ITALIAN AGENCY
FOR DEVELOPMENT
COOPERATION
AMMAN Office

Government
of Jordan

Ministero degli Affari Esteri
e della Cooperazione Internazionale

STRENGTHENING CHILD AND ADOLESCENT MENTAL HEALTH SERVICES AND SYSTEMS

A REGIONAL PERSPECTIVE

under the patronage of
HRH Princess Muna Al Hussein

Proceedings of the 1st Regional Conference
on Mental Health – Jordan, 2-3 October 2019

The conference “Strengthening Child and Adolescent Mental Health Services and Systems - a Regional Perspective” was sponsored by the Italian Government, which actively and constantly promotes universal health coverage and universal access to health services, focusing on building capacity across the health system and on empowering communities, families and children.

In 1978, Italy promoted a paradigm shift in the delivery of mental health services. The Law 180 “Reform of Psychiatric Care” was the first act worldwide to abolish mental asylums, reshaping psychiatry and building a new system for recovery. Now, as then, the rights of the patients remain key aspects in the delivery of services within the Italian mental health care system, which aims at providing hospitality instead of hospitalization.

Scientific evidence suggests that the first years of a child’s life are more pivotal for development and for future health than any other single moment in our life time. Childhood and adolescence are transition phases characterized by rapid growth and challenges, including the development of a person’s individual identity. Effective early intervention in support to children and young people works to prevent more challenging problems occurring in adulthood.

Protecting the nation’s health and wellbeing, and reduce health inequalities, is a shared responsibility.

Italy supports the mental health system in Jordan through two programmes. The first initiative launched in 2017, “Strengthening the mental health system, improve access and services for Syrian refugees and vulnerable Jordanian population”, has just ended. The second Programme has been recently approved and it will be implemented in partnership with the World Health Organization in view of its highly regarded collaboration with the Government of Jordan, particularly with the Ministry of Health.

The success of these initiatives includes putting children and young people at the heart of the policy-making process – both at the national and local level. The Italian Government congratulates the Jordanian Government for its strong commitment to mental health reform and is honoured to support the Ministry of Health in this ambitious effort.

Fabio Cassese
Ambassador of Italy to Jordan

The United Nations Convention on the Rights of the Child and the Adolescent is a transformative document which addresses mental health from a broad perspective, ranging from emotional well-being to mental illness and disorder. Mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

Mental health problems affect 10-20% of children and adolescents worldwide. Despite their long-lasting effect throughout life and their relevance as a leading cause of health-related disability, the mental health needs of children and adolescents are often neglected, especially in low-income and middle-income countries. Furthermore, evidence suggests that antecedents of adult mental disorders can be detected in children and adolescents.

In the occasion of the two-day regional conference on Child and Adolescent Mental Health (CAMH), the Italian Cooperation, in partnership with the Government of Jordan and the World Health Organization, intended to bring together scientists, researchers and practitioners to identify obstacles to and opportunities for providing child and adolescent mental health services in Jordan, Palestine, Lebanon and Iraq.

In line with Italy's commitment towards addressing mental health from a broad perspective, ranging from emotional wellbeing to mental illness and disorder, the conference aimed to provide an interdisciplinary platform for professionals to discuss the latest results in research, as well as challenges and solutions adopted for promoting mental health in the Region.

Several Institutions and Authorities from neighbouring countries Palestine, Lebanon and Iraq, have gathered to discuss, share and learn on how community mental health services can play a significant role in supporting children and their families to ensure their independent living within the community.

We, as the Italian Agency for Development Cooperation, are constantly working to ensure better access to preventive and curative mental health care services, as we recognize its economic value beyond its unquestionable impact on the wellbeing of communities.

We strongly encourage enhanced collaboration among governments, non-governmental organizations and the health sector, as well as inter-sectoral collaboration between the medical and social services. We firmly believe that prioritizing prevention and promotion is pivotal to decreasing the burden of mental disorders and to improving the coping capacities of individuals.

Our sincere hope is that this opportunity to share achievements in academic delivery, research and customer services within the Region could effectively promote the inclusion of mental health as an essential component of health initiatives and intersectoral strategies, as well as contribute to successfully address mental health needs of affected children and adolescents, in the near future.

Michele Morana
Head of Office, AICS Amman

This publication presents the proceedings of the first **Regional Conference on Mental Health** that took place at the Dead Sea in Jordan on the 2nd and 3rd of October 2019, under the patronage of Her Royal Highness **Princess Muna Al Hussein**.

The conference was opened by the head of the AICS Office in Amman **Mr. Michele Morana** and welcome remarks delivered by H. E. the Ambassador of Italy to Jordan **Mr. Fabio Cassese**, H. E. the Ministry of Health in Jordan **Mr. Saad Jaber**, AICS Director **Mr. Luca Maestripieri**, the Chair of the Committee on Foreign and EU Affairs of the Italian Chamber of Deputies **Ms. Marta Grande**, and WHO Jordan Representative **Ms. Maria Cristina Profili**. Closing remarks were delivered by **Mr. Giorgio Marrapodi**, General Director of the General Directorate for Development Cooperation (DGCS).

The head of the AICS Office in Beirut, **Ms. Donatella Procesi**, and the head of the AICS Office in Jerusalem, **Ms. Cristina Natoli**, partecipated to the conference, in consonance with the consolidated strategy of the Italian Cooperation in the MENA Region to promote regional dialogue, learning, collaboration and coordinated action.

The Italian Agency for Development Cooperation would like to express sincere appreciation to **WHO Jordan** and H. E. the Consul of Italy in Erbil **Ms. Serena Muroni** for the excellent support provided in organizing the conference.

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CONFERENCE AGENDA

2ND October 2019

09.30 - 10.00	**REGISTRATION**
OPENING AND WELCOME *Chaired by* **Michele Morana**, Head of Office – AICS Amman	
10.00 - 10.40	**H.E. Fabio Cassese**, Ambassador of Italy to Jordan **H.E. Luca Maestripieri**, AICS Director **Marta Grande**, President of Foreign Affairs Committee of the Chamber of Deputies - Italian Parliament **Maria Cristina Profili**, WHO Representative to Jordan **H.E. Saad Jaber**, Minister of Health of Jordan
THE ITALIAN MENTAL HEALTH REFORM: **THEORY AND PRACTICE OF THE ITALIAN EXPERIENCE** *Chaired by* **Cristina Natoli**, Head of Office - AICS Jerusalem	
10.40 - 11.00	**Roberto Mezzina**, Director of the Department of Mental Health, Trieste, Italy *Discussant:* **Enrico Materia**, Global Health Expert
11.00 - 11.30	**GROUP PHOTO AND COFFEE BREAK**
SESSION 1. **REFORM OF MENTAL HEALTH SYSTEMS: ITALIAN AND REGIONAL PERSPECTIVE** *Chaired by* **Donatella Procesi**, Head of Office - AICS Beirut	
11.30 - 13.15	**Italian Community Mental Health: current status and future developments** **Fabrizio Starace**, Director of the Department of Mental Health, Modena, Italy **Mental Health System Reform in Jordan** **Fateen Janim**, Director of the Mental Health and Substance Use Directorate, Ministry of Health, Jordan **Mental Health System Reform in Lebanon** **Rabih El Chammay**, Head of Mental Health Programme, Ministry of Health, Lebanon **Public Mental Health Services in the West Bank** **Samah Jabr**, Head of Mental Health Unit – Ministry of Health, Palestine **Mental Health System in Iraq: an overview** **Salih Mahdi al Hasnawi**, Professor and Consultant Psychiatrist, Iraq *Discussant:* **Khaleed Saaed**, WHO Regional Advisor for Mental Health Eastern Mediterranean
13.15 - 14.30	**LUNCH BREAK**

SESSION 2. **CHILD AND ADOLESCENT MENTAL HEALTH: THE IMPORTANCE OF EARLY INTERVENTIONS** *Chaired by* **Maria Cristina Profili**, WHO Representative to Jordan	
14.30 - 16.30	**Mental Health in Children and Adolescents: A Public Health Perspective** **Khaled Saeed**, WHO Regional Advisor for Mental Health in the Eastern Mediterranean Region **Child and Adolescent Psychiatry** **Banaz Adnan Saeed**, Department of Psychiatry, College of Medicine, Hawler Medical University, Erbil Governorate **New Challenges and Perspectives in Child and Adolescent Psychiatry** **Ernesto Caffo**, Chair Professor of Child and Adolescent Psychiatry at the University of Modena and Reggio Emilia and Full-time Director of the Department of Pediatrics for the Hospital of University of Modena, Italy *Discussant:* **Enrico Materia**, Global Health Expert

3RD October 2019

SESSION 3. **DEALING WITH TRAUMA: A RESILIENCE APPROACH TO POST-TRAUMATIC STRESS DISORDERS** *Chaired by* **Enrico Materia**, Global Health Expert	
10.00 - 11.30	**The Global Awareness for Children in Trauma Programme** **Panos Vostanis**, Professor at the Department of Neuroscience Psychology and Behavior, University of Leicester, United Kingdom **Childhood traumatic life events in Lebanon: Prevalence and Predictors of PTSD** **Fadi Maloouf**, Chairperson, Chief, Division of Child and Adolescent Psychiatry, Department of Psychiatry, American University of Beirut, Lebanon **Trauma: illness or resilience** **Leslie Scarth**, Child and Adolescent Mental Health Specialist, UK
11.30 - 12.00	**COFFEE BREAK**
12.00 – 13.00	**Psychological well-being of Palestinian Children and Adolescents in Gaza Strip and West Bank** **Abdel Aziz Thabet**, Emeritus Professor of Psychiatry, Quds University of Gaza **Strengthening Child and Adolescent Mental Health Services and Systems: Beyond narrowly defined traumatic reactions of children and adolescents** **Boris Budosan**, Expert of Mental Health and Psychosocial Support, Croatia *Discussant:* **Khaleed Saaed**, WHO Regional Advisor for Mental Health Eastern Mediterranean
13.00 - 14.30	**LUNCH BREAK**

SESSION 4. **SCALING-UP MENTAL HEALTH SERVICES IN THE REGION: ITALIAN COOPERATION SUPPORTED INTERVENTIONS** *Chaired by* **Giorgio Marrapodi**, General Director of the General Directorate for Development Cooperation (DGCS) of the Ministry of Foreign Affairs and International Cooperation	
14.30 - 15.30	**Strengthening the Mental Health System, Improve Access and Services for Syrian refugees and vulnerable Jordanian population** **Alessio Santoro**, Project Manager, WHO Jordan Country Office **Improving Child Mental Health and Psychosocial Development through Community-Based Organizations** **Chiara Giorgio – Irene Panarello**, Beit Al Liqaa (Sermig) Madaba **Italian Cooperation Contribution to the Mental Health Sector in Duhok Nizar Esmat**, Director General of the Directorate General of Health, Duhok Governorate *Discussant:* **Emanuela Forcella**, Human Development Office, AICS Roma
SESSION 5. **ROUND TABLE DISCUSSION** *Chaired by* **Enrico Materia**, Global Health Expert and **Maria Cristina Profili**, WHO Representative to Jordan	
15.30 - 17.00	**Priority needs for Mental Health in the Region** **Khaleed Saeed**, WHO Regional Advisor for Mental Health Eastern Mediterranean **Nizar Esmat**, Director General of the Directorate General of Health, Duhok Governorate **Fateen Janim**, Director of the Mental Health and Substance Use Directorate, Ministry of Health of Jordan **Fadi Maloouf**, Chairperson, Chief, Division of Child and Adolescent Psychiatry, Department of Psychiatry, American University of Beirut **Samah Jabr**, Head of Mental Health Unit – Ministry of Health, Palestine **Salih Mahdi al Hasnawi**, Professor and Consultant Psychiatrist, Baghdad *Questions and answers*
CLOSING REMARKS *Chaired by* **Michele Morana**, Head of Office, AICS Amman	
17.00 - 17.15	**H.E. Luca Maestripieri**, Director of the Italian Agency for Development Cooperation **H.E. Giorgio Marrapodi**, General Director of the General Directorate for Development Cooperation (DGCS) of the Ministry of Foreign Affairs and International Cooperation

H.E. Saad Jaber
Minister of Health,
Jordan

Welcome speech

H.E.Mr. Fabio Cassese, Ambassador of Italy in Amman,
Excellencies, Distinguished Guests, Ladies and Gentlemen,

On behalf of Her Royal Highness Princes MUNA ,it gives me great pleasure to be among you today to join you in inauguration ceremony of the Strengthening Child and Adolescent Mental Health Services and Systems Conference, patronized by HRH Princes MUNA.

I would like to seize this opportunity to welcome our guests and wish them pleasant stay in our beloved country, and it is my strong conviction that this event will be an ideal platform for experts and specialists to share views and expertise in mental health.

Ladies and gentlemen,

Jordan is a signatory to the UN Convention for the child's and Adolescents' rights, and is committed to ensure high standards of healthcare for children and adolescents, especially in the field of mental health ,as half of the mental illness begins in general at the age of fourteen. In this regard, the Ministry of Health adopted a series of measures to improve mental health services exemplified in implementing the Bridging the Gap of Mental Health Program by integrating mental health services in primary health care in 2008 and supported by WHO.

Ladies and gentlemen,

The Ministry of Health is committed to implement the National Mental Health and Substance Use Action Plan 2018-2021 through the integration of services at primary health care level and strengthening of secondary care.

Finally, I would like to express my sincere gratitude for the Italian Agency for Development Cooperation for its continuous support, thanks and appreciation are due to the World Health Organizationfor their unlimited technical support and to the MHPSS partners for their sustained efforts in meeting the needs of the most vulnerable and marginalized populations.

Thank you all and wish you successful and fruitful deliberations.

