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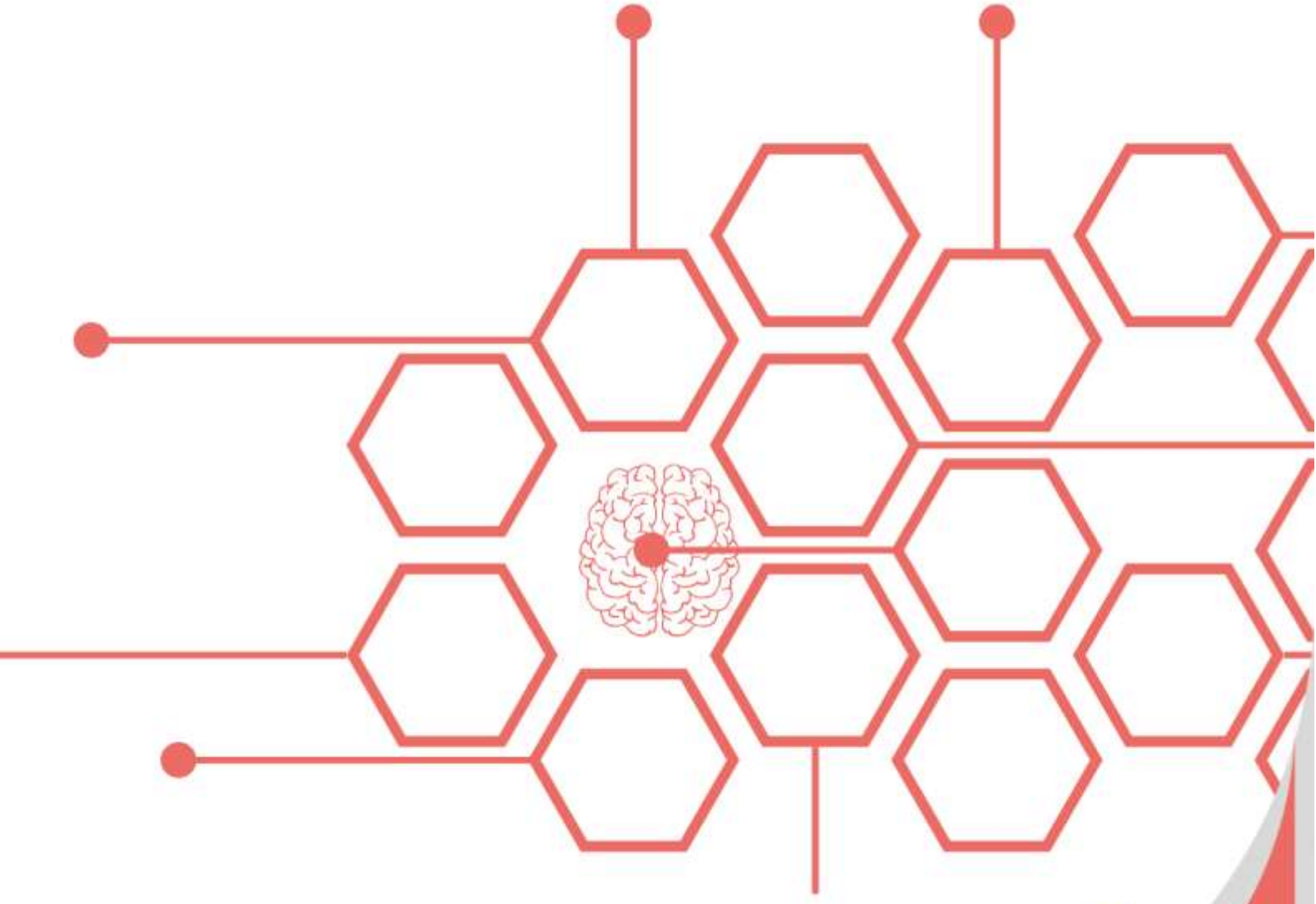
Methodological Framework for Promotional and Preventive Mental Health Activities aimed at Young People aged 14 to 18 in Bosnia and Herzegovina



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Contents

1. Introduction

There are 1.3 billion adolescents in the world today, more than ever before, which makes up 16 per cent of the world's population. According to UNICEF data from 2018, almost 90 per cent of these girls and boys live in low- and middle-income economies. Realising the rights of these adolescents and investing in their development contributes to the full participation of adolescents and young people in a nation's life. They represent a competitive labour, sustain economic growth, improve governance and make civil societies vibrant, accelerating progress towards the Sustainable Development Goals.

Adolescence is a defining time in the development of a child that is characterized by rapid physical growth and neurological sculpting, the onset of puberty and sexual maturity. It is a critical period for individual identity development when young people are figuring out who they want to be in the world; an opportunity for growth, exploration and creativity. Positive social relationships and environments enhance feelings of inclusion and belonging and lead to positive outcomes. Negative experiences, on the other hand, increase fear, self-doubt or lead to social isolation. These feelings can get amplified during this vulnerable period of development, leading to a cascade of negative and even pathological outcomes as young people grow into adulthood. When adolescents, including the most disadvantaged, are supported by caring families and adults, as well as policies and services attentive to their needs, only then can they develop to their full potential. In the post-war years in Bosnia and Herzegovina, the society has helped addressing the most pressing issues affecting children and young people. During the war, but also in a long series of years after the war, large mental health reform projects were implemented in Bosnia and Herzegovina, which included the development of a systemic response to the prevention and treatment of transgenerational war trauma. Services and centres for mental health were launched in order to provide the population with adequate professional help; the non-governmental sector was strengthened through the considerable assistance of international organisations and experts in the field of mental health. A large number of programmes with and for adolescents have been developed and implemented for many years. Attention was mainly given to the development of adolescents through education; work on communication, stress and trauma prevention; prevention of peer violence and juvenile delinquency; promotion of healthy lifestyles, HIV prevention and treatment; prevention of gambling and use of alcohol and drugs; strengthening the protective factors of parents and children; promotion of gender equality and social and child protection.

This guidance document builds on existing preventive and promotional programmes in Bosnia and Herzegovina intended for young people aged 14 to 18 and provides a framework for their creation and implementation. It seeks to present the specificities of the developmental period of adolescence, provide an overview of the current situation of young people in Bosnia and Herzegovina aged 14 to 18 and their problems, an overview of theoretical knowledge about behavioural issues in this age group, the causes of behavioural problems in young people associated with the individual, family, school and other environment/ecosystem-related factors, risk factors and protective factors for the mental health of school children specific to Bosnia and Herzegovina. Following the overview of the situation and causes, the theoretical concept of prevention and promotion in mental health aimed at the population of young people aged 14 to 18 is given, as well as instructions for creating programmes for this age group and guidelines for the implementation and reviewing of existing preventive programmes; as well as implementation experiences and lessons learned.

2. Youth and Mental Health

Adolescence and the early years of adulthood are a time of life when many external and internal changes occur, for example changing schools, leaving home, and starting university or a new job. For many, these are exciting times and for some, they can also be times of stress and apprehension, however. The expanding use of online technologies, while undoubtedly bringing many benefits, can also bring additional pressures, as connectivity to virtual networks at any time of the day and night grows. Many adolescents are also living in areas affected by humanitarian emergencies such as war, natural disasters and epidemics. Young people living in situations such as these are particularly vulnerable to mental distress and illness, as well as those exposed to violence, abuse and poverty. There are numerous challenges facing young people today, such as abuse, suicide, the onset of serious mental illnesses, the effects of trauma and gender identity discrimination. These challenges require our time and attention, global awareness and compassion, as well as new programmes and guidance on how to protect and empower the next generation.

Half of all mental illness begins by the age of 14, but most cases go undetected and untreated. Mental disorders account for 16% of the global burden of disease and injury in people aged 10 to 19. One in five young people suffer from a mental illness, which equates to 20 per cent of the population, but still only about four per cent of the total healthcare budget is spent on mental health. Globally, depression is one of the leading causes of illness and disability among adolescents. Suicide is the second leading cause of death among 15-29-year-olds (WHO,

2018). Harmful use of alcohol and illicit drugs among adolescents is a major issue in many economies and can lead to risky behaviours such as unsafe sex or dangerous driving. Eating disorders are also of concern. Every 10 minutes, somewhere in the world, an adolescent girl dies as a result of violence (UN Children's Fund, 2018). 83 per cent of young people say that peer violence has a negative impact on their self-esteem (ditchthelabel.org, 2018). The consequences of undetected and untreated adolescent mental health issues extend into adulthood, impairing both physical and mental health and limiting opportunities to lead fulfilling lives as adults.

There is a growing recognition of the importance of helping young people build mental resilience, from the earliest ages, in order to cope with the challenges of today's world. Evidence is growing that promoting and protecting adolescent health brings benefits not just to adolescents' health, both in the short- and the long-term, but also to economies and society, with healthy young adults able to make greater contributions to the workforce, their families and communities and society as a whole.

Much can be done to help build mental resilience from an early age to help prevent mental distress and illness among adolescents and young adults, and to promote recovery from mental illness. Prevention begins with being aware of and understanding the early warning signs and symptoms of mental illness. Parents and teachers can help build life skills of children and adolescents to help them cope with everyday challenges at home and at school. Psychosocial support can be provided in schools and other community settings, and it also includes training for health workers to enable them to detect and adequately treat mental health disorders in a timely manner. Investment by governments and the involvement of the social, health and education sectors in comprehensive, integrated, evidence-based programmes for the mental health of young people is essential (WHO, 2018). This investment should be linked to programmes to raise awareness among young people of ways to look after their mental health and to help peers, parents and teachers know how to support their friends, children and students.

3.Specificities of the Developmental Period of Adolescence

3.1. Adolescence

Adolescence is a time of change and a sensitive life period when there is a possibility of developing undesirable behaviours and habits that can turn into problems and continue into adulthood. The word itself originates from the Latin word *adolescere*, which means ‘to grow up’ or ‘to grow into maturity’ (Muuss and Porton, 1998; according to Duvnjak, 2018). At this stage of life, adolescents begin their transition from childhood to adulthood. There are different views on adolescence. From a biological point of view, this is a period of storm and stress characterized by turbulence. However, there are other points of view that consider this point of view excessive and state that adolescence can also be the most pleasant period (Mead, 1955; Lacković - Grgin, 2006; according to Duvnjak, 2018). Therefore, it can be concluded that adolescence is influenced by both biological and social factors. Adolescence is a period of rapid and inconsistent changes that vary among individuals. Difficulties related to achieving independence, attaining personal identity, sexuality and relationships with others define this developmental period. Every adolescent, both male and female, is exposed to risk factors, which ultimately shape their own behaviour patterns. Turbulence and problems in the behaviour of adolescents are very common and normal and can appear during this period.

