Promoting activities sensitive to vulnerable life stages

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The evidence surveyed in this article provides a substantial foundation for the strong potential of prevention programs as part of the spectrum of mental health interventions for children and adolescents. Effective preventive strategies already exist. This article advocates for activating the link between evidence–based research and practice to give every child access to these programs and the chance to fulfil their potential.

The scope of the problem

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 world-wide 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.[3]

There is evidence that adult mental disorders usually begin during youth

Developmental psychiatric disorders rarely have a spontaneous remission and may cause difficulties in social adaptation or mental disorders in adult life.[4] There is evidence that adult mental disorders usually begin during youth[5], although they are often first detected later in life.[6]

Besides personal suffering, stigma and discrimination, mental disorders may determine a high social impact, in terms of treatment and support costs, reduced or lost productivity, and expenditure of criminal justice. As an example, it is known that conduct and behavioural disorders in childhood imply costs for the social, educational as well as criminal and justice systems.[7]

Child and adolescent mental health in most countries receives a relatively small proportion of funding

The lack of investment

Despite these data, only a minority of vulnerable children and adolescents have access to mental health services, even in high-income countries[8]: 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.[9] The degree of coverage and quality of mental health services for the youths are generally

worse compared with the ones provided for adults.[10] Little information is now available about health and social investment into child and adolescent mental well being. However, as far as Europe is concerned, all indicators strongly suggest that child and adolescent mental health in most countries receives a relatively small proportion of funding, with, in turn, a general low investment for general health, on average only 5.6%.[11] The median percentage of governments' health budget earmarked for mental health is as little as 1% in low income countries.[12] The gap is not limited to the quantity, as the quality of services is often extremely poor, even in high income countries.[13]

More than two thirds of children reported at least one traumatic event by 16 years of age

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.[14] 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[15], both by strengthening protective factors and reducing risk factors.

Risk factors and protective 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 16 years of age, evidencing that potentially traumatic events are fairly common in childhood and adolescence.[16] Other well known risk factors include parental psychopathological disorders[17], domestic violence and bullying[18], physical abuse[19], having a chronic paediatric illness[20], poverty and material hardship.[21] Longitudinal studies have also shown that "consistent and engaging parenting styles, parents and friends who model health behaviour, being in fulltime 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".[22]

Preventive interventions that work

Preventive intervention should be consistent with these findings, evidence-based and possibly implemented by non-specialist health workers in primary health care settings.[23] But, what are the most promising examples of preventive interventions now available?

Preventive interventions have been classified as universal[24], selective[25] and indicated.[26] Several reviews and meta-analysis have demonstrated that prevention programs for children and adolescents produce significant benefit by reducing the rates of future social, behavioural and academic problems.[27] Durlak & Wells[28] 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[29] and reducing internalizing and externalizing problems. One year later, the same authors found significant mean effects[30] after reviewing 130 *indicated* prevention studies.[31] After the analysis of 130 *universal, selective or indicated* school-based programs, Greenberg et al.[32] concluded that multiyear programs are more likely to foster enduring benefits than short-term interventions; the most effective programs are the ones focused on multiple domains[33] and that the main goals of a program should be

children's behaviours, teacher and family behaviour, home-school relationship and neighbourhood support for healthy, competent behaviour.[34]

One of the most promising universal interventions is *Zippy's Friends*, an international programme designed to help children in the first years of school and to develop the necessary skills for life-long emotional well-being.[35]

Other promising interventions are directed at children at risk of developing specific mental disorders. Three among the most common and potentially preventable are conduct disorders, anxiety and depression: with regard to them, several effective preventive programs have been developed and tested in randomised controlled trials.

Nurse Visitation program[36], *Perry Preschool* program[37], *Johns Hopkins* program[38] and *Fast Track* program[39] produced significant results in preventing conduct disorders. These programs are designed for children at risk in their early years[40] and use parent training or child social skills training.[41] As far as concern mood disorder prevention programs, *Friends*[42] significantly reduced symptoms and new cases of anxiety and depression in school-age children[43] by using universal cognitive behavioural-training.[44] Significant benefits of cognitive-behavioural therapy[45] over the no-treatment control group were found at 6 and 24 months after the intervention.[46] When parent training was combined with child group CBT, there were some additional benefits for the children.[47] *Coping With Stress*[48] also used CBT in school-age 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.

Prevention is still not a sufficient high priority for state or federal policy makers and funders

Alleviating the negative[49] through psychological interventions is one target of efforts. Engendering the positive[50] could be another way to reach the same goal and may yield important protective factors in the face of future challenges and adversity.[51] Ryff and Singer[52] remark that the presence of distress together with the absence of psychological well being could influence mental health. As a result, the promotion of psychological well-being could have an important role in clinical and developmental settings. In this direction, a specific psychotherapeutic strategy for specifically enhancing well-being[53] has been developed[54] and tested in controlled trials, both alone[55] and in addition to cognitive-behavioral packages.[56] The results of these studies have documented its efficacy on adult population. Further, its use for treating PTSD has been suggested.[57] Well-being therapy is based on Ryff's multidimensional model of psychological well-being, encompassing six dimensions: *autonomy*, *personal growth*, *environmental mastery*, *purpose in life*, *positive relations* and *self-acceptance*.[58] The goal of this therapy is improving the patients' levels of psychological well-being according to these dimensions.

The Florence Declaration defines prevention as the essential first step for addressing child mental health

A protocol for the application of WBT in school setting has been developed. A pilot study documented its feasibility and showed a significant improvement in symptoms and psychological well being.[59] 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. In the same direction, the Florence Declaration - developed during the XIII European Society for Child and Adolescent Psychiatry[60] Congress and signed by WHO and by European Academy for Child and Adolescent Psychiatry[61] – defines prevention as the essential first step for addressing child mental health. It should be focused on:

- developing programmes in school settings, where children spend large parts of their time (e.g. school programs aimed at the promotion of psychological well-being, life skills and bullying prevention);
- identifying mothers at risk of post-natal depression and early mother-child intervention also through 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.

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 sufficient 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[62] 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.[63] Let's now activate a link between evidence–based research and practice and give every child in the world access to these programs and the chance to fulfil his/her full potential.

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Organization.

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