Marta Grande
President of Foreign Affairs Committee
Chamber of Deputies, Italian Parliament

Welcome speech

Your Excellencies,
Minister Jaber and Ambassador Cassese,
Dear Director,
Ladies and gentlemen,

It is a great pleasure to be here today with you. It is indeed a privilege to represent and welcome all the participants on behalf of the Italian Parliament to this Regional Conference on Child and Adolescent Mental Health.

In Italy, the transition from a hospital-based system of care to a model of community mental health care started in 1978 with a reform that has attracted international recognition as being the only instance of an industrial society eliminating detention in hospital from its range of mental health services. In the past three decades, mental health care has seen a gradual move from hospital to community care.

Improving mental wellbeing should be seen as natural as striving to improve our physical wellbeing. What we need to stress is that early intervention is key. The sooner people experiencing mental illness seek support, the greater the chance of their full recovery. One of the key messages I want to deliver here today is that we must continue promoting mental health. There should be more opportunities for people to connect with local health service providers and learn what support is available for people living with mental health issues, as well as for their families and friends.

We all know there is more work to be done. We need to work across all policy areas, not least in the education, employment and social sectors. Our future depends also on our ability to ensure that all children and adolescents have the opportunity to meet their full potential and live healthy and productive lives.

I personally want to thank all the practitioners who joined us here today, I wish you all fruitful work in the coming sessions of discussion.

Luca Maestripieri
Director, Italian Agency for Development Cooperation

Welcome speech

Your Excellency,
Honorable President,
Dear Ambassador,
Ladies and gentlemen,

It is a great pleasure to be here today to open this Conference, which provides a valuable opportunity to highlight the positive steps that can be taken to promote mental health and wellbeing in the region and I am very glad to express our full support on behalf of the Italian Agency for Development Cooperation.

The wellbeing and health of children are at the core of our social and economic development. The people centred approach to health is firmly positioned in the Italian Agency for Development Cooperation's objectives and interventions. Person-centred health care means ensuring that our interventions are directed at meeting the needs of the individuals who use them.

Above all, the mental and physical health of children and adolescents is essential to ensure their ability to succeed in school, at work and in society. That's precisely why mental health disorders are not only a health issue but also a global development issue. When children are unable to go to school or to participate fully in society, mental disorders become a significant economic burden.

The Sustainable Development Goals provide us with a framework for action on mental health and we, as Italian Agency for Development Cooperation, are committed to boosting national mental health services in the community. Community services can play a crucial role in promoting mental health awareness, reducing stigma and discrimination.

We are here today because we all share a common truth: Mental health and physical health are closely connected. Better mental health improves the physical health and viceversa. We must work together to nurture stronger synergies in strengthening community health services to support recovery and social inclusion and prevent mental disorders.

I wish all of you good work for the success of the conference and I look forward to exploring the outcomes of your contributions.

Maria Cristina Profili
WHO Representative
to Jordan

Opening remarks

Excellencies, distinguished colleagues and partners, Ladies and Gentlemen,

It gives me great pleasure to be with you today and to address this distinguished forum.

It is a great honour for WHO to join the opening of this meeting under the patronage of Her Royal Highness Princess Muna Al Hussein, for her ongoing support to the Minister and the Ministry of Health and to the mental health sector in Jordan and to be Patron for the National Action Plan for Mental Health and Substance Use (2018-2021).

My infinite thanks goes to the Minister of Health of Jordan to follow WHO guidance in reforming the mental health systems moving services at Primary Health Care level where the mental health services should be able to reach the most vulnerable.

I am very thankful to the Government of Italy for their generous support to the Ministry of Health through WHO for the implementation of the National Action Plan for Mental Health and Substance Use (2018-2021).

We are living in a Region that suffers from lots of crisis and conflicts and the rise of the mental health needs and mental health problems among the population especially among the vulnerable groups such as the children and adolescents and women.

This Regional Conference focusing on child and adolescent mental health is timely organised between the World Suicide Prevention Day on 10 September and the World Mental Health Day on 10 October that this year is also focused on Suicide prevention.

“Despite progress, one person still dies every 40 seconds from suicide. “Every death is a tragedy for family, friends and colleagues. Yet suicides are preventable”. Suicide is the second leading cause of death among 15-29 year-olds. Close to 800.000 people die due to suicide every year. 79% of global suicides occur in low- and middle-income countries.

Globally, child and adolescent mental health services are lacking- young people access mental health services less frequently than any age group because of symptoms are under detected, poor awareness and help seeking and insufficient in policy framework priority.

Therefore, act in early life course is key to prevent mental health problems later in life because most mental disorders in adult life have their onset in childhood.

I hope that all of us in our individual and organization capacity will join efforts to ensure that more people with mental disorders, in this Region and throughout the world, both seek and get help.

I wish for all a very successful Conference and its deliberations.

Thank you.

Cristina Natoli
Head of Office,
AICS Jerusalem

Support on Mental Health at national level

The Palestinian population is considered highly vulnerable due to protracted occupation, with exposure to instability, uncertain personal safety, displacement, arrests and detention, leading to a high prevalence of mental health (MH) disorders. However, there is a huge gap between the actual mental health needs and the provision of services, due to an under-resourced Palestinian health system.

A National Mental Health Strategy for Palestine was developed and implemented for 2015-2019, and its revision for the next years is currently ongoing. The priority actions include the development of legislation related to Mental Health, the strengthening of a routine information system with standard MH indicators, the integration of MH services in PHC, supported by a structured referral system. A specific focus is dedicated to psychological trauma and crisis situations, to the development of interventions for mothers, children and adolescents with MH problems, to the improvement of quality of care in psychiatric hospitals and in community mental health centers, and to designate strategies to reduce stigma and discrimination.

The Italian interventions on mental health are integrated in an overall strategy targeting non communicable and chronic diseases, in line with the Palestinian National Mental Health Strategy, in order to improve the quality of health care services and the equitable access to them, developing infrastructures, providing equipment, supporting interventions on awareness, training of health care workers and technical assistance to the Palestinian Ministry of Health (MoH). POSIT, CRONO and RING are AICS bilateral programmes addressing different needs in the MH sector, among other interventions.

AICS Jerusalem is also supporting a multilateral programme with WHO targeting, among others, the mental health sector. It aims to ensure comprehensive and integrated mental health services for Palestinians, supporting the MoH in the strengthening of rehabilitation care for patients and promoting integration of mental health services in PHC facilities.

Through the Humanitarian Programme, AICS Jerusalem is currently funding five projects implemented in the most vulnerable and marginalized areas of Palestine. In addition, Italian CSOs partnering with a local CSO, created in Gaza a database on mental health of minors and are currently offering psychological support through mobile clinics and counselling to the women of three villages in Gaza Strip.

Donatella Procesi
Head of Office,
AICS Beirut

Mental Health initiative in Lebanon

Lebanon has been witnessing an unstable situation since the end of the civil war in 1991. Poverty and a high degree of inequality were significant even prior to the influx of Syrian refugees, estimated to be 1.5 million and representing a quarter of the Lebanese population. In 2019, the socio economic deterioration has resulted in popular revolutions calling for drastic changes in the Lebanese political landscape and for more accountable public authorities.

The public health system in the country is weak, being 90% of secondary services provided by the private sector and the primary health services offered by a wide number of Primary Health Care Centres and dispensaries managed by Lebanese NGOs, under the supervision of the Ministry of Public Health.

In addition, public and private health insurances cover only 44.9% of the Lebanese population and health care of Syrian refugees is supported largely by the International Community.

Several surveys have been conducted in order to develop strategies coping with the needs of the country and it was found that Lebanon has a highest prevalence of mental health disorders. Therefore, the Ministry of Public Health, in collaboration with the World Health Organization (WHO), UNICEF, and International Medical Corps (IMC), launched on the 14th of May 2015 the Mental Health and Substance Use Prevention, Promotion, and Treatment Strategy for Lebanon 2015-2020.

The objectives are preventing of mental illness, increasing awareness of the public towards these issues, providing services in the community in an easily accessible way to those most at need, and treatment by qualified mental health professionals. However, the mental health strategy needs the development of legislation, the integration in a public health system and human and financial resources.

The Italian Cooperation has supported the Mental Health sector by rehabilitating and equipping the psychiatric hospital in the South of Lebanon and the “Blue House”, which is a section for detainees with mental disorders at the Central Prison -Roumieh.

In addition, the Italian Cooperation is supporting the social services provision with both a short and long term approach, with particular focus on Child and Women Protection.

Giorgio Marrapodi
General Director
for Development
Cooperation

Closing remarks

Excellencies, Ladies and gentlemen,

Allow me to join the Director of the Italian Agency for Development Cooperation, Luca Maestripieri, in closing this Regional Conference. I am very pleased to be here and encouraged as well by the outcome of this Conference: this is clearly the way forward to achieve the necessary health outcomes in Middle East neighbouring countries.

In the past ten years, evidence that health can drive socio-economic development has spurred the growth of an unprecedented number of health initiatives. Health has never before enjoyed such attention or such wealth. Nor have the ambitions, commitment, and level of consensus ever been so high.

The entire international community is working to ensure a greater health security, as well as a better access to preventive and curative care. However we realized that working within the health sector is not enough, especially in view of the challenges posed by mental health services.

Since long, we have developed considerable efforts to better understand the determinants of mental health. More recently, many relevant actors of the international community have engaged in a collective efforts to better understand and improve the impact on the social determinants of phisycal and mental health. Obviously, more research is needed. However, we all have already accumulated a considerable amount of information, knowledge, and know-how that is insufficiently used in the daily practice to help protect and improve the physical and mental health of children and adoloscents.

The discussions in the past two days gave me another reason to be optimistic about the outlook for preventive and curative health care which will impact also on the physical and mental health of children and adolescent.

I trust that the outcomes of this Conference will influence the future direction of the Italian Development Cooperation's initiatives and will set up the framework for planning our future action in the Mental Health sector in the Middle East Countries.

Thank you all for this opportunity to address you. I am committed to moving forward with you, in our closely coordinated roles.

CONTRIBUTIONS

The Theory and Practice of the Italian Psychiatric Reform. 40 Years of Basaglia Law

Roberto Mezzina
WHO CC for Research and Training
at MH Dept, ASUI Trieste
Italy

The history

Italy pioneered de-institutionalization in the 60's and the 70's and enforced a famous mental health reform law in 1978. The Law 180 (entitled to Franco Basaglia) was the first Act worldwide to abolish the psychiatric hospital and to give back the full rights of citizenship to people with mental health disorders. De-institutionalization has been completed in Italy till the very closure of all Psychiatric Hospitals in two decades (1978-1999). After another 20 year period also forensic hospitals were overcome (2014-2017).

The multifaceted aspects of the Basaglia Law encompassed:

- A new set of norms respecting full rights (the normative character)
- The climax of a crisis of psychiatric hospital as institution and the rising of community based mental healthcare (the policy character)
- A promise of a true paradigm shift in psychiatry that is a model for all countries (the seminal character)
- A social and political movement for expanding civil and social rights (the citizenship character).

WHO recognition to the Italian Law

The WHO resource book on legislation acknowledged the innovation of the Law 180:
"Legislation may require that admission to hospital be allowed only if it can be shown that community-based treatment options are not feasible or have failed".

"...the proposal for compulsory health treatment can envisage hospitalization care only if mental disturbances are such as to require urgent therapeutic intervention, if these interventions are not accepted by the patient, and if there are not the conditions and the circumstances for taking immediate and timely health care measures outside the hospital" (WHO, 2005).

Dangerousness was not anymore mentioned as the reason for involuntary treatment.

No power was assigned to the judiciary system but the role of the 'tutelary judge' to protect the rights of the person (e.g. checking the consistency of the proposal of involuntary treatment according to the law's criteria, the right to communication and right to appeal). Searching for voluntary care is a clear mandatory rule, and this is a recognition of contractual power to the person. Involuntary treatments are time limited (usually a week) and they do not suspend all constitutional rights including freedom (obligation of care, not detention or seclusion). All this guarantees a totally different career for the patients, without long-term institutionalization.

The Italian way to D.I.

Why the 'Italian way to deinstitutionalization' remains a model of reform?

Its community services and good practices derive directly from the process of deinstitutionalization and the transformation that results, and not only in institutional terms (i.e. eliminating the asylum) but also with respect to the philosophy of intervention, the values expressed, and the role and social significance of the services.

Some of the key lessons learned during the course of this experience are:

- Working directly within total institutions but without deceiving ourselves that their closure can come from outside or due to a 'natural death'.
- Creating alternative networks of coherent services – coordinated by a Mental Health Department - that work in synergy within the community, thereby avoiding useless and often harmful fragmentation and specializations, and thus working not according to preconceived models but by processes that are verified collectively by users, families and caregivers, and the community and its institutions.
- Avoiding priority implementation of hospital services for crisis/emergencies instead of community structures.
- Assign to the community services the task of taking responsibility for persons who come from their territory of competence, who are still interned in the PH.
- Plan the phasing out of PHs at the local, regional and state levels, with specific time-frames and the possibility of applying administrative sanctions in cases of non-compliance". (Trieste Declaration, 2011).

Processes and outcomes of the Italian Reform

We can describe the most relevant processes and outcomes after 40 years as follows:

a) Closure of all asylums (1978-1999)

Main indicator is involuntary treatment that dropped dramatically after 1978 as

an immediate effect of Law 180 and have sustained the lowest ratio in Europe (17/100.000 in 2015) and the shortest duration (10 days). Moreover:

b) Reconversion of budget

In Trieste for instance, the total cost of the new Mental Health Network doesn't exceed the former Mental Health budget and nowadays is about 39% of the above but it reaches 4.1% of health expenditure (Mezzina, 2014, 2016).