Adolescence is the transitional period between childhood and adulthood. During this period, young people must master important developmental tasks, develop physically and accept their newly developed body, develop their personality, that is, their personal identity, i.e. mature and acquire adult ways of thinking, finish schooling and gain emotional and economic independence, and learn to treat people of both sexes maturely (Berk, 2007; according to Duvnjak, 2018).

It is most often defined as the period between 12 and 20, i.e. 25 years of age. The average age for entering puberty is 12, although in developed societies, due to medical progress and improved living conditions, children enter puberty earlier, and entering puberty is considered the beginning of the adolescence period. Puberty primarily refers to biological, i.e. anatomical and physiological changes. The end of puberty is characterized by full sexual maturity and the ability to reproduce, but this does not mean that the period of adolescence ends here. Adolescence primarily refers to all psychological changes that accompany physical development during puberty. It is considered that the adolescence period ends when a young person has mastered almost all of the listed developmental tasks. In the past, and in less developed societies, this usually happened around the 20th year of a young person's life,

when formal schooling for a certain profession was completed and the young person got a job and began life independently of his/her parents. In more developed societies, the period of adolescence usually lasts longer, because young people, after finishing high school education, continue with higher education, at colleges, academies, etc., and remain dependent on their parents for a certain period of their lives. In these cases, the period of adolescence is most often extended until the end of higher education and gaining independence, which is usually around the age of 25 (Velki et al., 2018).

3.2. Personality Development of Adolescents

Erikson's personality theory provides one of the most detailed descriptions of personality development during adolescence. According to his theory, the main task that young people between the ages of 12 and 20 have is that of building their identity in order to grow into happy and productive adults. This developmental period is characterized by a phase of confusion during which young people need to find answers to questions such as "Who am I?" and "What is my goal in life?", and if they successfully find the answer, they create an identity, which is the main achievement in adolescence. Young people need to define who they are, what their values are, and decide on the life course they will follow (Berk, 2007; according to Duvnjak, 2018). In order to successfully create their own identity, young people must be able to take on different roles and integrate them into a unique being. The creation of one's own identity occurs partly through connecting earlier childhood identities, and partly through creating a new adult identity. Interactions with others, especially peers and adults, play a key role in creating a positive identity for young people. Other people play the role of a mirror in conveying information to the adolescent necessary to create a stable image of who he/she is or should be. Self-esteem, self-confidence and dealing with emotions are shaped during adolescence through the reactions of others (Velki et al. 2018).

For adolescents to be able to develop a unique identity, the development of self-concept and self-esteem is necessary. During adolescence, young people often show contradicting traits, which is a consequence of different views they have of themselves in relation to other people. Thus, at the same time, they are very smart in their relationship with their peers and not wise enough in their relationships with adults. During this period of development, they learn to combine their traits into an organised system and become aware of how traits can change depending on the situation. The emphasis is on social virtues such as kindness, consideration, etc. and they are very concerned about how others see and perceive them. During the transition to secondary school, there is a mild decline in self-esteem, but during the rest of

adolescence, there is an increase in self-esteem, which remains high for most young people. Self-esteem is most valued in relation to peers, and less in relation to school and/or family. Also, boys more often have a higher level of self-esteem than girls. The highest self-esteem is among young people who go to school or live in a neighbourhood where their socioeconomic or ethnic group is mostly located (Berk, 2007; Lacković-Grgin, 2005; according to Duvnjak, 2018). During the search for and creation of identity, a typical stage is that of confusion when adolescents tend to experiment with alternatives. Reviewing values, plans and priorities is necessary for creating a stable and mature identity. At this stage, young people are exploring different opportunities and trying out different lifestyles. For most young people, this is not a particular problem, although a certain level of anxiety may occur in individuals who are less successful in this process. The values and professional goals they choose lead to the creation of a permanent identity, and if they are not able to choose, perplexity and ambiguity arise due to future roles in adulthood, i.e. identity confusion. If they have not successfully created their own identity, young adults will have difficulties in creating close relationships, i.e. in intimacy (Fulgosi, 1985; according to Duvnjak, 2018). Identity development is a complex process that implies that the adolescent needs to develop different types of identity, i.e. different aspects of identity that will ultimately be amalgamated as a part of the personality. The first aspect of identity that an adolescent must develop is time perspective, i.e. the ability to reconcile the past and the future and develop a life plan that will be implemented in the future. Another aspect is the development of self-confidence, i.e. a clear awareness of oneself as a unique being. This is followed by role testing, where adolescents experiment with immersing themselves in different roles, searching for different goals and ideas, and their own characteristics that they consider desirable. Professional identity is the fourth aspect that they must incorporate in the personality. At this stage, adolescents explore different work activities before making a final decision on choosing their own occupation. This is followed by the development of gender identity, where identification with one or the other gender occurs, which is the basis for creating intimacy. The penultimate aspect of identity development refers to finding one's place in society, in relation to parents, friends, peers and teachers. In the last aspect, young people build their own ideology or philosophy of life on the basis of which they value people, ideas and events (Lacković-Grgin, 2005). Certain studies have also shown that identity develops gradually, i.e. that it is a process. About 44% of secondary school students were in a crisis of professional identity when they had to decide on the choice of profession, as opposed to only 14% of students who were not (Mihaljević, 2002). In addition, about 63% of students had a fully developed identity, as opposed to 26% of secondary school students who did not. Gender differences were also recorded where girls showed greater development of both sexual and professional identity, unlike boys (Meus and Deković, 1995; according to Duvnjak, 2018).

3.3. Cognitive Development in Adolescence

During adolescence, there is a transition from the tangible to the abstract world of ideas and concepts. Adolescents manipulate assumptions, possibilities and the future, which opens up new worlds for them, such as philosophical, political, aesthetic and spiritual. They see more clearly their inner, intrapsychic, but also the outer, real world. Unlike children, they are able to accept ambiguity and uncertainty. They understand that parents are not omnipotent, they are no longer their idols, which is an integral part of the process of separation and independence (Rudan, 2004; according to Duvnjak, 2018). According to Piaget, around the age of 12, young people enter the last stage of cognitive development, which is called the formal operational stage, when the development of the ability to think abstractly and scientifically is crucial. This stage lasts until the end of life (Vasta, Haith, & Miller, 1997). During this stage, adolescents no longer need concrete events and things, but the objects of their thinking can now be new, logical, abstract rules. According to Piaget, formal thinking consists of four main aspects: introspection, i.e. the ability of young people to have thoughts about their own thoughts; abstract thinking that includes a shift from the real to the possible, logical thinking and hypothetical reasoning (Lacković-Grgin, 2005; according to Duvnjak, 2018).

The development of formal thinking means that the adolescent is now capable of handling some thought operations at a higher level. Young people develop the ability to think inductively, which is manifested in the systematic testing of hypotheses on specific cases in order to derive a general conclusion or rule, i.e. to establish a cause-and-effect relationship. Furthermore, deductive thinking is also developed, i.e. the ability to predict certain laws in the real world based on one's own knowledge and familiarity with the rules. Combinatorial thinking develops gradually, and most often appears around the age of 16. Adolescents develop the ability to solve problems by systematically examining all possible combinations of all variables that are relevant for solving problems (Lacković-Grgin, 200; according to Duvnjak, 2018).

Other aspects of adolescent cognitive development are manifested in the development of attention, which now focuses on relevant information and adapts to the demands of the task. Furthermore, memory strategies become more effective, and young people store and recall information more easily. In general, knowledge expands. Metacognition develops, i.e. awareness of one's own thought processes, which helps in acquiring information and solving problems. Cognitive self-regulation occurs, meaning that they are able to control and more easily manage their own thought processes. Ultimately, an increased capacity for information processing leads to a higher speed of thinking, meaning that working memory is more efficient (Berk, 2007; according to Duvnjak, 2018).

3.4. Moral Development

Through cognitive maturation, adolescents become more aware of their environment, other people and their needs. Accordingly, a significant progress in moral development is recorded. According to Piaget's theory, adolescents are at the last stage of moral development (like adults, which lasts for the rest of their lives), and usually at the age of 10, young people are ready enough for the transition to this stage of development. Piaget refers to this stage as autonomous morality or morality of cooperation, and it is characterized by flexibility in setting rules and socially agreed principles that can be changed if it suits the majority (Berk, 2015; according to Duvnjak, 2018). Adolescents are ready to immerse themselves in someone else's perspective, look at situations from the point of view of different people, and when making a decision about the morality of an act, take into account the person's intentions, and not just the consequences of the committed act. Furthermore, adolescents develop an ability called ideal reciprocity, which refers to understanding the importance of reciprocity of expectations. In the adolescent period, the golden rule "*Do not do to others what you do not want them to do to you*" begins to apply for the first time. Rules can be interpreted and changed to ensure a fair outcome for everyone (Berk, 2007; according to Duvnjak, 2018).

3.5. Emotional Development

With increasing age, children become more aware of their own and other people's emotions, learn to control them and express them appropriately depending on the social situation. Although adolescence is often characterized as a turbulent emotional period for young people, significant progress in the emotional development of adolescents is visible. Emotions become more stable and their manifestation is less external and more internal. Adolescents successfully use emotion management strategies, so in situations of encountering a difficulty or problem, they first use a problem-oriented coping strategy to identify the difficulty and ways to solve it. If they assess that it is impossible to solve the problem, they switch to a emotion-oriented coping strategy, the goal of which is to control unpleasant emotions (Berk, 2015; according to Duvnjak, 2018).

During adolescence, young people have to solve a series of developmental tasks, which often leads them to stressful situations, frustration, and even conflicts with the environment. The main emotion they express in such moments is anger, and if they have successfully mastered the described strategies, they will be able to control their anger. Anger, or aggression caused by the emotion of anger, most often occurs when restrictions are imposed on the adolescent

(e.g. parental prohibitions) and when he/she experiences ridicule (by peers or adults). Jealousy is a common emotion during adolescence, which most often occurs due to the greater success of other peers in the group, but it can also come as a consequence of the fear of losing a loved one. Jealousy is a complex emotional state, and young people can express it openly or covertly (Velki et al., 2018).

