinical practice.
- Basing good practice on a mix of skills and approaches. Single-theory approaches should be avoided.
- Creating a European-wide formulary for the use of psychopharmacological medications with children and adolescents.

Prevention

We believe that the essential first step for addressing mental ill health is prevention. Promotion of mental health and well-being relies primarily on prevention strategies, which should focus on individual, family, community and social determinants of mental health, both by strengthening protective factors (e.g. resilience) and reducing risk factors (primary prevention). This can be achieved by:

- Developing programmes in school settings, where children spend large parts of their time. Examples include school approaches targeting psychological well-being, life skills and bullying prevention.
- Identifying mothers at risk of post-natal depression through nurses' home visits.
- Teaching parenting skills to at-risk families in order to improve child development.
- Supporting anti-stigma programmes that target social awareness and support the social inclusion of the patient and his/her family.
- Allocating appropriate funding, according to the needs and resources in each country.

Human Rights

We believe that services, intervention and prevention have all to be placed within a general framework which gives primary value to the respect for human rights and for diversity, including the rights of children and adolescents. Mental health cannot be imposed. It requires:

- Planning and developing actions with the active involvement of parents or legal tutors.
- Empowering children and adolescents respecting their age and development.
- Assessing needs in a way which is sensitive to the cultural background and diversity of children, families and communities.

Training

We believe that the training of young child psychiatrists and researchers represents a fundamental element for the growth of our discipline, and that greater partnership across Europe will benefit the quality of research and practice. Research funding should increasingly cross boundaries thereby achieving added value for Europe. We support this by:

- Achieving a greater cohesion in training goals and methods for Child and Adolescent Psychiatry in Europe as the knowledge in the field of children and adolescents mental health is constantly evolving and international activities are increasing.
- Stimulating the implementation of best practices and the application of latest scientific data by regular professional updates.
- Encouraging multi-disciplinary practice by shared training.

Research and Information

We believe that the common values of European child and adolescent psychiatry demand greater coordination of information and research, providing benefit to all participants. Experiences of one country increasingly are of value elsewhere. This requires:

- The harmonization of existing national and international indicators on child and adolescent mental health and disability, in order to create a comparable dataset across Europe.
- The stimulus of international research by committing research funding to multi-centre studies.
- The setting up of a mechanism for applying international studies to local circumstances.

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