On a national scale, even though no precise data are available, the current cost of psychiatry doesn't exceed so far 3,5% of the Italian National Health Service cost, ranging from 6.5 to 2.1 % according to different Regions, which demonstrates a loss of money for mental health in general (Starace et al. 2017).

c) Role and feature of the Community Mental Health Centre (CMHC)

The problem of the CMHC looks ever more to be the central practical-theoretical point in the pursuance of the law. On one hand, the original Italian concept of the CMHC was the standpoint of a Mental Health Department, as the main or the only point of reference for all psychiatric requirements of the entire catchment areas. This position can allow and even oblige the CMHC to conduct a continual cycle check on its own effectiveness on overall pathways of care in the community it serves.

Inversely, if the CMHC is conceived as a simple outpatient clinic, that means accepting an unavoidably subordinate situation in terms of structure and work similar to the hospital based services (SPDC) and private hospitals (De Girolamo et al. 2007).

In presence of weak and not focused community based services, the system is often dysfunctional and produces 'residuals' who stick in long term residential care, even if this happen in community settings (Rosen et al. 2012, 2014).

d) Mainstreaming

Each CMHC has to be linked to basic medical care, social services, services for the elderly, coordinated by "Health Care Districts", but this kind of mainstreaming does not apply easily because of wide regional variations, and when happened seemed to give priority to the treatment of Common Mental Disorders (Lora, 2009). Mainstreaming Mental Health in general healthcare has been interpreted according to several different models, e.g. Healthcare District Centers, "Case della Salute" integrating GPs, etc. (Berardi et al. 2014)

e) Rehabilitation facilities and Supported Housing

Deinstitutionalization was mainly implemented through a high number of community residential programs like small scale group homes, often 24hrs

run and mainly managed by NGOs who still represent in many areas the most expensive investment (De Girolamo et al. 2002; Picardi et al. 2014).

Sheltered community-based homes proved to be of great importance to more than 17,000 places at the end of the '1990s toward about 30.000 (estimated) in 2017.

These are mainly group-apartments for about 8-10 people who are attended by nurses or by NGOs (co-operatives, volunteer organizations). Anyway it is noteworthy that in Italy, rehabilitation and reintegration of former long-term patients in transitional community residential settings is more extensive than in any other HIC.

f) Citizenship and Recovery

For people with Mental Health problems, the issue of equality and the right of being cared for, includes a complete system of resources and provision intended for social reintegration and an actual citizenship (Mezzina, 2006a, 2006b). Integrated social co-operatives were developed as one of the most outstanding results of the change. The first one in Trieste started as a practical response to exploitation of mental health in-patients in cleaning the asylum, ensuring a real pay at trade union rates. More than 4,500 cooperatives are now operating in the country. Among them, "B" Type co-ops, namely for work placement, include at least 30% disabled service users and get a tax break to help them sustain a viable business (Leff & Warner, 2006; Fioritti et al. 2014, Rotelli et al. 1994).

They strive to be competitive in the market, involving people with mental illness as service users, people with "social disadvantage" as well as other citizens, in work activities that include agriculture, building, cleaning, tailoring, hotel operation, restaurant, home catering businesses, etc.

Social cooperatives represent the most important resource (80%) for people with severe Mental Health issues (49% with psychosis) to be employed as shown by a national survey (Bracco et al. 2013).
Moreover, self and mutual help groups, peer support and user–carer operated services, mental health associations have grown everywhere in the country, embracing a recovery vision, over the last 30 year (Mezzina et al. 1992) and advocating for their own rights (Javed & Amering, 2016). In many places there are experiences of co-production of services.

g) Public cultural change

Social acceptance of the law and a general decrease of stigma attached to psychiatry mark a series of fundamental changes in public attitudes with no way back. Carers associations as UNASAM, as well as professional ones (e.g. the Society of Italian Psychiatrists), for many years claim for better community services rather than for a new law, even if more than 30 Bills have been presented in these 25 years.

Research demonstrated a reduced family burden than in other European countries (Magliano et al. 2002). Now the change in the mentality, due to the closure of Institution, is an achieved goal, as demonstrated by the findings of Research of Lille CCOMS on the image of Mental Illness in the community done in Trieste.

h) The closure of large Forensic Hospitals

This sector, not considered by Law 180, has been included finally in a new phase of de-institutionalization (Rosen et al. 2014). On 31 March 2015 the law n. 81 declared the closure of all 6 Forensic hospitals, replaced by small (less than 20 beds) regional units linked to Mental Health Departments. This process is now completed, and also resulted in significant improvements, such as closure of all 6 forensic hospitals, the decrease in the number of forensic beds from about 1500 to 604 (of which 567 occupied). The integration of those smaller units in Mental Health Departments, linked to community mental health services and the rapid turnover (457 persons discharged in 18 months). This has been defined as a "second – gentle - revolution" after the closure of all psychiatric hospitals (Corleone, 2017).

The Trieste model

Trieste is an internationally known experience that started in 1971 under the direction of the great figure of Franco Basaglia, and resulted in the first closure of a psychiatric hospital in Europe in 1980.

Trieste showed a different way for an innovative community mental health that has moved from a narrow clinical model based on the illness and its treatment to a wider concept that involves the whole person – a whole life and a whole system engaging the social fabric.

The Mental Health Department is recognized as a WHO Collaborating Centre for 30 years and it is considered as a sustainable model for service development – even in a context of economic crisis, because of its clear demonstration of cost effectiveness. According to the WHO, Trieste is one of the clearest examples of how the Italian movement achieved deinstitutionalization, intended as a complex process "from within" a psychiatric hospital resulting in the gradual relocation of its economic and human resources, and the creation of 24 hour community based services together with the development of social inclusion programs.

The current MH Department (a model for the whole Region Friuli Venezia Giulia) is working without asylum from 45 years so far, replaced by a totally open door system, with a 24 CMH Centre with 6 beds for every sector, a system of supported accommodation and a small GH Unit.

The Personal healthcare budget system is now helping to taylor individual recovery and social inclusion plans of care. The integration of MH services in a system of healthcare districts for community based medicine (elderly, young and adolescent, disabled, specialized medicine, etc).

The wide range of social inclusion programs include congregate supported housing for about 95 persons located in the city. Social co-operatives provide place-and-train in a system of real job opportunities. Job training and placement for about 200 service users annually, with about 1/10 becoming full-time members/employees in the participating social co-ops and businesses each year.

Day centers, social clubs, community agencies and associations, including sport and cultural ones, as active partners for human development and social inclusion (Mezzina, 2014).

The organization and philosophy of the 24 hrs. CMHCs is based on the principles of:

1. Easy access, non-selection of demand and low threshold (i.e., not based on particular diagnoses, severity thresholds, or other exclusion criteria);
2. Non hospitalization and alternatives to it;
3. Service flexibility and mobility, proactivity and assertiveness - toward crisis and long term support;
4. The involvement of multiple comprehensive resources, such as a wide range of welfare provisions, in the therapeutic and support programs (Mezzina & Vidoni, 1995; Mezzina & Johnson, 2008) and, moreover,
5. Continuity instead of transitions in care (Segal, 2004).

Presently in Trieste, 94% of the mental health budget is spent in the community (18% directly to personalized and budgeted packages of care), with only 6% of the budget going to a 6-bed general hospital-based service that acts as an emergency first aid station at night.

WHO Action Plan 2013-2020 and the CRPD

Looking at the international landscape, we remind that, first of all, WHO has asked countries to update their legislation and policies (WHO, 2013) in line with the CRPD and other international and regional human rights instruments. The global target 1.2 points out that 50% of countries will have developed or updated their laws for MH in line with the international and regional human rights instruments by the year 2020. Stakeholder collaboration is also needed: strengthening and empowerment of people with mental disorders and psychosocial disabilities and their organizations must be pursued through "a formal role and authority to influence the process of designing, planning and implementing policies, laws and services".

In many ways, the Italian reform law anticipated the CRPD, issued by UN in 2006. The fundamental right to health care, including MH care, is highlighted in a number of international covenants and standards (WHO, 2005). Chiefly,

the right to health is now also included in the promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to personal, social, economic, cultural and political development (United Nations, 2017).

Even the WHO Resource Book has been withdrawn because of the CRPD, as far as it legitimated involuntary treatment, no coercion in care is now admitted by the Committee of CRPD (2015) and this is a clear direction also for WHO Quality Rights Programme (WHO, 2017).

In the Law 180, involuntary treatments are made possible through a substitute decision-making, seen as a denial of legal capacity. The CRPD is based on substantive rights: they are imperative and non-negotiable, but they can remain abstract - unless they are connected to citizenship and participation to a society, challenging social exclusion, acting on social determinants of health (Marmot, 2005; WHO & Calouste Gulbenkian Foundation 2014) to achieve greater equity of quality and stability of home, work, income, supports (Mezzina et al. 2018).

These political, legal and social actions have to be combined with our own emancipation as clinical professionals from institutional thinking and practices in MH and social care (Mezzina et al. 2018).

Paradigm shifts

The Italian experiment, implemented through the reform law, and achieved by successful experiences such as Trieste, opened to a series of paradigm shifts from the institutions to the community, and from the illness to the person - its subjectivity and social being can bring a move toward a "gentle" Psychiatry.

Therefore:

- **Choice**, e.g. offering consistent home care;
- **Negotiation** as a main principle, but with a citizen with rights, instead of coercion and locked doors, or mechanical restraint;
- **Psychosocial** interventions, e.g. work, home, talking therapies;
- **Shared responsibility, supported decision making, guarantees for treatment**;
- Shared **alternatives**, dialogical approaches, crisis and recovery homes, early support, de-escalation of crisis, easy accessibility of services.

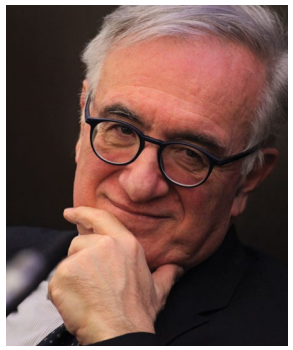
Basic values are related to democracy - as the main transformation in mental healthcare. Then there is a cascade of other relevant shifts:

- From (unmet) needs to (affirmed, declared) rights - through laws. This point is connected to addressing social determinants of health, that is "the way people live", their quality of life, and it is now addressed in several ways, e.g. through personal budgets.

- From hospitalization of an "inpatient" to hospitality of a guest" in a community facility, such as CMH Centre.
- From the monologue of psychiatry (and of the psychiatrist), that is based on a judgement of diversity, to listening and dialogue (not only as a specific therapy), and trustee relationships. Knowledge is based on information that must be provided to all stakeholders, starting from the person in need.
- From power on - (a person subjected to a power), through the pedagogy of power (Basaglia), toward empowerment, that is bottom-up, or power with - (shared power, power of the subjects).
- From seclusion and restraint to freedom, as the fundamental move of deinstitutionalization. Acceptable care is the first step to achieve an accessible care, and then to fulfill the right to the highest attainable degree of health.
- From individual to collective rights: awareness of citizenship, self-reflection on a person social life. Citizenship is exercising rights and acting rights, not just a status but a development, and it includes civil and social rights (work, house, social roles). All of this can be called human rights.
- From guardianship to free will, from imposition to negotiation (working out micro-conflicts), toward a therapeutic alliance, shared decision making and self-determination.

All these changes involve the overall paradigm shift from illness to the person in a whole life view (the kind of life we want) and a whole system of care and support.

Capability to deal with power issues and microsocial conflicts (Mezzina et al. 2018; MHEN, 2017) is based on a form of empowerment that recognizes "the other" in a conversation and a negotiation towards a therapeutic alliance that respects people's wills and preferences and that is displayed in their living environments (on 'their turf and terms').



New challenges and perspectives in child and adolescent psychiatry

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The World Health Organization (2005) describes mental health as "a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community". Mental disorders can appear in many forms, but in general they characterized by abnormal behaviors, emotions, thoughts and relationships with others.

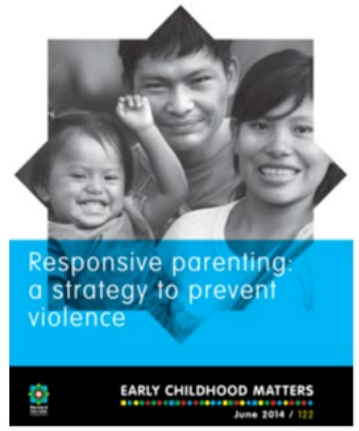
Child mental health problems are common: according to the WHO, the 10-20% of children and adolescents experience mental disorders. If untreated, these problems can have a strong impact on the individual: it is well documented that mental disorders in childhood lead to problems of varying degrees of seriousness in adulthood. Approximately half of all lifetime mental disorders starts by the mid-teens and three quarters by the mid-20s; later onsets are mostly secondary conditions (Kellers et al., 2007).

Children with mental health problems are more likely to experience problems in social functioning (i.e. isolation and peer victimization) and low education later in childhood (Sellers et al., 2019). Suffering from mental disorders in adolescence is associated with depressive disorders, anxiety disorders, substance use and/or substance abuse. (McLeod, Horwood e Fergusson, 2016), and high mortality rate due to suicide (Vijayakumar, Pirkis & Whiteford, 2005).

Long-term consequences of mental disorders seem to have worsened over time. Recently, Seller and colleagues (2019) analysed the secular changes in prevalence and later outcomes of mental health problems in three cohorts of 7-year-old children recruited in three different periods (1965, 1998, 2008). Although the prevalence of mental disorders in childhood has not increased, there is an increase in adverse outcomes over time. Understanding the reason for this worsening is very important.

In all the fields of medicine and health the culture of prevention and early intervention is gaining importance. The aim of prevention is to reduce the influence of known risk factors and increase the effect of protective factors in an attempt to reduce the likelihood of children developing mental disorders. To date, there are few empirical-based preventive interventions; some of them

are individual-based while others involve families. Intervention programs that involve parents are particularly important, considering that both genetics and the environment in which the child grows up are well-documented risk factors in the development of psychopathologies (O'Loughlin, Althoff & Hudziak, 2017). In addition, families play an important role in the continuity of young patients' healthcare (Signorini et al., 2017).