The most common source of happiness and joy for young people is acceptance in the peer group, achieved success in various domains, as well as attention from people of the opposite sex. To be happy, young people need to feel accepted and respected, to be given the opportunity to achieve success in their work, to love and be loved, and to enjoy the activities they perform. Grief occurs as a result of the loss or separation from a loved person or thing. Also during the period of adolescence, specific fears appear: fears related to physical appearance and own competence, fear of medical interventions, fear of social rejection (ridicule, rejection from the group), fear of public appearances and fear of war; and they are more frequent and intense in girls (Vulić-Prtorić, 2002; according to Duvnjak, 2018). Recognizing and using a wider range of emotions, as well as their proper expression in different social situations, helps young people to develop empathy. Adolescents are able not only to take the perspective of a person in a current unpleasant situation and respond with empathy to their problem, but they are also able to respond empathetically to the general life conditions of a person, such as oppression, poverty, etc. (Berk, 2015; according to Duvnjak, 2018). One of the main characteristics of adolescence is the young person's ability to love another person and to accept another person's love. Adolescents show respect for a loved one, are ready to sacrifice themselves for another person, are attached to a loved one and take responsibility in love relationships.

Low self-esteem in adolescence develops when there is a gap between one's self-concept and what one believes one "should" be (Harter, 1990; according to APA, 2002). How can a professional know if an adolescent has low self-esteem? The following characteristics have been identified by various researchers as being associated with low self-esteem in adolescents (Jaffe, 1998; according to APA, 2002):

- Depressiveness
- Lack of energy
- Disliking one's own appearance and refusing compliments
- Feeling insecure or inadequate (APA, 2002) most of the time
- Unrealistic expectations of oneself
- Serious doubts about the future
- Excessive shyness and rarely expressing one's opinion

• Adapting to what others want and assuming a submissive attitude in most situations

Given that consistently low self-esteem has been found to be associated with negative outcomes, such as depression, eating disorders, delinquency, and other adjustment issues (Harter & Marold, 1992; Striegel-Moore & Cachelin, 1999; according to APA, 2002), it is important for professionals to identify young people who exhibit such characteristics and assist them get additional help.

3.6. Social Development

A special place in the life of an adolescent is occupied by the importance of peers. Between the ages of 12 and 15, peers become the main criterion when choosing clothes, but also patterns of behaviour. Previous parental opinion and rules become less important, they often conflict with peer rules and become a source of disagreements and arguments between parents and adolescents. On average, adolescents spend between 9 and 12 hours interacting with their peers, whether at school or during extracurricular activities (Berk, 2007; according to Duvnjak, 2018).

Adolescents feel best in the company of friends. They perceive a friend as an extremely close person. The most important characteristics of adolescent friendships are intimacy, that is, psychological closeness, understanding and trust, and loyalty, i.e. they expect their friends to be loyal to them and stand up for them. Friends are similar in their interests, beliefs, educational aspirations, but also in risky behaviour. Socializing with peers and gathering interest groups among young people has many advantages. Group processes and group dynamics that take place within groups of young people have a significant contribution to the development of social awareness, i.e. to the enabling young people to make decisions, create organisational prerequisites for implementing decisions and taking responsibility if decisions are not implemented. Thus, young people understand the logic of social relations, which is crucial for social maturation (Berk, 2007; according to Duvnjak, 2018). Young people within the group seek to achieve harmony and similarity with other members of the group in order to be accepted, which leads to the process of conforming. Adjusting the rules of behaviour, speech, dress, value system in order to achieve popularity in the group can have both positive and negative consequences on the development of young people, certainly, depending on the group to which young people want to belong. Whether young people will obey group rules and values, i.e. how strong the influence of conforming will be, largely depends on the relationship with parents and upbringing. If young people have supportive parents, whom they respect and

who supervise them appropriately, they will be able to resist peer pressure more easily (Berk, 2007; according to Duvnjak, 2018).

3.7. Internet Generation

Veen/Vrakking (2006) talks about Homo Zappiens, Tapscott (1998; according to Lisek, 2012) about the Net Generation, and many papers abound with the names, such as Y-generation, Millennials. We are talking about the "new" generation born from 1980 onwards, for whom their own computer, internet, mp3/mp4 device, mobile phone and iPod, and all "old" media, formed a natural environment for growing up (Vrcelj, 2009; according to Lisek, 2012). Homo Zappiens represent the generation that was born with a computer mouse in their hands and a computer screen as a window to the world: they consider the Internet and the tools of new technologies to be a way of life. They are aware that there is a huge amount of knowledge that, with the help of technology, is quickly and easily accessible, and they build their knowledge profile at the moment they are interested in it and when they assess that they need it for employment, a hobby or something else. It is precisely because of this kind of thinking that the understanding of the education process, the place, time and manner in which it is carried out is changing, and the concepts and ideas of "just-in-time-learning", "learning on demand", "just enough learning" and "just for you learning" are becoming increasingly current.

Generation Z, also referred to as Post-Millennials, I-generation, Digital Natives – are names for people born from about the mid-1990s until the late 2010s. We can safely say that this generation makes up the majority of young people all over the world. According to Prensky, no generation so far has had the opportunity to live in an era where technology is available to them at any time and in any place (Prensky, 2001).

With technological breakthroughs such as smartphones, high-speed internet, tablets, and sociological phenomena such as social networks and applications, Generation Z has changed the way of everyday communication (Turner, 2015).

In conclusion, Generation Z or Post-millennials are all people born since 1997, and according to some sources, the final year of that generation is 2012, however, this also varies, considering that there are already predictions about the new generation (Pew Research Centre, 2009).

Characteristic motifs that pervade this generation are, indeed, a high level of digital media literacy, familiarity with technology - some of them already knew how to use technology such as computers, tablets and smartphones at a very early age.

Generation Z has a positive attitude towards technology and is not afraid to try new things. When they want to find out some additional information, they often do it on the Internet, because it is their natural environment (Fudin, 2012; according to Goljanin et al., 2019). One of the most striking characteristics of Generation Z is their ability to multitask. Time magazine called them GenM, due to their ability to simultaneously talk, listen, write, search the Internet and sometimes do homework (Wallis 2005; according to Goljanin, 2019). The disadvantage that occurs due to the excessive use of technology is the fact that they believe they can do everything at the same time. One of the worst consequences of multitasking, according to the California Teachers Association, is reduced attention span. In addition to attention, teachers feel that their reliance on technology causes their demands for quick results and constant feedback, as is the case on the Internet and when using new technologies. Also, one of the major disadvantages of the availability of information through a wide range of technologies is the loss of the ability to recognize the reliability of information as well as relying too much on opinion rather than facts (Wallis, 2005; according to Goljanin, 2019).

One of the risk factors that occurs due to constant exposure to the Internet and other ICT technologies among young people is exposure to electronic violence. Due to the availability of the Internet anytime and anywhere and the development of smart devices, unlike victims of traditional forms of peer violence, victims of electronic violence can be abused 24 hours a day, seven days a week.

4. Overview of the State of Mental Health of Youth Aged 14 to 18 in Bosnia and Herzegovina

4.1 Research Results in the Area of Work with Children and Adolescents in Bosnia and Herzegovina

Research on the presence of disorders and/or issues in children and adolescents through obtaining own and collateral reports on evidence of behavioural, emotional, social and thought problems and advantages in Bosnia and Herzegovina was conducted during 2022 through the Mental Health Project in Bosnia and Herzegovina. The measuring tool that was used for the purpose of this research was the ASEBA questionnaire for preschool and school-age children and it consisted of a set of parallel forms (CBCL, YSR and TRF). It is intended to assess competencies, adaptive functioning and emotional, behavioural and social problems of preschool and school children.

The results shown for Bosnia and Herzegovina refer to children of the YSR age group (12-18 years of age) using a sample of 56 service users who underwent initial and repeated evaluation (i.e. evaluation and re-evaluation). The results show an equal percentage of male and female children between the ages of 14 and 18 who reported for treatment at mental health centres. In most cases, the parents of the children are married. However, 33% state that their parents are divorced. When it comes to the work status of the parents, the majority are employed, although there is significantly higher unemployment rate among mothers compared to fathers (see Chart 1).

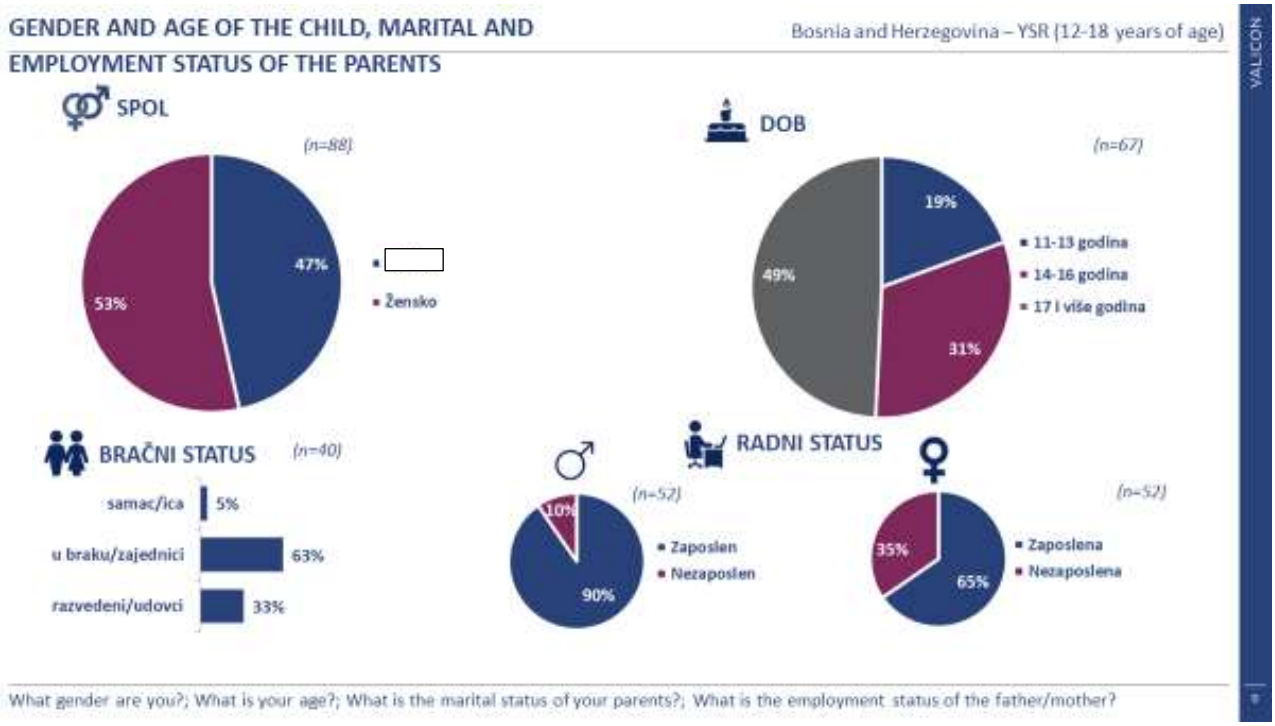

Chart 1: Age and gender of the child, marital and work status of the parents

Football, basketball, but also handball, volleyball and tennis are the most popular sports among the children surveyed, and the parents' assessment is that their children play sports like most other children (see Chart 2).