An example of preventive intervention that involves families is parent training This is mainly used in presence of externalizing disorders, although it is useful in the absence of mental problems as well. These programs aim to provide parents with strategies to improve their children prosocial behavior and reduce their oppositional and aggressive behavior (O'Loughlin, Althoff & Hudziak, 2017).

Research shows that the first onset of mental disorders usually occurs in childhood or adolescence; nevertheless, treatment typically does not occur until a number of years later (Kessler et al., 2007).

Stigmatization is one of the reason why children and their families refrain from seeking help (Walters, 2018). Children and adolescents with mental health problems have to deal with stigmatization, both by other children and by adults, moreover they are more vulnerable to stigmatization than their peers with other kind of health problems. (Kaushik, Kostaki e Kyriakopoulos, 2016).

The severity of stigmatization varies according to the type of disorder and gender. For example, depressive disorder seems to be more stigmatized than anxiety disorder or ADHD, and males seem to be more stigmatized and more stigmatizing than females (ibidem).

Poor access to quality mental health services and supports is hindering many young people's ability to actively participate in society.

A recent survey (Signorini et al., 2017) investigated service configuration, characteristics, and activity of child and adolescent mental health services (CAMHS) in all 28 European Union (EU). Findings show that access to CAMHS is difficult, owing to a large discrepancy between the number of young people needing help and the availability of resources, particularly in low-income and middle-income countries. Moreover, one third of sampled countries do not adequately meet specific needs of children under certain special circumstances, e.g. refugee and asylum seeking children, children from minority ethnic backgrounds (ibidem).

Table 2 Estimates of the most frequently experienced difficulties by children or young people with mental disorders, who need transitional care in each EU country

	Lack of connection between CAMHS and AMHS	Lack of specific competencies in AMHS	Lack of specific destination	Full AMHS caseload	Eligibility differences	System culture differences	Ignorance of other systems	Territoriality
Austria	√	√		√		√		
Belgium	√	√		√	√	√		
Bulgaria		√		√				
Croatia	√		√				√	√
Cyprus		√	√	√		√		√
Czech Rep	√							
Denmark	√					√		
Estonia		√		√		√		
Finland	√			√		√		
France	√	√	√	√	√	√	√	
Germany	√	√	√	√	√			
Greece	√	√						
Hungary	√							
Ireland	√	√				√		
Italy	√	√			√			
Latvia	√	√				√		
Lithuania					√	√		
Luxemburg	√		√				√	
Malta	√							
Netherlands	√	√			√	√		
Poland	√	√	√	√	√		√	
Portugal	√	√						
Romania	√							
Slovak Rep				√	√			
Slovenia	√	√						√
Spain	√	√			√			
Sweden	√	√				√		
UK	√	√			√	√		
Total	23	18	6	10	10	13	4	3

In the lights of these data, it is clear that much still needs to be done in the area of prevention and early intervention, starting with the identification of new and efficient methods to reach children and adolescents in need for help. With that in mind, we have to acknowledge the power of listening to children and supporting them in competent and professional way.

Child helpline provide free, accessible and confidential support for children suffering from different issues, such as abuse and violence, bullying and cyberbullying, mental health and psychological distress (Van Dolen et al., 2019). Helplines all over the world offer support and help to children and adolescents in need through volunteers and/or professional staff and are able to make referrals to the agencies and Institutions (i.e. social services, schools, law enforcements, mental health services) (Child Helpline International, 2019). Child Helplines provide support through different means, such as telephone, chat, SMS, apps. Helplines can be considered as an important point of contact for children suffering of mental health issues, since these lack the barriers often associated with the use of other health services (Van Dolen et al., 2019). A recent report of Child Helpline International shows that helplines across all regions of the world have received in 2017 and 2018 a total of 13.329.537 contacts regarding children and adolescents in need (Child Helpline International, 2019).

Telefono Azzurro is a non-profit organization that has been working for more 32 years to protect and promote children and adolescents' rights. Telefono Azzurro's core service is the helpline (1.96.96) which is a free toll number available for children and adolescents up to the age of 18 and to adults concerned about an issue involving a minor. Telefono Azzurro's helpline is available via telephone, but also via chat and email. In 2018, Telefono Azzurro's helpline has handled 2.794 cases. Among these, the 25% regards mental health issues in children and adolescents.

With regard to new challenges in the field of child and adolescents' mental health, we can identify different areas and perspectives.

With no doubts, one of the relatively new concerns the World is facing is the refugee crisis.

An increasing number of minors are experiencing dangerous journeys to reach Europe completely alone or lose their families along the way. According to UNICEF, in 2018 more than 638,000 asylum applications have been made in European countries, and the 10% of these came from children and adolescents without accompanying family members. According to the Ministry of Labor and Social Policies (November, 2019) the UAMs in the Italian territory are 6.369.

This population is at high risk of being exposed to human trafficking, exploitation (Digidiki, Bhabha, 2018), health problems, psychological and physical harm, violence. Many of them have witnessed violence, have lost a part of the family and have faced deprivation (Pejovic-Milovancevic, Klasen & Anagnostopoulos, 2018).

For these children, violence can happen prior to their journey, during the travel to the host Country, upon arrival, or after resettlement (ibidem).

Are refugee children more affected by mental health issues than normal population? Evidence shows that children and adolescents refugees are more likely to show emotional problems (sadness, grief, fear, frustration, anxiety, anger), cognitive problems (loss of control, helplessness, worry, hopelessness), physical symptoms (fatigue, problems sleeping), social and behavioral problems

(withdrawal and aggression, difficulties in interpersonal relationships) (Fazel et al., 2012).

Along with the refugee crisis, another challenge to be addressed is the relationship between young people and the digital world. Worldwide, 71% of young people are online. According to a Broadband Commission report (October, 2019), in the least developed countries, 35% of the Internet users are young people. In 2013, a publication of the London School of Economics showed that children up to the age of 18 represented more than one third of all Internet users (Holloway et al., 2013).

Our society is definitely changing: new technologies and the internet permeate the lives of our youth and their families. For young people the internet helps shape their identities and self-image, but it also shapes the way they interact and socialize, their sexuality and the way they search for a partner.

Internet can be identified as a great opportunity for the cognitive and social development of children and adolescents. At the same time, it can expose them to risks and dangers that can compromise their safety and their healthy development.

Young people in the online can face serious problems such as sexting and sextortion, cyberbullying and hate speech, grooming and child sexual exploitation online. In fact, the digital world could be a prolific ground for exploiters and those who victimize children. Moreover, the exposure to unwanted sexual material and in particular to adult pornography online has to be considered as a toxic factor that interfere to their healthy development, in particular if we take into account that young people build their first relationships in the online. According to a recently published study, 1 out of 5 children and teens see unwanted sexual material online (Madigan et al., 2018).

At the same time, given the "dark side" of the web, one important point is to understand, if technology be useful in providing new forms of help and support. New technologies might help reducing the gap between the need for help and the search for help in mental health services. e-Mental Health has been identified as a tool that could increase the number of adolescents who seek help (Younes et al., 2015). These tools could allow us to reach a wider audience, cutting costs and waiting lists. Digital tools could be considered a valid option for several reasons. First of all, as previously stated, children and adolescents' lives are shaped in the digital world. Moreover, technological tools and resources provide accessibility, confidentiality, diminish stigma associated to mental illness. Mental health apps directed at children and adolescents have the potential to be used as assessment, management and treatment tools and can help both in the prevention of severe mental health issues and in empowering young people in case of need (Punukollu & Marques, 2019). Nevertheless, the literature available on the use of mobile apps and technologies in CAMH is not yet sufficient and further studies must be done to determine the potential

clinical benefit and to investigate which could be the best solutions (ibidem). Along with expanding research, in order to validate the effectiveness of the tools available, specific clinical guidelines should be developed and agreed by the professional community. These guidelines should indicate how to combine online mental health tools and face-to-face services.

With regard to this promising new field of research and practice, it would be recommended the collaboration with other disciplines (i.e. ICT) and sectors (i.e. technological companies), in order to develop e-tools. Young people themselves should be considered as active participants in the process of shaping new solutions. Considering the possible use of new and innovative tools implies the necessity of developing specific trainings and resources for health professionals, in the field of psychiatry, psychology and psychotherapy.

Our goal and recommendation is to encourage new policies to promote mental health and prevention of diseases in children and adolescents, planning new projects for specific diseases and populations at risk. Further research in this field is necessary; new issues require new thinking, new approaches, and a new global awareness of the importance of listening to children and their needs.

Early child development and mental health

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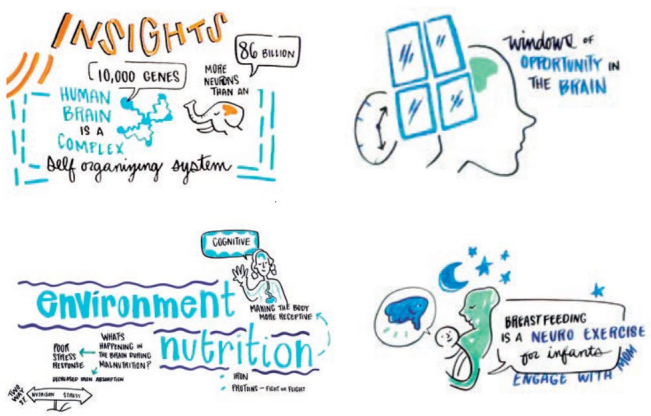
The convergent model

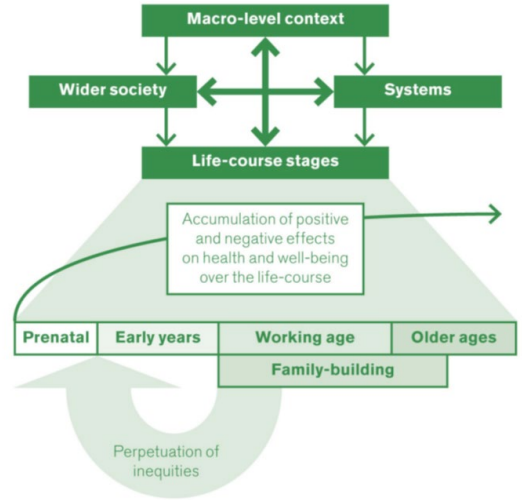
Despite mental disorders affect 10-20% of children and adolescents worldwide, their mental health needs are often neglected, especially in low-income and middle-income countries due to the gap with resource availability. Mental disorders have a deep impact on the life potential of the children and on the human capital of the society. Moreover, it is known that many mental health conditions emerging in adulthood originate in early life. For all these reasons, it is imperative to reduce the burden of mental disorders in the early periods of life and allow the full development of children and adolescents.

According to the widely accepted convergent model, mental health is the product of psychosocial, environmental and genetic factors. The complex interplay of social determinants and biological factors occur across the life course but is of particular importance during the sensitive developmental periods of childhood and adolescence. In fact, new evidence shows that the development of brain in the first period of life is astonishingly fast: neurons form new connections at 1,000 per second, and 50–75% of energy absorbed by the body from foods is allocated to brain development resulting in almost 90% of brain weight acquired by 3 years of age.



Thus, it is not surprising that neuroplasticity, i.e. the ability of brain to adapt to the internal and external environmental conditions through the formation of new neural pathways, is extremely high in the early years of life, plummeting to 50% at 7 years when most of neurodevelopment has occurred. Brain is a complex adaptive system, capable of programming coherently to the "weather forecast" set on the basis of biological, sensorial and psychosocial context and input.

This explains why the dilemma between "nature or nurture" is an outdated debate as nature with nurture play together in shaping the brain and mental health with a degree of interdependence never imagined before. Adverse conditions in early life are associated with higher risk of mental disorders although the accumulation of positive and negative effects on mental health occur over the life course interacting with genetic blueprint in a dynamic way.



In the last years, research has made impressive advances in studying the effects of early child conditions on neurodevelopment, providing solid evidence for effective interventions. Child's early nutrition, security and safety (attachment, bonding, parenting) have effects on the formation and combination of neural pathways. Toxic stress due to exposure to violence, abuse and neglect influences how the brain absorb nutrients as the autonomic nervous system responds to threats that triggers the stress response and directs energy away from the brain with an influence on a child's developmental status. Epigenetics is exploring how parenting and caregiving may change the expression of genes in the brain thus affecting the future whole life of the child and potentially the future generations as well.

It is therefore of critical importance to invest in the early window of developmentally sensitive periods to give to the child the best possible start of life, promote mental health, prevent mental ill-health and reduce the burden of mental disorders among the population.

Early interventions

Based on the new research evidence from neuroscience, early childhood development programs focus in particular on the first 1,000 days of life child (including the period from the conception) when the brain is developing at a fast rate.

It is noteworthy that plasticity of brain allows to organise or re-organise the neural connections on the basis of the psychosocial and environmental context; it is therefore not surprisingly that in psychiatry early psychosocial rehabilitation is needed after the onset of a severe mental disease in order to avoid permanent intellectual disability.

Early caregiving interventions are based on several actions including health and nutrition, stimulations, safety and security. Nutrition feeds the brain, stimulation fosters the development of neural pathways, and nurturing interactions confer a secure basis to the child protecting the brain from the negative impact of stress.