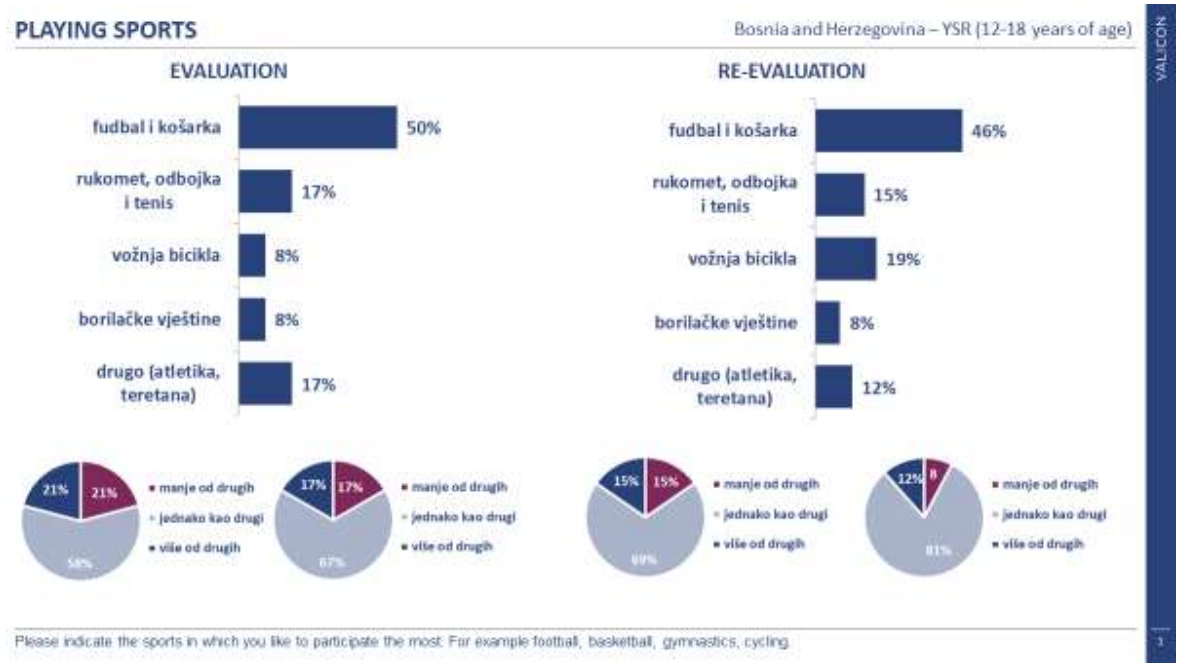

Chart 2: Playing sports among adolescents

The most prevalent diagnoses/difficulties in children of this age are depressiveness/anxiety (48.4%), self-reclusion and low self-confidence in young people (48.2%), and problems with attention (43.2%). This is followed by social problems and relationships with other people (33.1%), (see Chart 3).

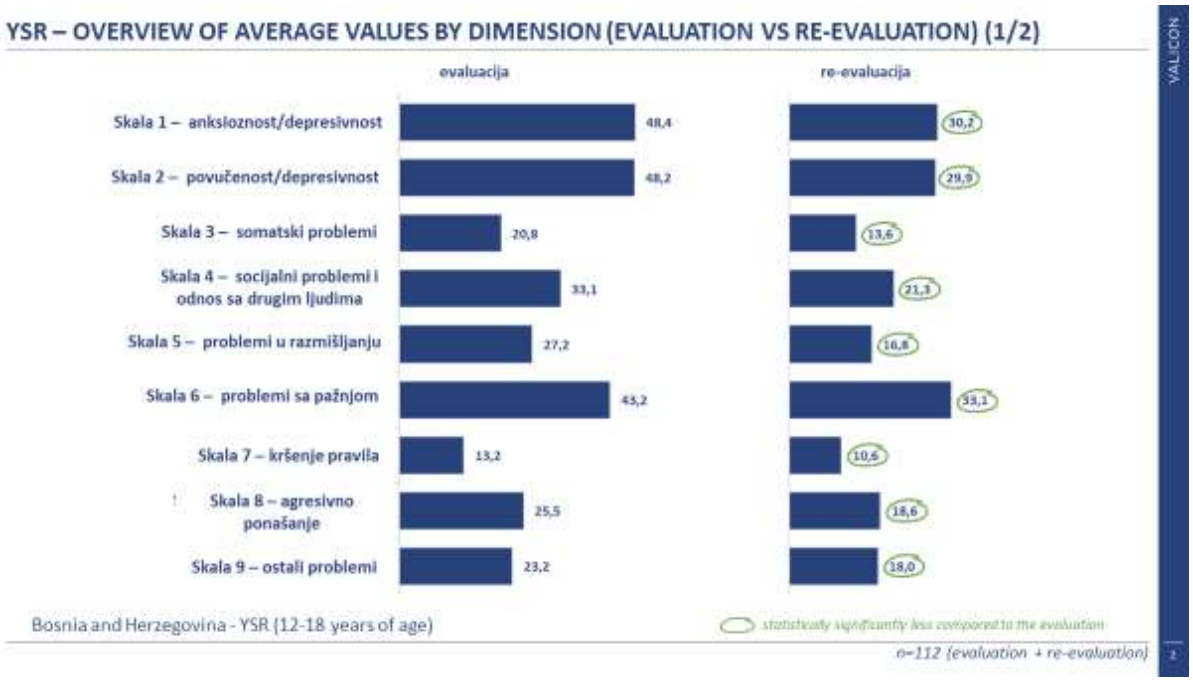

Chart 3: Overview of the most common diagnoses according to the questionnaire dimensions, evaluation and re-evaluation.

After the re-evaluation, there is a significant recovery for all diagnoses/difficulties. **YSR (for ages 12-18), 88%;** (for the Federation of Bosnia and Herzegovina 85%, and for Republic of Srpska 100%); (M 83%, F 90%)

The greatest recovery is observed in anxiety/depressiveness, self-reclusion and low self-confidence, social problems and relationships with others, as well as attention-related issues. The smallest recovery (although significant) is observed in the case of problems with violation of rules of conduct and other undefined problems (see Chart 4).

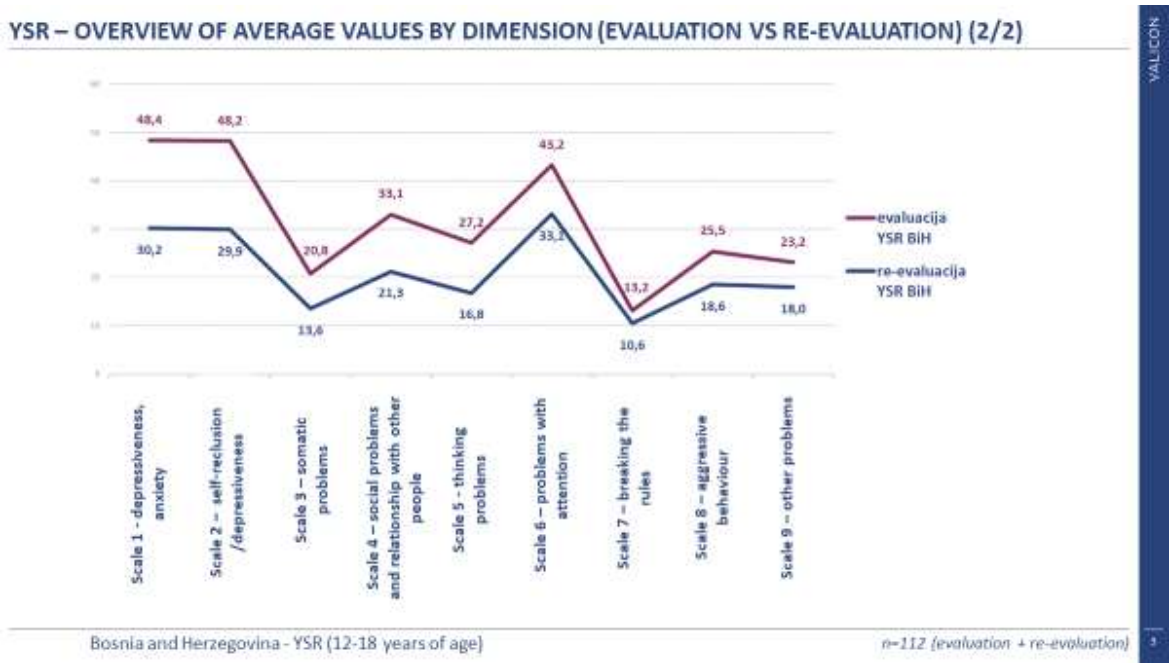

Chart 4: Overview of average values according to the questionnaire dimensions; the difference between evaluation and re-evaluation results.

Federation of Bosnia and Herzegovina – YSR (12-18 years of age)

In the sample of children in the Federation of Bosnia and Herzegovina for whom initial and repeated measurements (evaluation and re-evaluation) were made, the percentage of boys and girls is almost equal. In most cases, the parents of the children are married. When it comes to the work status of the parents, the majority are employed, although there is a significantly higher unemployment rate among mothers compared to fathers. See Chart 5.

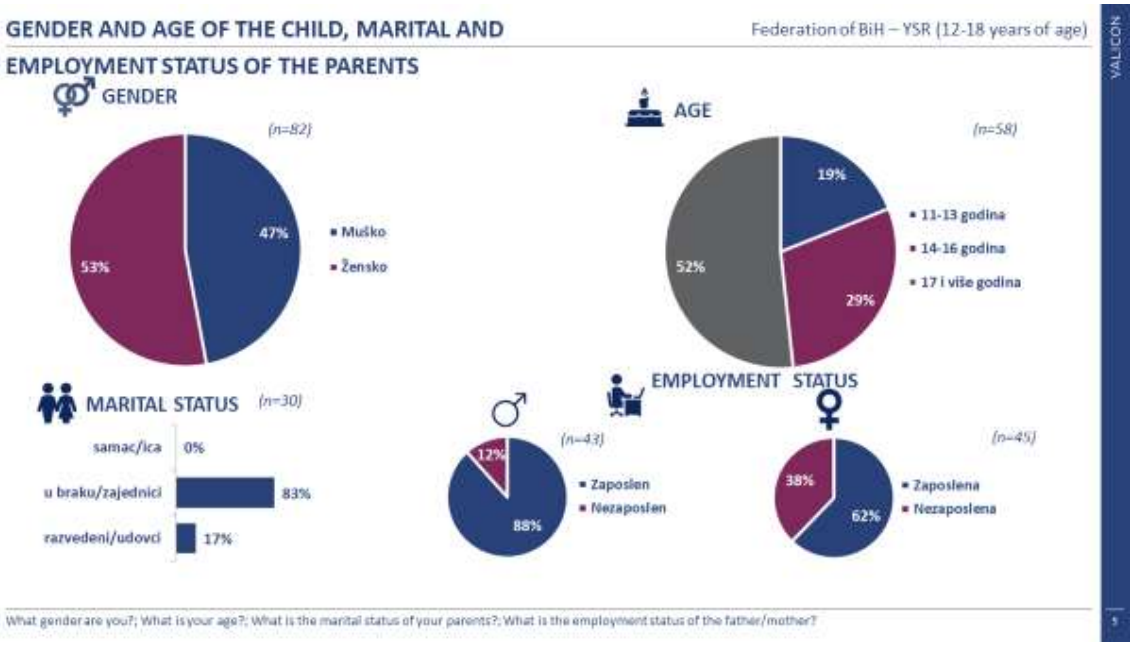

Chart 5: Age and gender of the child, marital and work status of the parents in the Federation of Bosnia and Herzegovina

Football and basketball are the most popular sports among the children surveyed, and the parents' assessment is that their children play sports like most other children (see Chart 6).

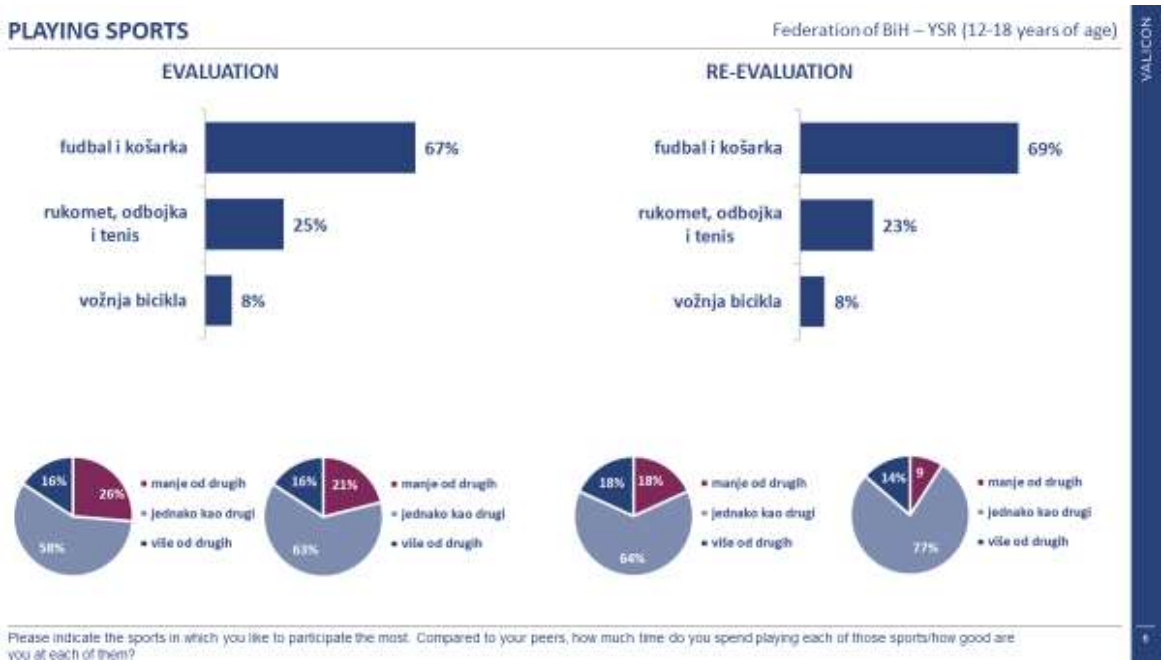

Chart 6: Playing sports among adolescents in the Federation of Bosnia and Herzegovina

The most prevalent diagnoses/difficulties in children of this age are **self-reclusion and depressiveness, depressiveness/anxiety and problems with attention** (see Chart 7)**.**

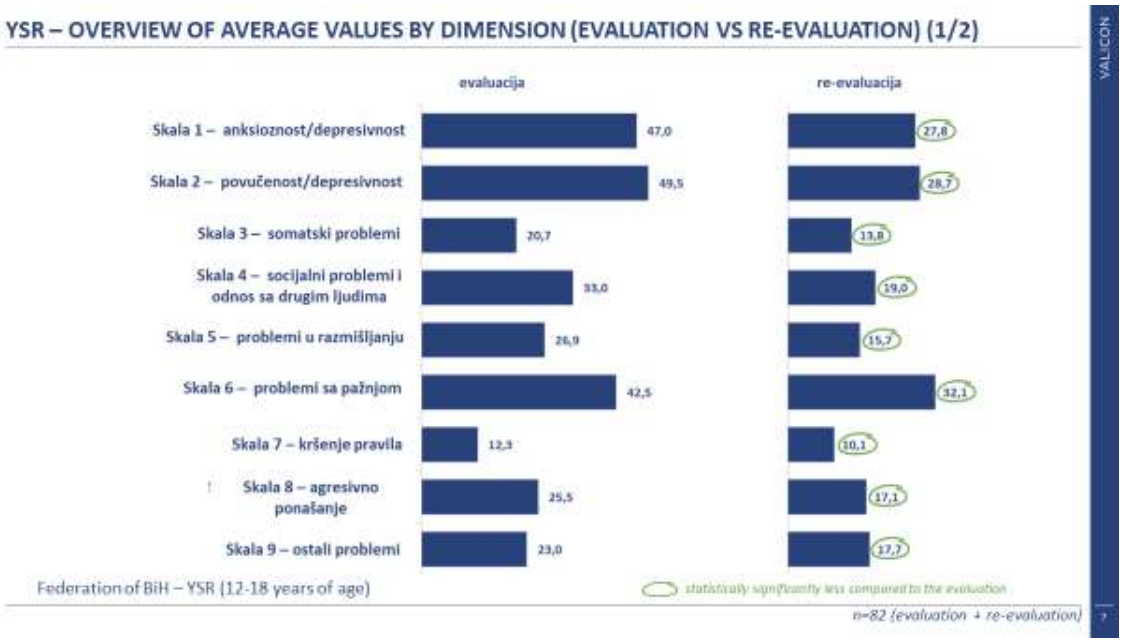

Chart 7: Overview of the most common diagnoses according to the questionnaire dimensions, evaluation and re-evaluation in the Federation of Bosnia and Herzegovina.

After the re-evaluation, there is a significant recovery for all diagnoses/difficulties. The greatest recovery is observed in attention-related issues, depressiveness/anxiety and self-reclusion and depressiveness. The smallest recovery (although significant) is observed **in the case of problems with violation of rules of conduct** (see Chart 8).

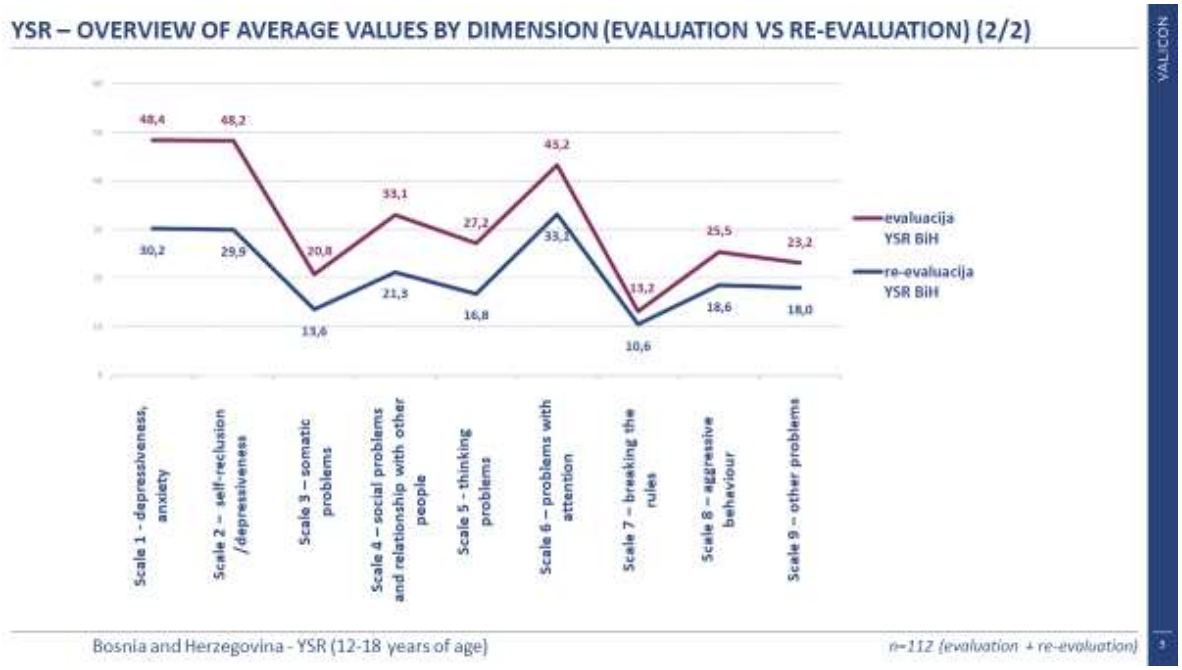

Chart 8: Overview of average values according to the questionnaire dimensions; the difference between evaluation and re-evaluation results in the Federation of Bosnia and Herzegovina.

Republic of Srpska – YSR (12-18 years of age)

In the sample of children in Republic of Srpska for which initial and repeated measurements (evaluation and re-evaluation) were made, there is a slightly higher percentage of girls (69%) compared to boys (31%). Almost 80% state that their parents are divorced. When it comes to the working status of the parents, the majority are employed, although there is a significantly higher unemployment rate among mothers compared to fathers (see Chart 9).