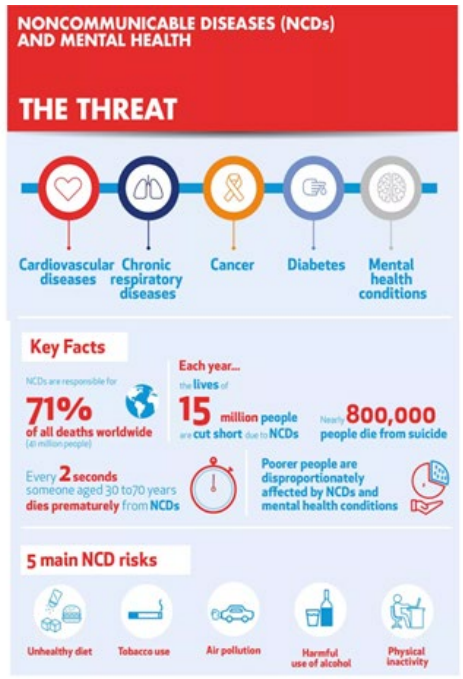
Inadequate nutrition of the child affects the structure and functions of the body and of the brain and trigger a stress response. In fact, there is evidence of associations between low body weight at birth and risk of both depression and of noncommunicable diseases (NCDs) in adulthood. For healthy development

it is of key importance also the nutrition of the mother during pregnancy and lactation. Breast feeding is recommended not only for the key nutritional and immunologic effects, but also as a neural exercise for the infant as it provides nurturing and strengthen the bond between mother and child and thus supports brain development.

Literature reviews indicate that early cognitive, emotional and social stimulations have an impact on future social behaviour, ability to learn and educational outcomes, employment status and mental and physical health.

For regular development the brain must detect features of safety. This internal process of risk assessment (known as "neuroception") is granted by a nurturing environment with caregivers' protection, attachment and bonding. Strong early attachment with the caregiver also stimulates the release of oxytocin that produce neural and behavioural effects in the child and the mother. When the expectation for sensitive and stimulating caretaking is not met, the brain cannot organise the neural connections properly. Adversities may influence behaviour in early childhood and also predict functioning and mental health later in life. "Toxic stress" associated to abuse, neglect and deprivation increase the level of cortisol that damage brain development and have metabolic effects increasing the risk of NCDs, such as diabetes type 2 and cardiovascular diseases, in adulthood.

Systematic reviews of studies on maternal depression and early childhood growth in developing countries showed that children of depressed mothers were



a greater risk of being underweight and stunted. Moreover, maternal depression is significantly associated with anxiety and conduct disorders such as ADHD among their children. The importance of first-line psychosocial interventions for maternal depression is highlighted in the WHO's mhGAP guidelines Thinking Healthy with the recommendation to integrate them within MCH services.

Adverse life conditions, poverty, conflicts between parents and domestic violence can increase both maternal stress and risks for mental development of children. It is well known that children in lower socioeconomic groups are less likely to experience conditions allowing optimal development and that exposure to multiple risks is particularly dangerous as effects accumulate.

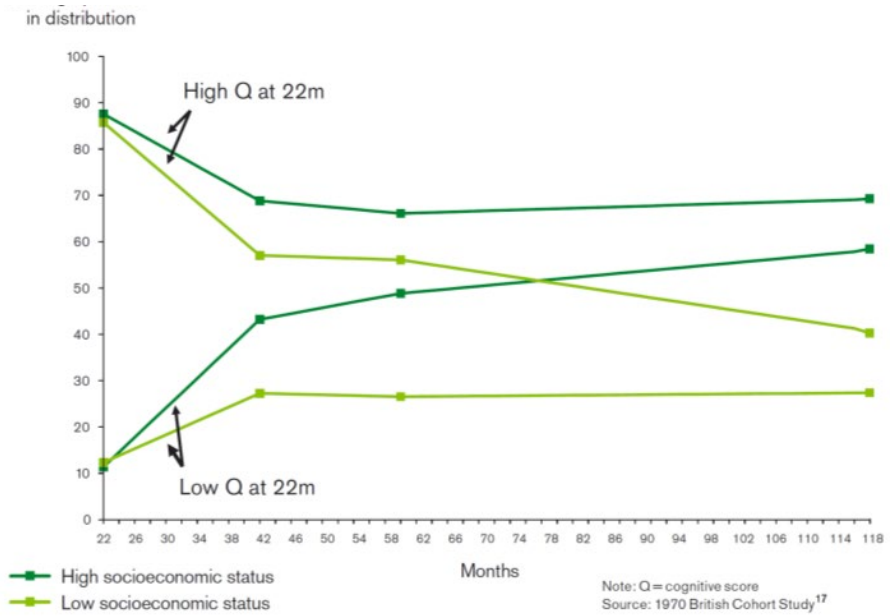
Policies and governance

Research evidence is producing a solid basis for effective interventions to improve child development, promote mental health and expand life opportunities for millions of disadvantaged children living in both developmental areas and humanitarian crisis situations. Governments should decrease reliance on institutionalization and sponsor nurturing care programs oriented to provide more psychosocial support and child friendly spaces for these children.

Multisectoral Early Childhood Development programs, including actions for promoting healthy nutrition of mother and child, breastfeeding, parenting skills for mother and family, nurturing care, child stimulation and early learning, screening for maternal depression and domestic violence, should be integrated within existing MCH services. When resources are available, access of nursery and kindergarten should be enhanced.

Early interventions improve mental health at population level and offer the hope to avoid later adult mental health problems. As disadvantage starts before birth, affect gene expression and accumulates throughout life, early interventions will also help to reduce socioeconomic inequalities by breaking

the vicious cycle poverty - poor mental health. As childhood experiences of neglect and deprivation influence also the risk of NCDs in adulthood, they also improve physical health. Giving every child the best possible start of life will generate the greatest societal and mental health benefits and help in disrupting intergenerational transmission of poverty and inequity. This is a global public health priority and a way for the achievement of several Sustainable Development Goals.



World Awareness for Children in Trauma: Capacity Building Activities of a Psychosocial Program

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Child mental health challenges in low- and middle-income countries (LMICs)

Despite the increasing policy and public attention to children's mental health, service provision remains underdeveloped in many parts of the world. Children's mental health needs are thus largely unmet, especially in low- and middle-income countries (LMICs) in Africa, Asia, and Latin America, with limited access to specialist resources (Vostanis, 2017). These needs are compounded by socioeconomic disadvantage, war and other conflicts, population displacement, and community and domestic violence. Without early and appropriate interventions, children's mental health problems are likely to continue in young life, indeed into adulthood, and to be associated with a range of adverse life outcomes such as unemployment, criminality, and social exclusion.

In addition to the lack of infrastructure and adequately trained staff, barriers in improving child mental well-being in LMICs include stigma and negatives attitudes towards mental illness (even among professionals), parental engagement, help-seeking patterns, availability of culturally sensitive and contextualized approaches, and evidence-base (Patel & Rahman, 2015).

In order to address these inter-linked gaps, capacity-building is a strategic priority for LMICs.

In contrast with high-income countries, where mental health systems and interdisciplinary teams are relatively well established, acquisition of staff competencies in LMICs should reflect their specific needs in relation to a defined service model. A phased or stepped-up response is recognized by major international organizations as the most appropriate and cost effective model in LMICs, which can adapt skills to the requirements of local sociocultural needs, rather than uncritically extend existing and largely western-based models (WHO, 2014). For example, training of community volunteers or paraprofessionals is an increasingly important first level of response. Active involvement of stakeholders, delivery through schools and communities, maximization of existing community strengths and resources, and exploitation of new technologies offer additional opportunities to LMICs (Vostanis, Maltby, Duncan, & O'Reilly, 2018). Addressing capacity in LMICs thus was the rationale for the development of the World Awareness for Children in Trauma program (www.wacit.org). This program, in particular its capacity-building arm and activities, is described as a case study in this article, supported by emerging evaluation data.

A psychosocial program for vulnerable children

As children living in disadvantage and facing trauma have multiple and complex needs, these are better understood under a broad "psychosocial" definition, which refers to the dynamic inter-connection between psychological (internal, emotional, and thought processes, feelings, and reactions) and social (relationships, family and community networks, social values, and cultural practices) functions (Inter-Agency Standing Committee, 2010). This program was designed to enhance the impact through new partnerships with academic centers, non-governmental and statutory organizations (NGOs) operating in areas of conflict and disadvantage, through interlinked research and capacity-building activities. This has the dual objective of enhancing practice, by integrating psychosocial skills in relation to professionals, community volunteers, and agency roles, and to improve service delivery by refocusing provision and connecting agencies and communities to maximize their strengths and resources. These components were chosen to reflect international policy and direction (UNHCR, 2013) and following consultation with local stakeholders (e.g., in Kenya by Getanda, Vostanis, & O'Reilly, 2017). Local co-production was ensured throughout the program by a lead local agency engaging services, community, and religious groups. The program was underpinned and informed by several theoretical frameworks. Its content and scaled approach were influenced by the socioecological systems theory (Bronfenbrenner, 1979) and Maslow's hierarchy of needs (Maslow, 1943), because of the multitude of children's needs and their dynamic relationship with their environment, as well as the best available evidence on child mental health needs in LMICs (Patel & Rahman, 2015). Co-production with LMICs partners and communities was informed by decolonization theory in relation to both psychology (Ratele et al., 2018) and research methods (Barnes, 2018), thus adopting a collaborative and dialogical stance. For example, we used participatory action research methods in the service transformation evaluation, including the active involvement of children and young people. This research process enables groups collectively affected by a problem (especially those marginalized from decision-making) to address that problem through active engagement of community members, and relying on them as a source of expertise in facilitating possible solutions (Reason, 1994).

The goal of the first phase of the program (2015–2016) was to establish partnerships and networks, develop and pilot practice-focused training, assess the readiness of stakeholders and communities in tackling child mental health issues (Getanda et al., 2017), and test the appropriateness of adapted training materials to the target groups (Vostanis et al., 2019).

The developmental process involved the identification of a host partner agency in each country, which acted as the coordinator to the pilot training and evolving network. International partners reflected the LMICs income spectrum according to Organization for Economic Co-operation and Development (OECD) criteria (OECD, 2016), i.e., upper middle (Turkey, Brazil), lower middle (Pakistan,

Indonesia), and other low-income countries (Kenya, Rwanda). The targeted vulnerable population groups were children living in slums and favelas, on the streets, refugees or internally displaced, and children in care. Over this period, an organizational model emerged of linking the local host, usually an NGO, with an academic center and a mental health service where possible.

The second phase (2017–to date) led to the development of a research and a capacity-building arm within the program. Each arm includes a number of confined and independently funded projects, which are conceptually and strategically linked. The research arm incorporates projects along the four themes of needs analysis, identification of resilience factors, evaluation of interventions, and service impact. The educational activities of the capacity-building arm are described below, with some supporting activity and stakeholder evaluation data. Where data was collected for research purposes, through interviews or participatory action workshops (see below), approval was granted by the Psychology Research Ethics Committee of the University of Leicester.

Capacity-building components
Psychoeducation materials

As mental health awareness is an essential first step in improving service provision, a range of psychoeducational materials were developed in relation to the broad target group of children who suffer complex trauma, and with LMIC settings in mind. These were based on different aspects of the training, but were subsequently developed as stand-alone resources aimed at caregivers, teachers, social workers, NGO volunteers and other primary care practitioners; however, these can also be useful for mental health professionals in their own right or in supporting universal staff. The resources are based on evidence and particularly focus on practice implementation. Topics include child development in the face of trauma exposure, impact of trauma and implications for child mental health, the emotional dysregulation context of aggression in traumatized children, and resulting attachment-related challenges for caregivers and teachers. Other resources address wider service issues such as equipping and supporting volunteers and helping specific groups like refugee children and young offenders. All resources were developed by volunteers, interns, or international visiting students in collaboration with the author, by building on components of the practice-focused training described below.

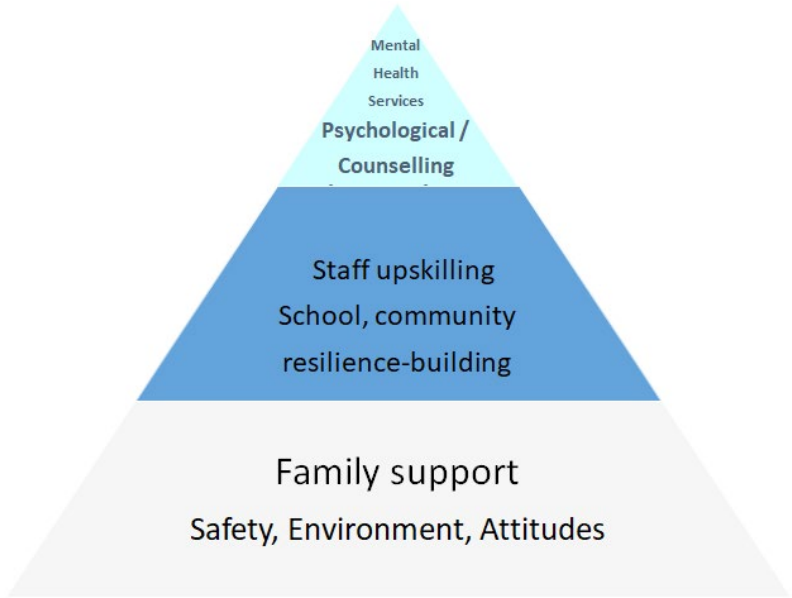
Practice-focused training workshops

The objective of these workshops is to provide a framework on the impact of complex trauma on child mental health, and its implications for assessment and planning of interventions within existing agency roles, i.e., to enhance participants' skills with key psychosocial competencies. Principles of attachment and ecological systems theories, as well as current evidence, are linked with practice. Approaches from previous inter-professional training with caregivers and practitioners of vulnerable children are adapted to each context (Vostanis, 2016). Sessions include mental health awareness; understanding of how trauma impacts on children's mental health; key aspects of child development; building resilience in relation to one's role; recognition of common child mental health problems in conjunction with related family, social care and educational needs; and formulation of integrated intervention goals along four domains of the ecological systems framework, i.e., child, family or caregiver, school, and community. The workshops involve small group and case-based discussions tailored to participants' experience. The training is delivered in an interdisciplinary context to encourage the resource-effective establishment of local networks, and joint working in accordance with the complexity of children's needs. In a target area of disadvantage, the host agency typically invites an average of 25–30 key professionals, volunteers, and community leads to attend a two-day workshop co-facilitated by the author and a local trainer, who also acts as interpreter when required. In practice, the duration of workshops varies between one and three days, depending on staff capacity and availability. During the last four years, over 500 participants have attended this program. Some workshops incorporated evaluation questionnaires. For example, in a residential care staff workshop in Brazil (n¼21), the topics were considered relevant to participants' practice (16 exceeded and 5 met expectations), and potentially strengthening their skills (9 exceeded, 11 met, and one partially met expectations). Free text identified participants appreciating opportunities to actively contribute in group discussions. An evaluation study based on interviews with participants from six countries identified the tiered approach to training as a strength (Vostanis et al., 2019).

Service transformation

The next stage was to develop, implement, and evaluate a method (framework) to assist organizations in LMICs to improve service provision. Its specific aims were as follows: (a) to establish mapping of local needs, existing resources,

community strengths, and readiness of stakeholders in selected target areas of disadvantage; (b) to establish interdisciplinary networks; (c) to coproduce action plans, by identifying realistic and staged goals in addressing service gaps according to the World Awareness for Children in Trauma (WACIT) framework; and (d) to define indicators of impact. This framework includes six domains of child safety, namely caregiver support, building resilience through school and communities, enhancing skills of frontline practitioners and community volunteers, counseling and psychological interventions, and access to mental health services. The training is supported by a manual and follows a similar sampling process of identifying key stakeholders in target areas of vulnerability. This program was tested for feasibility in three countries (Kenya, Turkey and Brazil), and captured stakeholders' perspectives through participatory action research methods. Emerging themes in developing action plans across the six domains of the WACIT framework related to community awareness, empowerment and mobilization of children and families, interdisciplinary working, and scaled skills acquisition (Vostanis et al., submitted).



Digital learning

New technologies offer opportunities for widening access and reducing cost through self-learning, facilitated distance learning, supervision, and other INTERNATIONAL JOURNAL OF MENTAL HEALTH 5 approaches. These can be combined with face-to-face training, for example as booster modules with reflective and case-based exercises. So far, the practice-focused foundation training on the impact of trauma has been adapted to such an e-learn module, which is applicable to both high-and LMIC practitioners.

Conclusions

This article describes the educational components of a psychosocial program for practitioners, volunteers, and caregivers in LMIC. This has taken into consideration the limited, albeit evolving evidence-based, multiple stakeholders' perspectives, emerging findings, and new technologies, in order to widen access and contribute to capacity-building. The program is based on limited resources, but relies on the establishment and maximization of partnerships and networks with NGOs, services, and academic centers in LMIC. The lessons learned from this initiative can be applied in similar contexts, as well as in the development of modular courses over a longer period, which can thus achieve impact through participants' practice. Digital technologies can be variably used in combination, for example in supervising the implementation of new skills. Parallel planning of training for trainers and future leaders, with the involvement of LMIC academic centers, will ensure sustainability in line with national policies and workforce strategies.

Trauma: Illness or Resilience

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"To be or not to be: That is the question.
Whether 'tis nobler in the mind to suffer
The slings and arrows of outrageous Fortune,
Or to take Arms against a sea of troubles,
And by opposing end them?"

William Shakespeare.
Hamlet (1601), act 3.sc.1.Line 56.

This literary picture of a distressed adolescent who has just lost his father, whose ghost has been haunting him and whose mother has formed a liaison with his uncle. This is one of many accounts from history and literature of reactions to violent events.

Definition of Trauma

Trauma is a physical shock or an emotional reaction following any stressful event. It results from events as wide as sexual abuse to war related events. It is worth noting that such events commonly combine physical injury and emotional reactions. It is worth mentioning that the views mentioned in this article are those of a clinician rather than of an academic or researcher, with respect to both.

The disorders which traumata cause have been more clearly defined over the years. Since the 1980s, descriptions of Post Traumatic Syndromes in the young adult troops involved in the Vietnam War.

Post-Traumatic Stress Disorder

- Criterion A: Stressor.
- Criterion B: Intrusion Symptoms.
- Criterion C: Avoidance.
- Criterion D: Negative Mood & Thinking.
- Criterion E: .Arousal Level.

- Criterion F: Duration.
- Criterion G: Functional Effects.

This is a much more dimensional approach and allows the inclusion of a wider ranges of trauma types. In the interests of simplicity, the psychiatrist prefers to think in terms of actual quotations from victims:

Quotation 1. Intrusion.
"I can see the blinding flash and smell the smell. My whole body shakes. It keeps coming back to me, day and night as if it is all happening again"

Quotation 2. Avoidance.
"I cannot walk down that street anymore. I just go the long way round. I don't even want to think about it at all"

Quotation 3. Hypervigilance.
"Even when I hear a door bang or people talk too loud, I just shake and sweat"

Prevalence of PTSD

72 worldwide studies (Alisic et al .2014) showed a 16 % general prevalence, at all ages. Females and the young are worst affected. Thus the records show that this is a worldwide phenomenon, though the reasons which provoke it may vary from region to region.

Natural History of PTSD

27 Longitudinal studies (Hiller et. al.2016) showed that PTSD prevalence at 1 month has the percentage of 21%. At 3 months (15%). At 6 months (12%). At 1 year (11%).

Clearly, even in clinically diagnosed people, there is a declining prevalence over time. So, it is helpful to use a model analogous to that of physical wound healing. With such a wound, the majority will heal with simple care. However, in some cases, healing will be longer and require more intervention but will eventually heal. A minority will not heal well and will require more intensive and longer treatments.

Persistence of PTSD

- Poor social support
- High life threat of trauma
- High level of initial fear generated by the event
- Poor family functioning
- Previous Mental Health Problems
- Social withdrawal
- Marked avoidance.

Clearly, the social environment surrounding the victim is of vital importance. This involves families (if they are available) and the social network in which the victim is embedded. Such interventions based on these vulnerabilities has shown that provision of Child Friendly Spaces (Metzler et. all Journal of Child Psychology and Psychiatry. 2019. Vol.60.no 11.p1152-1164) can be effective. Loneliness is dangerous.

Resilience

Resilience is defined as a dynamic ability to adapt successfully, in the face of adversity, trauma or any significant threat. It must have been part of man's "survival kit" biologically and account for the survival of mankind over the millennia. It seems amazing that it is only relatively recently that the scientific literature has become interested in it and now factors it into research projects.

Principles of Interventions

- Security First
- Includes Safe People and Situations
- No " Big" Psychology (initially)
- Listening ears
- Watchful eyes
- Not authoritarian but caring
- Need for simple training.

In thinking of interventions, the concern is for "psychological first aid" in addition to "simplicity".

Security provision is self-evident but often hard to provide. Food, water, physical protection and health care must come first. The issue of providing "Safe People" is a thorny one but we have to trust children's own views in the matter. Hopefully it may be a parent or relative or perhaps, a trusted peer. Nowadays, social media and networks may be the psychological prop these victims use and feel comforted by. Clearly, there are risks.

In terms of "Big Psychology", we can realize that in established cases of PTSD, there is strong evidence for therapies such as Trauma Focussed Cognitive Behaviour Therapy and Eye Movement Desensitisation and Reprocessing and their spin-offs. However, even in the system there is a shortage of trained therapists. Such therapies require a commitment of time and energy which traumatised individuals and families cannot spare.

As someone who has been teaching professionals of various disciplines for nearly 50 years, the psychiatrist feels that training people in the simple tasks of listening and watching children and families is no easy task but vital. Children will inform us directly or indirectly, though their conversations, play and imagination, their ways of processing their experiences and their own needs.

The ability to stand back (a little) and to enter the child's world is important and exceeds the pressure to intervene. It can mark the extra –vulnerable and gives clues about the child's thinking processes and coping strategies.

We can tap into the child and families resilience strategies and reinforce them as mentioned in the article on Child Friendly Spaces, mentioned above. Sadly trauma is part of many lives, however, I stand in admiration for those children and families who recover from the "illness" and whose resilience carries them through to relatively healthy lives.

Strengthening CAMH services and systems: Beyond narrowly defined traumatic reactions of children and adolescents

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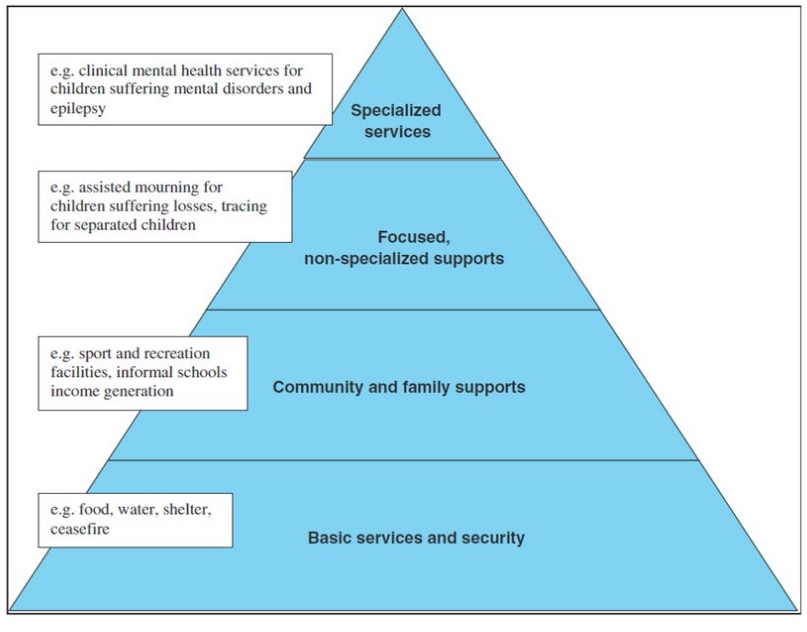
Main objectives of the presentation:

1. To share the lessons learnt on child psychological traumatic reactions in emergencies and discuss how they can be used in strengthening Child and Adolescent Mental Health (CAMH) services.

2. To address the importance of holistic approach of mental health / psychosocial support (MHPSS) to traumatized children / adolescents to include the current problems of daily life that address both the needs of children and family in which s/he lives.

3. To emphasize need for paying greater attention to the child's perspective, their individuality and the cultural, social and political context in which they live.



Literature review

Some relevant research on child / adolescent reactions to traumatic or terrifying events has been reviewed. The results of the research from different countries, including the countries of the Middle East, have been presented. Two research studies showed that stress and stress related mental health conditions including Post-traumatic stress disorder (PTSD), anxiety and depression were not uncommon in children / adolescents in the aftermath of a traumatic event. For example, stress-related disorders constituted a fifth of the case-load of newly established CAMH services in Kosovo in the first year after the Kosovo war in 1999. Follow-up of 143 children in one Lebanon study found that PTSD, major depression, overanxious disorder, and separation anxiety disorder were not uncommon in children in first months after exposure to a traumatic event (stressor); 24.1%, 23.6%, 24.9% and 17.9% respectively.

These studies also showed that the prevalence of stress / stress related mental health conditions by children / adolescents dropped significantly some time later after the traumatic event. For example, in the second year after the 1999 Kosovo war, stress-related problems had fallen to only 4% of the case load of CAMH services. Non-organic enuresis and learning disability were the most common diagnoses in the second year after the war. Many children / adolescents had a complex mix of social and psychological difficulties that did not fit conventional diagnostic categories (behavioral problems related to changing social environment). In the Lebanon study, rates of self-recovery were high and the prevalence of PTSD, depression, overanxious disorder, and separation anxiety decreased to 1.4%, 5.6%, 5.6% and 4.2% one year after exposure to the traumatic event.

However, there are other research studies which showed higher prevalence of stress / stress related problems over a longer period of time. For example, in one study in Baghdad in Iraq, 47% of primary school children reported exposure to a major traumatic event in the previous 2 years and 14% of them had PTSD. In a study conducted at the child psychiatric department of a general pediatric hospital in Baghdad during 2005, the distribution of diagnoses included: anxiety disorders (22%), behavioral problems (hyperkinetic and conduct disorders) (18%), non-organic enuresis (15%), stuttering (14%), epilepsy (10%) and depression (1.3%).

Different risk factors and different compositions of multiple traumas per country may be responsible for different traumatic reactions of children / adolescents to traumatic events and different rates of their self-recovery. For example in Iraq, a number of daily stressors contributed to the higher rate of mental health problems in children and adolescents in the years following the major traumatic event, i.e. 2003 Iraqi war. They included but were not limited to malnutrition, deterioration of education, a high and increased rate of truancy, child labor, trafficking of children, involvement of children with militia and insurgency groups, kidnapping for ransom and loss of parents. Miller & Rasmussen

emphasized the role that daily stressors play in mediating direct war exposure and mental health outcomes. Also, a number of studies have shown that multiple exposure to traumatic events—either to the same type of event or to different types of events—is associated with higher levels of symptoms of PTSD.

How to help children recover from traumatic events?

Although traumatic reactions of children differ in regard to their age, there are some common principles on how to help them recover:

- Understand emotional reactions a child is presenting
- Develop a warm friendly relationship with a child
- Accept a child totally
- Offer emotional support and security to a child
- Help a child adopt healthy coping strategies
- Observe child's behavior
- Monitor child's progress at school/ home
- Accept and acknowledge any changes in child's reactions and behavior
- Listen to a child
- Reassure child
- Model child's healthy coping behavior
- Normalize child's life routines
- Talk to a child
- Play and use other activities with a child

These principles are summed up in the case of one 8-year old Syrian boy who had lived as a refugee in Turkey for 4 years. His mother brought him to a psychologist because of a bed wetting problem. His family lived in Turkey for 4 years after leaving Aleppo where his sister died in bombing. His mother said he always liked to stay with her and he did not want to stay alone or with his friends at school. The mother said that after coming to Turkey, he often seemed to be very alert as he was anticipating something to happen. He has also been afraid of loud voices, and even his father's voice. A psychologist developed a warm and friendly relationship with a boy and offered him emotional support and sense of security. She listened to him and encouraged him to talk about his fear of loud voices. She also tried to help him adopt healthy coping strategies by finding out what makes him feel safe and how he could feel safe when his mother was not around. Slowly, he has been integrated in recreational activities with other children. His enhanced sense of security and building new relationships with other children made him feel more self-confident and safer. His fear of loud voices slowly disappeared. A psychologist managed to solve his problem of bed wetting after 6 months by explaining him about bed wetting problem, encouraging him to pee before bedtime and restrict his fluid intake before going to bed. She also practiced with him bladder stretching exercises.