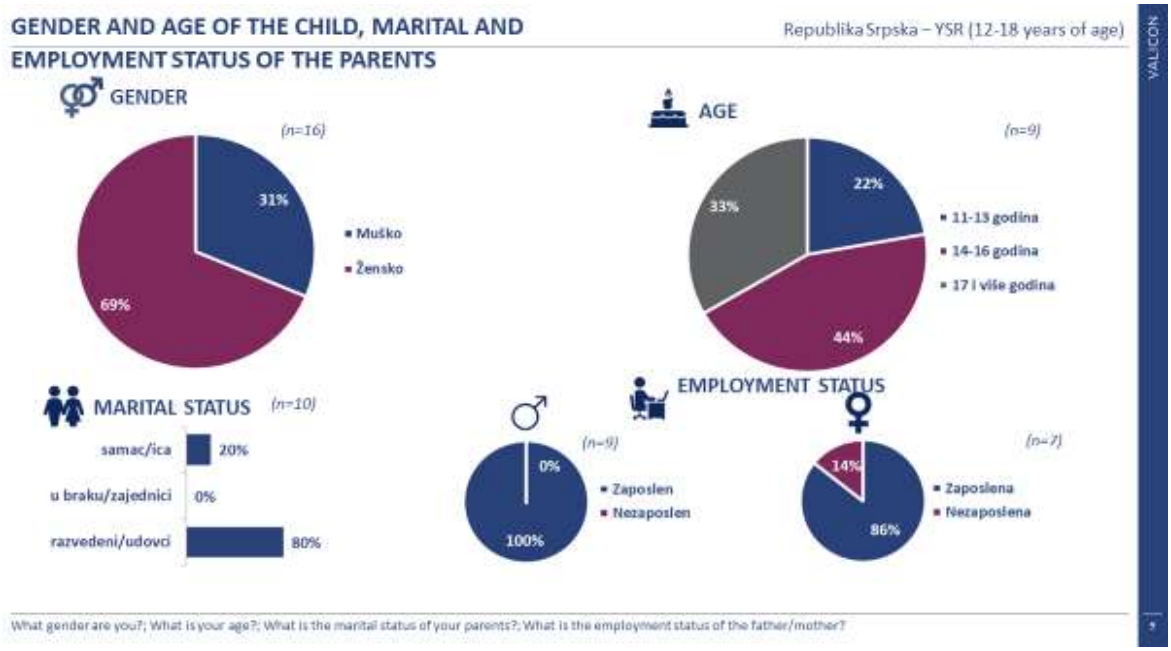

Chart 9: Age and gender of the child, marital and work status of the parents in Republic of Srpska

Combat sports are the most popular sports among the children surveyed, and the parents' assessment is that their children play sports like most other children (see Chart 10)

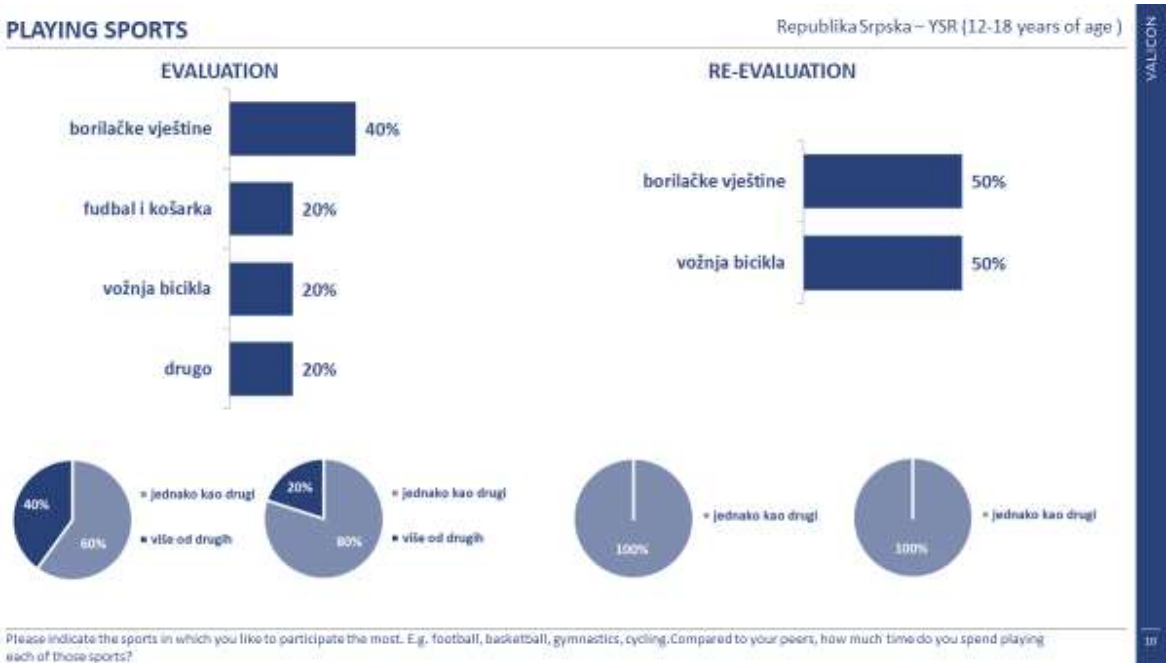

Chart 10: Playing sports among adolescents in Republika Srpska

The most prevalent diagnoses/difficulties in children of this age are **depressiveness/anxiety, problems with attention and self-reclusion/depressiveness in children** (see Chart 11).

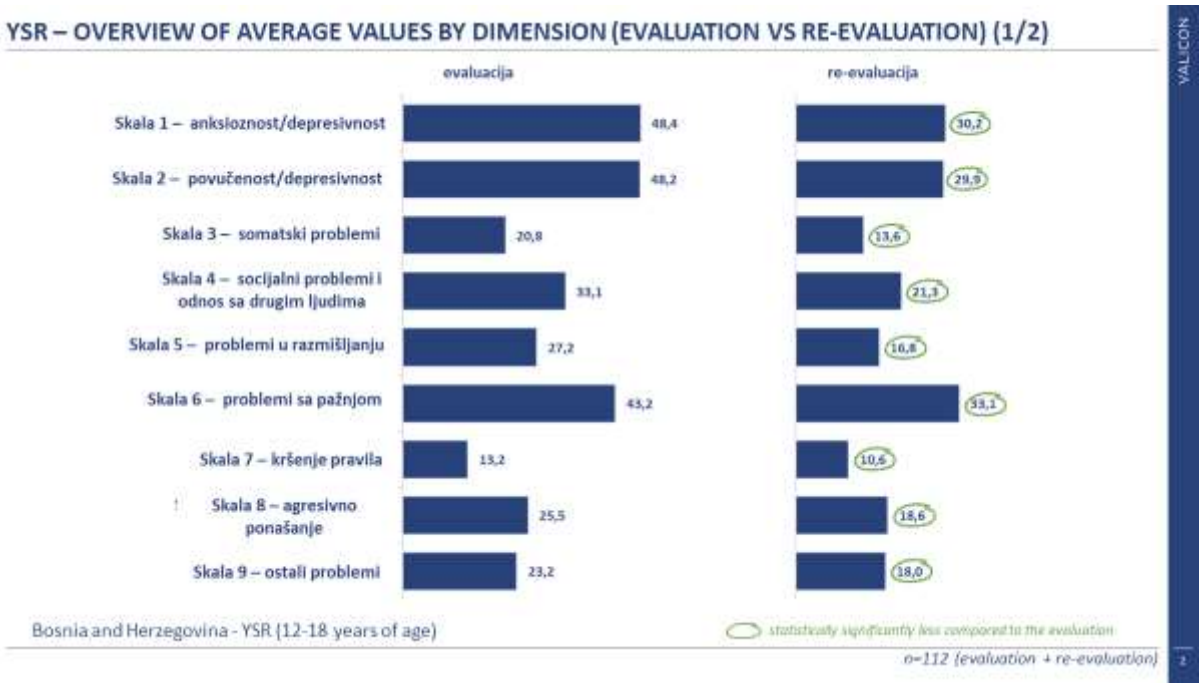

Chart 11: Overview of the most common diagnoses according to the questionnaire dimensions, evaluation and re-evaluation in Republic of Srpska

After the re-evaluation, there is a significant recovery for all diagnoses/difficulties. The greatest recovery is present in depressiveness/anxiety, low self-confidence in children and problems with attention. The smallest recovery (although significant) is observed in **aggressive behaviour** (see Chart 12).

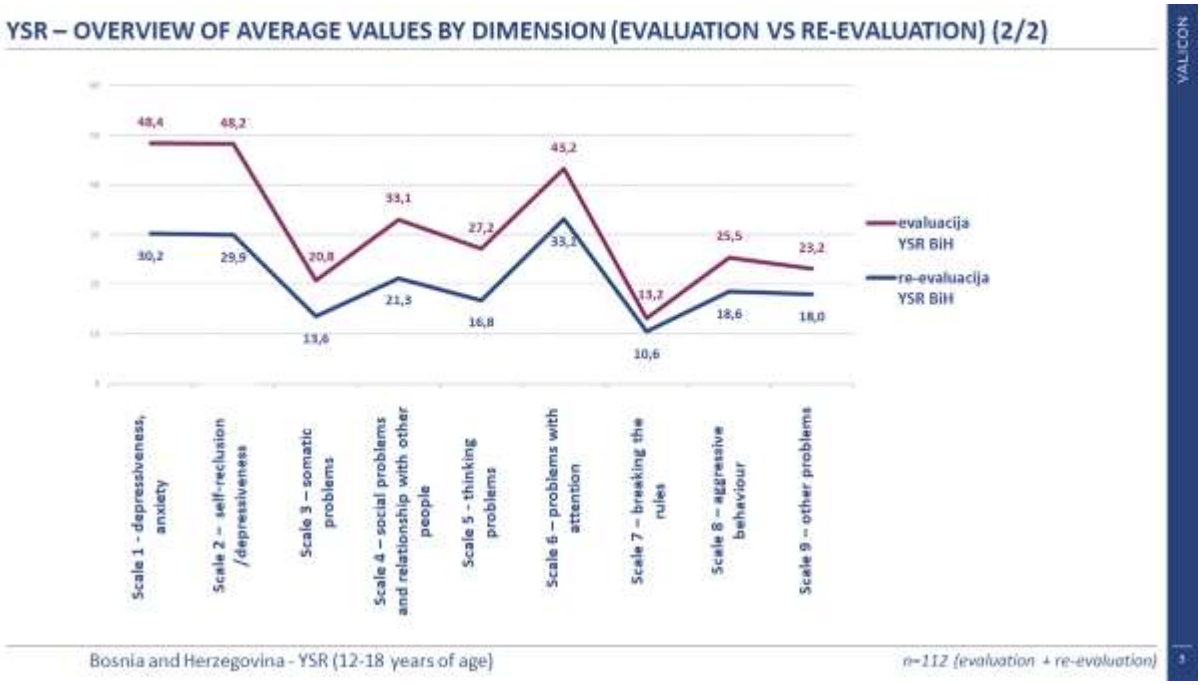

Chart 12: Overview of average values according to the questionnaire dimensions; the difference between evaluation and re-evaluation results in Republic of Srpska

4.2. Research findings on the mental health of youth in the Sarajevo Canton

Research on the mental health problems of children and adolescents in our area (Sarajevo Canton) indicates that the prevalence (29%) of the spectrum of internalised problems (self-reclusion symptoms, depression and anxiety, and somatic problems) is almost twice as high as the prevalence of clinically significant externalised problems (16.3 %) observed on the subscales of predelinquent and destructively aggressive symptoms. The research was conducted in eleven elementary schools in Sarajevo Canton on a sample of 743 children aged 10-15. These two extremes of s single continuum do not exclude each other and are in significant statistical correlation (Badurina, 2013 according to Badurina et al. 2021).