Holistic vs. trauma-focused approach

There is a stereotype still prevailing in the media which is that the majority of children exposed to traumatic or terrifying events will be 'traumatized' and that the trauma will have long term debilitating consequences. Symptom checklists focused on pathological symptoms which are often used to assess trauma do not allow children to express how they feel, nor to identify their perception of causes of their problems. A focus on pathology prevents children from expressing their other needs and concerns. This kind of trauma-focused approach is often used in practice and it relies on trauma counselling as a therapeutic approach in order to prevent long-term psychological problems.

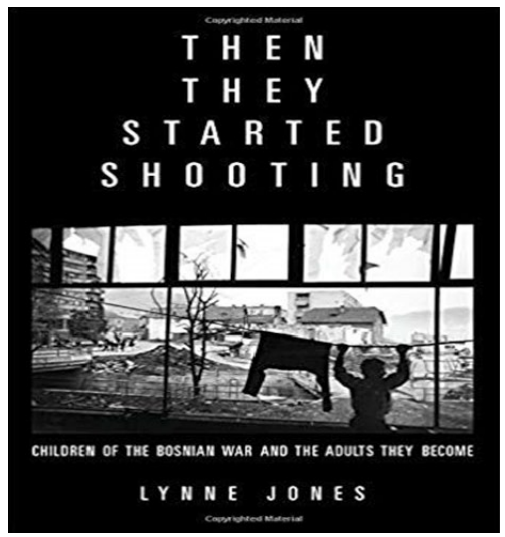
However, during the assistance to children / adolescents affected by traumatic event(s), a holistic approach is preferred because children's mental health needs and problems are varied, complex and intimately connected with their social and practical needs and family connection. It is necessary to access resources to address basic needs of children, advocate for their security and protection, and recognize and address the needs of the more vulnerable children. It is important to consider child's perspective, their individuality and the cultural, social and political context in which they live. Daily stressors in a child's life may be more important for a child than e.g. major man-made or natural traumatic events (conflicts, natural disasters). Also, different children have different experiences of a traumatic event and are often more concerned about "here and now" than about previous experience of trauma. Current and daily stressors in child's life such as separation from family, violence inside the family, child abuse and neglect and poverty are often more important concerns for a child than the traumatic event in the past. The Inter-Agency Standing Committee (IASC) pyramid illustrates how to construct a holistic response to children's needs after traumatic events on a larger scale, i.e. in humanitarian emergencies.

Curriculum for training primary health care workers to address the mental health needs of children

- Communicating with children and families
- Grief and loss
- Stress-related responses and disorders
- Behavioural disturbance
- Early child development and developmental disorders
- Mental retardation
- Epilepsy
- Sleep, feeding and elimination disorders
- Sexual and physical abuse
- Severe depression and other severe mental disorders
- Suicide and self-harm

A problem focused approach to addressing children's mental health needs in the PHC clinic

- The withdrawn and isolated child
- The aggressive child
- The child who cannot learn
- The fearful child
- The abused or neglected child
- Bedwetting
- Problems with sleeping and eating
- School problems



How can lessons learnt in emergencies be used to strengthen CAMH services and systems?

Several different systems of care (e.g. education, welfare, and health) need to be involved in CAMH policy and plan to ensure that mental health services for children and adolescents are effective. The process of integration of mental health care into primary healthcare can provide children/adolescents and their families with a better access to CAMH care. The mental health training of non-specialized healthcare providers is one important component of this process and can help to address the shortage of CAMH specialists in many low and middle-income (LAMI) countries.

The recommended curriculum for primary healthcare workers to address the mental health needs of children is presented in the photo Mainstreaming educational opportunities for disabled children is recommended too. Early childhood development (ECD) interventions which consist of psychosocial stimulation combined with nurturing parental behavior can promote better longer term cognitive development, better growth of children and may increase the resilience of children to stress during their lifetime.

The principles of ECD intervention are summed up in the case of one young mother who lost her husband during Ebola outbreak in Sierra Leone in 2015. A 21-year old woman survived Ebola while her husband had died of Ebola Virus Disease. She had low mood and the disrupted relationship with her 1.5 year old child. She kept herself isolated from other people after discharge from International Medical Corps' (IMC) Ebola Treatment Centre (ETC) and she was not eating well. She has been crying most of the time without paying much attention to her child which was left hungry, crying and taken care by neighbors. IMC psychosocial worker approached her and invited her to attend one mother and child support group. Other mothers from the group supported her and convinced her to come to the group. She agreed and found the group joyful and informative. Her mood slowly improved and she became more attentive to her child's needs for love, play and communication. Already after the third group session, she started showing some improvement in her mood and neighbors said that she had started to better respond to her child's needs. She has attended altogether nine mother-child support group sessions and she has also received an extra individual psychosocial support from a psychosocial worker. The ECD sessions in mother-child support groups included different activities (lectures on ECD, toy-making, singing, dancing and story-telling), all aimed at improving her mood and the relationship with her child. As a result of ECD activities, her mood and her nurturing parental behavior improved which also resulted in a better psychosocial stimulation of her child's development.

School-based mental health interventions for traumatized children/adolescents have controversial results most probably depending on the context, quality and duration of the intervention. For example, in one Lebanon study there was no significant effect of this kind of intervention on the rates of major depressive disorder (MDD), separation anxiety disorder (SAD) or PTSD one year after war trauma, but specific aspects of the intervention may have had deleterious effects on some. Post-war MDD, SAD and PTSD were associated with pre-war SAD and PTSD, family violence parameters, financial problems and witnessing war events. In one other study in Sri Lanka, the results showed that preventive school-based psychosocial interventions in volatile areas characterized by ongoing war-related stressors may effectively improve indicators of psychological wellbeing and posttraumatic stress-related symptoms in some children but they may undermine natural recovery for others.

Long term consequences of childhood trauma - myth or reality?

Today, there is a growing consensus in the research literature that the majority of children exposed to traumatic events do not develop traumatic disorders except after multiple traumas or a history of anxiety and that rates of self-recovery are high. One must of course not forget specific needs of disabled children/adolescents and/or children/adolescents with more severe traumatic reactions and/or mental disorders.

The following text from the book of British Child & Adolescent psychiatrist Lynne Jones describes her work with traumatized children during and after the war in Bosnia. Although the number of cases described in this book is small, her work showed that the majority of children traumatized due to war events became later adults with no serious mental health consequences.

Dr. Lynne Jones interviewed over forty children who came of age during the Bosnian War and returned twenty years after the war began to discover the adults they have become. When she followed up 14 of those children 20 years later, including some who had suffered from post-traumatic stress disorder (PTSD) before, the only one whose mental health was still problematic was one girl who had spent the war separated from her parents. She felt nervous, insecure and unhappy, and saw this as partly related to being forced to live away from her parents. Thus, she had given up a university course and returned to her home town to live with her family.

Strengthening the Mental Health system, improve access and services for Syrian refugees and vulnerable Jordanian population

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Jordan

Over the last decade, Jordan has increasingly prioritized mental health as a core programme in the broader primary health care agenda. Such prioritization has started with the inclusion of mental health in the national vision and strategy "Jordan 2025", has continued with its reflection in the National health strategies, and has been operationalized through the development of National Mental Health and Substance Use Action Plan (2018-2021). The Action Plan has been developed in line with the intervention pyramid for mental health and psychosocial support (MHPSS) in emergencies, and - in turn - witnesses the commitment of the Ministry of Health (MOH) to re-address resources from the more specialized services to the lower layers of the system.

The Italian Agency for Development Cooperation (AICS) contribution to WHO - titled "Strengthening the Mental Health system, improve access and services for Syrian refugees and vulnerable Jordanian population" - was designed to support the MOH in its efforts to implement the Action Plan and to re-orient resources to primary health care (PHC). The project aimed to enhance the mental health system, to improve access to services for Syrian refugees and vulnerable Jordanians, and to promote human rights approaches. The project was implemented nation-wide from November 2017 to June 2019, in coordination with the MOH Disabilities and Mental Health Directorate and its partners.

The project consisted of several interventions, focused on the implementation of large-scale community awareness campaigns, the strengthening of the mental health system at primary and secondary levels, and the support to the MOH governance capacity as well as coordination of mental health partners.

The Italian NGO "Un Ponte Per" implemented the community awareness activities, in collaboration with the National users association "Our Step" and other local partners. Information on mental health principles, availability of services and patients' rights, early detection, and on addressing stigma and discrimination was delivered through support groups, radio episodes, mental health campaigns, and dissemination of technical material, and targeted around 1,500 direct and 7,000 indirect beneficiaries respectively. Additionally, WHO partnered with the Jordanian Psychological Association to serve the communities affected by October 2018 tragedy, where 21 people lost their lives in the Dead Sea flooding.

Furthermore, the project supported the MOH to integrate mental health services at PHC level. Seventy-five health professionals were trained on the WHO mhGAP package as well as on the rationale prescription of psychotropic medications, nation-wide. Also, the conduction of mhGAP trainings of trainers targeting specialized providers of the public and non-profit sectors supported the further expansion of mental health services at the lower levels of the system.

Moreover, WHO partnered with the Jordanian Nursing Council (JNC) to support the MOH in strengthening its mental health services at secondary health care level. Four community mental health centers were established in Amman, Irbid, and Karak, and one inpatient mental health unit in a general hospital in Zarqa. Accordingly, extensive trainings and supervision on bio-psychosocial interventions were delivered to more than 40 health professionals (nurses, counselors, social workers, occupational therapists) to ensure effective staffing of the established facilities. Also, WHO supported the Italian Hospital in Karak - through "Bambino Gesù Children Hospital" - and "Bayt Illiqa" to integrate targeted activity lines to the services offered to children affected by disability.

Eventually, the project supported the governance of the mental health system and the coordination of partners. A multi-disciplinary Jordanian delegation of stakeholders and providers had its capacity on de-institutionalization and integration of mental health services at community level built, through a study visit to the WHO Collaborating Center for Research and Training in Mental Health in Trieste, Italy. Also, WHO worked closely with International NGOs to co-chair the Mental Health and Psychosocial Support (MHPSS) Working Group and to develop the 2018 MHPSS 4Ws platform (Who is doing What, Where and When).

The project successfully supported the mental health system at all levels. However, its achievements have to be further sustained to ensure sustainability in the medium- and long-term. Community-based activities need to be institutionalized, and primary and health care providers need continuous training and supervision to ensure quality in service provision. Also, the MOH Disabilities and Mental Health Directorate remains in need of support to generate knowledge, to operationalize the Action Plan, and to lead a mental health response. The upcoming contribution of AICS to WHO has been designed to further support the MOH Disabilities and Mental Health Directorate in the implementation of the National Mental Health and Substance Use Action Plan (2018-2021) and to ensure sustainability on the medium- and long-term.

The last decade highlighted an increasing commitment of Jordan in scaling-up its mental health system. Currently, there is momentum to further assist Jordan in addressing such efforts. Firstly, the existence of a Mental Health Directorate operating in line with a well-established Action Plan represents a golden opportunity to improve the system. Secondly, the recent mental health system achievements need to be further consolidated to ensure sustainability over time.

Thirdly, international actors should advocate to integrate external assistance in mental health with local resources. Fourthly, partnerships are a critical element for successful implementation of the Action Plan, since they allow addressing the mental health system complexity from different angles. Fifthly, specialized mental health actors need to be further engaged and need to play a role in the re-orientation of mental health services at lower levels. And finally, investing in the mental health system has beneficial effects impacting on the broader primary health care agenda and supporting the advancements towards Universal Health Coverage (UHC).

Reforming Mental Health: the experience of Jordan

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Jordan started the process of reforming its mental health system in 2008. The Ministry of Health, supported by WHO and other partners, guided the mental health reform, which led to significant achievements, including:

- The launch of the first National Mental Health Policy (2011-2021), and of the related National Mental Health Plan (2011-2012) to implement it;
- The establishment of a Mental Health Unit within the Primary Health care Administration in the Ministry of Health, and its upgrading to Disabilities and Mental Health Directorate;
- The establishment of a permanent National Technical Committee to advise the Disabilities and Mental Health Directorate, and support its governing function. Chaired by MoH Secretary General, its members include the Ministry of Health, the Ministry of Social Development, the Ministry of Education, the Royal Medical Services, universities, professional associations, and service users.
- The establishment of 3 inpatient units in general hospitals (King Abdulla Hospital, Jordan University Hospital and Ma'an Governmental Hospital) and of 1 inpatient model unit in the National Center for Mental Health;
- The establishment of 3 community mental health centers with multidisciplinary teams adopting bio-psychosocial and recovery models and providing a wide spectrum of assistance (i.e. medical treatment, psychological interventions, social and family interventions, community-based rehabilitation, psycho-education, and awareness activities in the community);
- The selection of Jordan as one of the first countries to implement WHO technical package "mental health Gap Action Programme" (mhGAP), focused on the integration of mental health at Primary Health Care level. Currently, more than 350 health professionals (general practitioners, family doctors, nurses and midwives) in 64 Primary Health Care centers in all Governorates were trained and supervised;
- The establishment of the first National Users Association "Our Step" (October 2010), representing service users and family members.

In order to re-affirm its commitment in further strengthening the mental health system in Jordan, in April 2018, the Ministry of Health launched the National Mental Health and Substance Use Action Plan (2018-2021). Developed with the support of the WHO, the Action Plan aims to expedite the mental health reform with a focus on the establishment of community mental health services, whilst introducing a specific Substance Use component. The Action Plan is the result of extensive consultation, and is structured around domains, strategic directions, activities, indicators, timeline, and costs (figure 1).