After the family, the school is the social institution that has the closest contact with children during their "formative" years. The primary and most demanding purpose of school is educational. At the same time, schools are a unique place where students are observed, where their social and emotional difficulties and needs are recognized, which can affect the learning process and which can appear even in adulthood. Emotional and social needs are fundamentally private, unclear even to the person experiencing them, and in school they are often camouflaged by maladaptive behaviour that can prevent or repel help and understanding rather than attract them. Therefore, the challenge is to create conditions in which the struggling

student feels safe enough to disclose his or her needs and in which someone pays attention and responds appropriately (Heller, in Tudor, 2008).

4.3. Conclusions of the Focus Group Discussions

Discussions within the framework of the focus group held with assistants, therapists from the governmental and non-governmental sectors throughout Bosnia and Herzegovina show the same results as the aforementioned research. **The most common symptoms in young people are anxiety, depressiveness, self-harm, personality disorders, addictions, attention problems, and peer violence.** In addition to the aforementioned problems, the problems of disconnection with adults at all levels are of particular concern. Peers bring important things in life to each other, but they are not connected to each other either. They have imaginary friends on the Internet, and in real life, they are without support and have no communication with them either. In the parent-child relationship, there is a big gap between the children's needs and what the parents think the children need, so there is a difference between the perceived needs and the children's wishes. Professionals specifically looked at the problem of sexting, the behaviour of young people on the Internet and creating an image of themselves accordingly.

The Focus Group participants from the education sector presented risk factors that are relevant in our society and reflected in the mental health of adolescents. In addition, the participants also mentioned mental health problems faced by adolescents aged 14 to 18. The text below summarizes the conclusions of the Focus Group.

In secondary schools in Bosnia and Herzegovina, there is a lack of non-teaching staff members, i.e. school psychologists, and at the same time, a large number of students need treatment with a psychologist. In addition, psychologists are employed in several schools, which makes it difficult to provide adequate treatment for all students. Furthermore, schools do not have a sufficient number of teaching assistants to work with students with developmental disabilities. The 2014 floods and the Covid-19 pandemic had a significant negative impact on the mental health of adolescents in Bosnia and Herzegovina. In addition, the situation in Bosnia and Herzegovina was highlighted as a risk factor: insecurity, impossibility of employment or proactive use of free time, but also transgenerational trauma, which results in unemployment of parents, poor economic situation in the family, parents who use psychoactive substances and parents who have mental health difficulties. Experts further state that parents are less motivated to be involved in the upbringing of their children, as well

as the lack of family care for children and the exposure of adolescents to domestic violence, including the exposure of adolescents to peer and online violence.

Internet addiction, addiction to gambling and psychoactive substances, test anxiety, self-harm, suicidal ideation, attempted suicide, psychosomatic complaints, absenteeism from school, violence towards teachers, and a decrease in motivation to do schoolwork and abide by school rules are observed in adolescents who need professional treatment. Another important risk factor in the education sector is the professional burnout of teachers, as well as their lack of education in recognizing and dealing with students who have mental health problems. As a risk factor for the mental health of young people, the participants cited an insufficient number of specialised child psychiatrists and psychologists in Bosnia and Herzegovina in relation to the needs of young people, for which reason adolescents wait longer for psychiatric treatment.

From the results of the research and Focus Group discussions, it is evident that it is still necessary to work on **prevention programmes tackling anxiety and depressiveness among young people**, and that long-term **endeavours are especially needed to address problems related to breaking the rules and aggressive behaviour**, given that they fall under the category of pre-delinquent behaviour. Changing these requires a multisectoral approach and extensive effort.

Young people's need for direct contact with therapists, to hear them and help them in live sessions, was particularly emphasized, because such an approach produced the best effects in therapy. Young people long for someone to hear them, to understand them, to have real relationships and a friendly approach to working with them because they want a connection with someone.

It is necessary to establish more youth centres because it has been proven that connecting with other young people who have the same or similar problems gives the best results in treatments. This is especially important for young people who are questioning their sexual orientation.

It is necessary to ensure the availability of mental health services without referrals and long waiting lists when they urgently need such services. Facilitating access and being informed about where to seek professional help, what is the role of Mental Health Centres (MHC) in Bosnia and Herzegovina in terms of help and therapy lead to the prevention of more serious problems in this sensitive phase of life. In addition to availability, anonymity and confidentiality of data are key in working with young people, especially when it comes to small communities.

When it comes to the education sector, the conclusion that emerges from the Focus Group discussions is the need for a unique preventive programme at the level of Bosnia and

Herzegovina, as well as the need for a centralised database at an institution at the level of Bosnia and Herzegovina or at the entity level, where difficulties in the mental health of young people would be monitored. Furthermore, it is necessary to continuously educate parents about adequate parenting and mental health, so that parents themselves can recognize when children need professional treatment. Given that teachers and non-teaching staff members have the opportunity to observe the behaviour of children in schools, it is necessary to organise continuous training for school staff on the mental health of adolescents. Professionals from the education sector emphasize the need for school protocols when it comes to suicidality among adolescents, as well as standardized protocols for the work of non-teaching staff members with clearly defined performance outcomes. Given that the peer group is very important in the adolescent period, it is necessary to provide greater availability of group support for adolescents as part of mandatory treatment.

5. Theoretical Knowledge about Behavioural Issues in School-age Children Aged 14 to 18

5.1 Behavioural Disorders

The term behavioural disorders refer to a wide spectrum of the behaviour of various manifestations, characteristics, intensity, duration, danger, harmfulness and complexity. Furthermore, this term refers to the age group of children from 0 to 18 years, exceptionally up to 21 years. It is common knowledge that behavioural disorders of children and young people usually develop gradually from mild, less disruptive to more severe, obvious and dangerous disorders, although deviations from this rule are also possible. The problem in defining the appearance of behavioural disorders also stems from differences in approach, and therefore some definitions of behavioural disorders are based on a phenomenological approach, some on an etiological approach, and the third ones on the need for society to intervene in the upbringing and socialisation of a child (Koller-Trbović, 2003).

Koller-Trbović, Žižak and Bašić (2001) define behavioural disorders as all those behaviours that in some way hinder the individual, i.e. the child or young person in their regular functioning, and can be harmful and dangerous for the individual and/or his/her environment.
According to the DSM-V (2014) classification of the American Psychiatric Association, behavioural disorders are defined as repetitive and persistent patterns of antisocial behaviour that are associated with aggression towards people or animals, destruction of property,

cheating or theft, and serious rule-breaking. Furthermore, the classification according to the dimensions of behaviour, or Achenbach's dimensional classification of disorders, includes two groups of behaviours: internalised and externalised. Internalised symptoms are behaviours that are overly controlled or self-directed. These include depression, self-reclusion and anxiety. With externalised symptoms, we are talking about behaviour that is insufficiently controlled or directed towards others. An example of such behaviours is aggressiveness, hyperactivity, delinquency, etc. (Koller - Trbović, 2003).

The author Koller-Trbović (2003), combining the definitions of the aforementioned authors, states that behavioural disorders:

- represent a significant deviation from the usual, socially acceptable behaviour of a certain environment for the specific age and gender of the child, and the situation;
- represent a directly or indirectly threatening, harmful, dangerous situation for the child;
- point to clear indicators of the future unfavourable development of the child if no intervention is made;
- require additional professional or wider help without which the person alone cannot overcome the difficulties.

5.2 Externalised and Internalised Problems in the behaviour of Children and Adolescents

According to the socio-ecological model, behavioural problems are classified into two major groups discussed by Achenbach and Edelbrock (Scholte, 1995), namely:

- externalised problems and
- internalised problems.

The first group of behavioural and emotional problems refers to those types of behaviour that are directed towards the outside world, such as peer abuse, hyperactivity, aggressiveness, theft, etc. the second group of behavioural and emotional problems includes self-directed behaviours such as anxiety, depression, loneliness, and social withdrawal.

Research in child psychopathology has established two broad groups of symptoms that indicate the existence of externalized and internalized problems in children's behaviour (Davison and Neal, 2002). *Externalised problems* are manifested as insufficiently controlled and excessive behaviours and include behaviours such as hyperactive disorder, conduct

disorder, aggressiveness, and antisocial behaviour. We also call them active behavioural disorders.

Internalised behaviour *problems* refer to over-controlled behaviours. Such behaviours create more problems for the child than for the people around the child. They are more difficult to notice because the child keeps all his/her fears and problems to himself/herself and usually withdraws from society. People with this disorder manifest fears, tension, shyness, feelings of unlovedness, inferiority, sadness, withdrawal and depression. In addition, the symptoms of these disorders are similar to the symptoms of anxiety and depression in adults. The appearance of overly controlled behaviour is more characteristic of girls. Children with internalised disorders show more negative emotionality, deficits in appropriate ways of responding and a high level of behavioural inhibition (Lebedina Manzoni, 2007). Disorders of over-controlled behaviour can be divided into behavioural disorders of the child itself (his/her fears or depression) and disorders caused by external factors such as bullying by other children or neglect or excessive control by parents or guardians (Lebedina Manzoni, 2007). If the problem arose due to some fears or depression, the child does not know how to express it. If the problem is an external factor, the child is afraid to turn to someone for help.

5.3 Prevalence of Behavioural Issues and Differences by Gender and Age

One-year prevalence within the population varies from 2 to over 10%, with a median value of 4%. It occurs equally in all ethnic and racial categories. The prevalence rate increases from childhood to adolescence and is higher within the male gender population (APA, 2014). Previous research has shown that the most important and at the same time the most effective is early prevention, i.e. prevention in the preschool period. The need for early detection of disorders in the behaviour of children and young people, or their treatment, is of great importance for the subsequent growth and development of the child (Koller-Trbović, 1998).