No	Domains	Strategic Directions
1	Governance	Operationalize the Mental Health Directorate with specified ToRs and appropriate resources, and support it through the National Technical Committee: • Develop a National Human Resource Development Plan • Integrate MHPSS in the National Emergency Preparedness and Response Plans • Strengthen inter-sectorial collaboration mechanisms
2	Health Care - Move from institutional to community-oriented model of care - Move from bio-medical to bio-psychosocial care	Primary care • Strengthen the capacity of PHC personnel through mhGAP • Ensure availability of essential psychotropic medicines • Strengthen the capacity to provide a multi-layered MHPSS response for population affected by the Syrian crisis Secondary care • Establish outpatient clinics in at least 12 general hospitals • Establish inpatient units in 5 general hospitals Tertiary care • Redistribute resources
3	Promotion and Prevention	Strengthen promotion and prevention through: • Development of a Suicide Prevention Program • Implementation of School Mental Health Package, Parent skills training for children, Support Online Programme for caregivers of persons with dementia Reduction of stigma and discrimination through: • Initiation of targeted Mental Health Literacy Program
4	Surveillance, Monitoring, and research	Strengthen the monitoring function of: • The quality of services provided, through the Quality Right package • The monitoring of the Mental Health System through available tools (i.e. ATLAS) Incorporate relevant categories of Mental health disorders in National health information systems(i.e. Interactive Electronic Information System)
5	Substance Use Disorders, first response	Strengthen the Substance Use care through the: • Development of the National Substance Use Strategy • Integration of Substance Use care in PHC • Strengthening of inpatient and outpatient Mental Health to include detection, harm reduction, pharmacological and psychosocial treatment, rehabilitation, and social re-integration for people with Substance Use disorders • Support to the Ministry of Health National Centre for Rehabilitation of Addicts • Establish self-help groups and associations

Fig 1. Domains and Strategic Directions of the National Mental Health and Substance Use Action Plan (2018-2021)

The Ministry of Health and its Directorate on Disabilities and Mental Health re-affirmed their commitment to continue and further increase their efforts to strengthen and reform mental health in Jordan. Such reform will keep it being guided by the Action Plan, as the main strategic and operational platform to align national resources and international assistance. The Ministry of Health will further promote partnerships and exert its leadership to coordinate and harmonize response ensuring sustainability in the medium and long-term.

Mental Health Services in Iraq: An Overview

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Mental Health services in Iraq has had great development in the last few years with transformation from mental hospital-based service to the psychosocial support units in general hospitals. Up to 2005 there were only two mental hospitals in Iraq both in Baghdad with public and private out-patient clinics in governorates.

The current Mental Health System in Iraq

Hierarchy of Mental Health Services

1. National Mental Health Commission

According to the Mental Health Act (No -1-year 2005), the National Mental Health Commission was established in MOH in 2005. It includes representatives from different ministries with psychiatrists from MOH and MOHE and it's leaded by mental health advisors directly connected with the Minister. This Commission is responsible by law for all mental health policies, strategies, plans, guidelines, monitoring of services. Local Mental Health bureau in each governorate is the local representative of the national commission and connected directly with the Director General office.

2. Mental Health Committees

1. Primary psychiatric committee: in charge of civil issues referred from different courts like parenting, power for will, fitness for proxy, etc.
2. Forensic psychiatric committee: in charge of criminal responsibility, fitness to defense in courts, etc.
3. Appeal psychiatric committee: second level, which is responsible for all appeals from the previous committees. Its verdict is final and not appealable.

3. Mental Health Hospitals

There are five mental health hospitals in Iraq:
1. Al Rashad Hospital: a state hospital containing 1200 beds located in Baghdad for acute and chronic cases with beds, rehabilitation centers and safe forensic psychiatric unit.
2. Ibn Rushd Hospital: containing 65 beds located in Baghdad for acute cases.
3. Soz Hospital: containing 86 beds located in KRG, Sulymania Governorate.
4. Shahid Sallah Al-Muhandis: containing 30 beds located in KRG, Sulymania Governorate.
5. Howlear Hospital with 140 beds located in KRG, Erbil Governorate.

4. Mental Health Units in General Hospitals

1. Psychiatric units in general hospitals: 24 units with total of 260 beds distributed over all the 18 governorates.
2. Two child psychiatric units in the Central Child Hospital in Baghdad and Duhok, 16 beds each.

5. Other services

1. Addiction Rehabilitation Centers in Basra, established according to Act 50, and one in Ibn Rushed mental Hospital.
2. Mental Health Day Clinics in Mousel governorate.
3. Mental Health services managed by trained health workers in Primary Health Care Centers which involve about 400 PHC in different governorates.
4. Mental Health Outpatient Clinic in all general hospitals in governorates run out by consultant psychiatrists.
5. Institutions for children with special needs.
6. Private Clinics and Centers. All physicians have the right to have their private business.

6. Scientific Association

Iraqi Psychiatric Association is a scientific association established according to the law and represents the psychiatrists activates.

7. Psychosocial Support Centers

The below mentioned centers have been all established after 2003 and are responsible for delivering services for victims of trauma including counseling and non-pharmacological treatment.

1. Al-Yarmuk Hospital Center (Baghdad)
2. Sulemaniya Center (Sulemaniya Governorate)
3. Imam Ali Hospital Center (Baghdad)
4. Kirkuk Center (Kirkuk governorate)
5. Basrah General Hospital (Sara Center)
6. Falluja Hospital Center (Anbar Governorate)
7. Baguba General Hospital Center (Diala Governorate).

Mental Health Legislation

Two important acts have been issued in the last decade:

1. Mental Health Act (No. 1, Year 2005)
This law regulates the structure of the national committee, its responsibilities, the services and the patient's right.

2. Narcotic Control Law (No. 50, Year 2017)
This law updates the lists of substances, regulates the services, changes the concept of addiction from crime to disease and preserves the patients' rights.

Human Resources

Iraq as all the countries of Middle East has shortage in human resources in quantity and quality. Below are the total numbers of health workers who work in the mental health sector:

- Qualified psychiatrists: (Iraqi and Arab board, diploma certificate) = 169 psychiatrists
- Practitioner psychiatrists: (trained psychiatrists without certificate) = 55 psychiatrists
- Post graduate trainees: (Iraqi and Arab Board) 80 psychiatrists
- Nurses = 395
- Social workers = 45
- Psychologists = 90

Mental Health Surveys

It is important to have an idea about the distribution and epidemiology of mental disorders in Iraq. Therefore, below are some results of some of national mental health surveys which have been conducted in collaboration with UN and other organizations.

1. Iraq Mental Health Survey (IMHS, 2009). The prevalence and correlates of DSM-IV disorders

World psychiatry: official journal of the World Psychiatric Association (WPA) 8 (2): 97-109.

IMHS was carried out by the Iraq Ministry of Health in collaboration with the Iraq Ministry of Planning and the World Health Organization (WHO) World Mental Health (WMH) Survey Initiative.

The estimated lifetime prevalence of any disorder was 18.8%. Twelve-month prevalence of any disorder was 13.6%. Anxiety disorders were the most common class of disorders (13.8%). Panic dis. 5.4 GAD 3, PTSD 5.3, OCD 4.3. The major depressive disorder (MDD) the most common disorder (7.2%). Only 2.2% of IMHS respondents reported receiving treatment for emotional problems 12 months before the interview.

2. Iraqi National Household Survey of Alcohol and Drug Use, 2014 (INHSAD)

Self-reported Substance Use in Iraq: Findings from the Iraqi National Household Survey of Alcohol and Drug Use, 2014: Iraqi Survey of Alcohol and Drug Use, 2014

Addiction 112 (8): 1470-1479, 2017: 3,200 adult, non-institutionalized Iraqi citizens residing across all 18 governorates of Iraq. Findings: Self-reported past-month tobacco use was 23.2%. Past-month alcohol use was 3.2%. Only 1.4% (0.67, 3.02) reported past-month non-medical use of any prescription drugs, and only 0.2% (0.07, 0.49) of men reported using any illicit drugs in the past month. Approximately 90.5% (88.58, 92.11) knew someone who uses tobacco, 42.4% (39.53, 45.24) knew someone who drinks alcohol, 27.9% (25.53, 30.45) knew someone who uses medication outside of a doctor's instructions, and 9.2% (7.87, 10.75) knew someone who uses an illicit drug.

3. The Iraqi national study of suicide: Report on suicide data in Iraq in 2015 and 2016

Mar 15; 229:56-62. doi: 10.1016/j.jad.2017.12.037. Epub 2017 Dec 27. J Affect Disord. 2018.

The study covered 13 out of 18 provinces in Iraq. A data collection form was designed by the researchers. The forms were completed by police stations in the 13 provinces. Data were extracted from the legal investigation (which include police investigation, family reports and postmortem reports) of cases of when there was no clear cause of death and where there was final verdict of suicide made by judge after examining these reports. The study results:

There were 647 cases of suicide. The crude rate of suicide per 100 000 population was 1.09 (1.21 for males, 0.97 for females) in 2015 and 1.31 (1.54 for males and 1.07 for females) in 2016. The majority of cases (67.9%) were aged 29 years or below. The most common method was hanging (41%) followed by firearms (31.4%) and self-burning (19.2%). 24.1% of cases were reported to have psychiatric disorders, of which the most common diagnosis was depression (53.9%). In the majority of cases (82.1%) there were no previous attempts. Only a small minority were reported to have had psychological trauma (15.5%), financial problems (12.4%) or childhood abuse (2.2%).

Child & Adolescents psychiatry. Some epidemiological studies

1. Prevalence of childhood and early adolescence mental disorders among children attending primary health care centers in Mosul, Iraq: a cross-sectional study

Out of 3079 children assessed, 1152 have childhood mental disorders, giving a point prevalence of 37.4%. The top 10 disorders among the examined children are post-traumatic stress disorder (10.5%), enuresis (6%), separation anxiety disorder (4.3%), specific phobia (3.3%) stuttering and refusal to attend school (3.2% each), learning and conduct disorders (2.5% each), stereotypic movement (2.3%) and feeding disorder in infancy or early childhood (2.0%).

2. Post Traumatic Stress Disorder risk among Iraqi Displaced Children, 2016

This study aims to detect risk of PTSD among displaced children in primary schools in the three governorates (Baghdad, Duhok, Erbil). The prevalence was (83.3). It is mainly associated with trauma.

3. Mental Disorders in Children Attending Child Psychiatric Clinic in Pediatric Hospital in Baghdad, 2005

The number of children and adolescents involved in the study was 149. The finding was: Anxiety (22.1%), conduct & ADHD (14%), Enuresis (13.4%).

4. PTSD, Depression and Anxiety among Young People, One Decade after American Invasion

Number of participants was 224 in Al- Ramdi and Falloja in 2016. PTSD (55.8%), Depression and anxiety (63%).

Current Mental Health Problems

- **Substance Abuse**: a lot of governmental reports reported increase cases of transit and trading of illicit drugs and increase number of users.
- **Suicide**: media attention despite the prevalence is less than the regional prevalence.
- **IDPs**: mental health issues and effect of trauma and ideology of ISIS especially in the governorates occupied by ISIS.

The way forward

The conference represented a first step towards building a common ground for addressing mental health services in Jordan, Palestine, Lebanon and Iraq.

Mental health is a global health priority that is crucial for maintaining individual wellbeing, as it enables people to realize their potential and to work productively. It is also a fundamental prerequisite for sustainable human development, as it plays a key role in efforts to achieve social inclusion. Therefore, mental health is unequivocally a valuable asset to both individuals and society.

Mental health problems affect 10-20% of children and adolescents worldwide. Despite their long-lasting effect throughout life and their relevance as a leading cause of health-related disability, the mental health needs of children and adolescents are often neglected, especially in low and middle-income countries.

The interdisciplinary platform provided by the conference has allowed professionals to discuss how to deliver and expand child and adolescent community services to promote mental health, prevent mental illness, and reduce the treatment gap and the burden of mental disorders.

The contributions of speakers and participants represented a starting point to identify the Italian Cooperation's future interventions in the mental health sector in the Middle East. Furthermore, highlighting the common challenges that these Middle Eastern countries are facing, the conference provided a space for further dialogue to trace common guidelines and values to protect child and adolescent mental health.

The conference was structured in several sessions focusing on the Italian mental health models, the reforms of the mental health systems in the MENA Region, the importance of the child and adolescent mental health and of the early interventions, as well as on the effects of trauma on mental health.

The final part of the conference hosted a round table session where country experts from the Eastern Mediterranean Region have discussed the way ahead for strengthening child and adolescent mental health services and systems, at a region level.

Families, workplaces, schools, social services, institutions, and communities have been identified as potential resources to support healthcare systems. It was stressed how multi-sector and community-based mental healthcare approaches can help address health and social inequities, by promoting social wellbeing and addressing structural determinants of mental health. This resulted pivotal in conflict-prone countries and countries that have been involved in complex emergencies and are also providing healthcare to refugees and displaced families with children and adolescents.

The conference therefore stressed urgent need for countries to integrate mental health services into Primary Health Care towards achieving the Universal Health Coverage, in line with the recommendations of WHO, based on equity and financial protection, and focusing on building capacity across the health systems and on empowering communities and families.

This ambitious goal is fully aligned with the priorities of the 2030 Sustainable Development Agenda.

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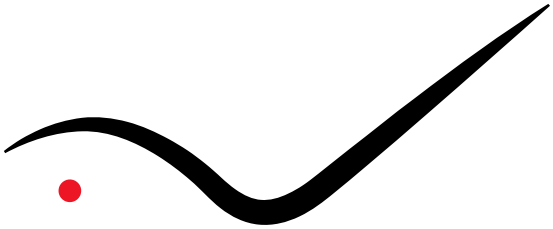

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