More recent research on aggressive behaviour conducted on a sample of young adolescents (Omersoftić, Zvizdić, 2020) reveals that gender is a variable that somewhat less, but still statistically to a significant extent explains exposure to violence in the community in the form of violence committed at school. Boys are characterized by greater exposure to violence in the community in the form of violence committed at school, compared to girls.

6. Theoretical Knowledge about Protective Factors in Young People

6.1 Risk and Protective Factors

Risk factors represent all those factors that increase the probability of disease occurrence, lead to higher morbidity, and longer duration of mental health problems.

Protective factors are those that promote resistance to risk factors and diseases.

Typical risky behaviours of children and young people are:

- tendency to lie and cheat,
- socializing with problematic peers,
- not feeling guilty,
- provoking authority,
- callousness,
- non-cooperation with peers and non-participation in organised leisure activities (sports, sections, youth clubs, etc.),
- missing classes,
- inadequate free time (excessive use of the Internet, coffee shops, wandering the streets, sleeping for a long time, not having hobbies, etc.),
- irresponsibility for daily duties and
- poor communication.

Long-term, intense risky behaviours become a constant pattern of behaviour and they do not happen to "someone else". Risky behaviours are interconnected and continuously present.

Garmezy (1981) emphasizes the role of factors such as dispositional attributes, the state of the environment and positive events that can mitigate the effects of negative or traumatic experiences.

Individual characteristics such as high intelligence, a certain type of temperament, the ability to cognitively evaluate a traumatic experience and relationships with significant people from the environment are examples that can mitigate or be protective factors for children/youth.

According to the stages of psychosocial development, Erikson lists the signs of dysfunction in young people aged 12 to 18:

- antisocial behaviour,

- lack of healthy coping skills,
- weak ties with peers and
- somatic difficulties (regret).

Protective factors are all those internal and external forces that help the child to bear risks better or that mitigate risks (Fraser, 1997; according to Bašić, 2000). Both protective and risk factors are found in the areas of individual characteristics of a child or young person and in the areas of the social environment where young people live (Bašić, 2000). Protective factors work in two ways: they reduce exposure to risk factors or mitigate the effects of risk factors. They are divided into:

- individual,
- family,
- social,
- economic,
- social and
- ecological.

Protective factors include certain characteristics of temperament, skills and values that lead to more efficient use of potentials, openness to opportunities in important life situations, the ability to seek help, quality communication, problem-solving skills, intelligence, academic success and competence, and a positive self-image (Bašić and Ferić, 2004).
Williams, Ayers and Arthur also described protective factors that reduce the risk of delinquency in young people, as well as other forms of behavioural disorders. These are female gender, connection with parents, agreement with the family, positive temperament, ability to adapt, warm family climate, a strong external support system that strengthens the child's efforts in dealing with stressful events and risks, healthy beliefs, skills for solving social problems (Bašić and Janković , 2000). It has been shown that some children, who were exposed to stressful events and grew up with high-risk parents who abused them, in the future do not show any form of behavioural disorder and in adulthood have good mental health because they had appropriate characteristics and support from the environment (Ajduković , 2000).

Some foreign authors, including Artur, Hawkins et al. (2002; according to Meščić, Blažević, 2007), list the following protective factors, the presence of which reduces the risk of behavioural disorders:

- individual (positive/resilient temperament, problem-solving skills, prosocial behaviours),

- family (good relationship with parents and connection with family, agreements with family, stable family),
- school (motivation/positive attitude towards school, good relationship with teachers, high-quality school, clear school rules regarding behaviour and responsibilities),
- peers (involvement in positive activities, good relationships with peers, parental approval of friends) and
- community (economically stable communities, safe environment, neighbourhood connection and social cohesion) (Meščić Blažević, 2007).

Strengthening the aforementioned protective factors already in early education contributes to the empowerment of children and their environment, and this is precisely the point of primary prevention. In this way, the resilience and ability of young people to resist the various pressures and challenges they are exposed to during adolescence are developed. There is no doubt that the school, along with the family, has crucial importance in the development and socialisation of each individual, and accordingly, it offers a broad set of opportunities for the application and implementation of various pedagogical strategies for the prevention of behavioural disorders in young people. Pedagogical prevention refers to all educational and social procedures, measures and activities aimed at preventing the emergence and development of behavioural disorders. Pedagogical prevention includes early detection of behavioural disorders and timely and adequate provision of help and protection. Pedagogical prevention is also based on the concept of strengthening protective factors, and empowering and meeting the basic psychological needs of adolescent students.

According to Erikson's theory, the most important activities that should be done with adolescents in this period are: integrating childhood experience into personal identity, helping the adolescent to make decisions, encouraging active participation in household activities and assisting in future planning.

6.2. Family and Social Risk and Protective Factors

Numerous studies have shown that it is very important how well the family is ready to face stress, whatever the cause of the stress may be, and how stress affects the relationships between family members. Conger and Elder (1994, according to Cudina-Obradović and Obradović, 2006) developed a model of family stress that explains how stress affects processes within the family and how these adverse influences affect children. Stress endangers the mental and physical health of parents, causing depression and irritability.

According to the model of Conger and Elder (1994, according to Čudina-Obradović and Obradović, 2006), stress harms children the most because it disrupts parental relationships and damages the quality of parenting.

In the early 1970s, researchers noticed that some children were more resistant to stress than others, regardless of the stressful conditions in which the family found themselves.

Studies point out that the level of self-concept, competence, connection between children and adults, so-called "protectors" (Masten, Coatsworth, 1998, Masten, 2001) **but also families that have good cohesion, provide mutual support and have a common goal** (Seccombe, 2002, Cole, Clark, Gable, 2001, Čudina-Obradović and Obradović, 2006) **contribute the most to this property of "resistance to stress"**.

Research shows that there are individual characteristics and environmental properties that influence the success of overcoming stress and risk in family life.

According to the authors Masten and Coatsworth (1998) these are:

- individual's traits - good intellectual functioning, self-concept, self-esteem, sense of efficiency, sociability, charm, talent and faith in the future,
- family characteristics - strong connection with one adult, authoritative upbringing (warmth, structure, expectation of success), family cohesion (joint activities, meals or at least one joint meal), connection with the wider family,
- wider environment - closeness to an adult outside the family, closeness to a peer from another "healthy" family, good school organisation, closeness to an interested teacher, connection to other organisations such as a sports club, church, etc.

In addition, resistance to stress is not only an individual characteristic of a child or adolescent but also of the family as a whole. Several authors highlighted the characteristics of stress-resistant families (Masten, Coatsworth, 1998, Masten, 2001, Seccombe, 2002, Cole, Clark, Gable, 2001, Čudina-Obradović and Obradović, 2006) and divided them into protective factors and recovery factors.

Ecological Systems Theory, also called "Development in Context" or "Human Ecology" theory, lists four types of interconnected environmental systems, with two-way influence within and among the systems. The theory was developed by Urie Bronfenbrenner, who is considered to be one of the world's leading scientists in the field of developmental psychology. Each individual is immersed in multiple systems that directly and indirectly influence their behaviour and these influences are reciprocal and two-way. The external environment in which others participate and influence is called the exosystem, and all these systems (micro, meso and exo) are included in the macrosystem, which includes the values and norms of a certain culture

as well as ideological values. The chronosystem is also mentioned, which refers to the influence of changes and permanence over a longer period of time on the development of a person in the environment in which the person lives (Jankovic, 2004). Bronfenbrenner (Bubolz, Sontag, 1990; according to Janković 2004) describes the human environment as structures that are each integrated into the next one like a set of *babushkas* (Russian wooden dolls that are placed inside each other).

Some studies highlight the importance of family processes that are influenced by economic stress, i.e. the subjective experience of economic vulnerability. In sociological works, the term social exclusion is used, which refers to the inability to participate in material and cultural events offered by modern life (housing conditions, transportation, participation in sports, culture, social life).

In some studies, social exclusion is associated with depression, poor health, and early adolescent pregnancies (Roosa, et al. 2005; according to Čudina-Obradović and Obradović, 2006). Economic poverty is a form of stress that the family faces as well as unpredictable difficulties such as death, serious illness, natural disasters, war, job loss.

Owing to the Ecological Systems Theory, a model of ecosystemic interventions has been developed in systemic family therapy, which involves intervening at all levels of the system that are related to problems. This model is based on the Ecological Systems Theory, according to which there may be a worsening of symptoms and return of the problem, if we effect changes in the individual without changing the environment and all essential actors involved in the problem, even after improving and reducing the symptoms.
The programme is based on the general systems theory and the social ecology theory, and it has nine principles according to which it operates:

1. the primary goal of the assessment is to understand the connection of the problem to the broader concept of the system;
2. the accent is on the positive and the use of the strengths of each system to which the child/young person belongs (family, school, peer) as a driver of change;
3. interventions are aimed at encouraging responsible behaviour of family members;
4. interventions are focused on the present, action and specific, well-defined problems;
5. interventions are focused on aspects of family relations/social ecology that are related to identified problems and contribute to behavioural problems;
6. interventions are adapted to the developmental needs of young people;
7. interventions require daily and weekly engagement of family members;
8. the effectiveness of interventions is continuously measured;

9. interventions aim to achieve long-term effects.

Illustration of the ecological model:

6.3 Risk Factors for the Emergence of Mental Health Difficulties among School Children in Bosnia and Herzegovina

6.3.1. Effects of the 2014 Floods and the COVID-19 Pandemic

The 2014 floods left consequences for the mental health of the population in the affected areas in Bosnia and Herzegovina. Experts from the Mental Health Centres and numerous volunteers from the field of mental health responded by providing crisis interventions with an emphasis on children and youth. One cannot ignore the fact that for many young people, the experience of floods was a traumatic experience that included their own lives being threatened or that of their family, loss of property, etc.

Like floods, Covid-19 also acted as a trigger for war trauma in a large number of residents. The crisis situations that children faced during the Covid-19 pandemic are limited movement, suspension of the usual way of attending classes, lack of social contact with peers, interruption of usual activities such as training, courses, etc., infection with Covid-19 and death in close and extended family, their infection with Covid, their hospitalisation or hospitalisation of their close family members, death of several family members caused by Covid-19. For schools to provide an adequate response to student crisis situations, it is necessary for teachers and non-teaching staff members to be trained in dealing with crisis situations.

6.3.2. Transgenerational Trauma

Transgenerational transmission of trauma is a term that is used very often in our society, especially after the war, where the generation of the students' parents we work with experienced war trauma in various forms. This term refers to the phenomenon that parental or later generations' trauma affects the child's functionality, i.e. the occurrence of certain changes in children's behaviour as well as maladaptive behaviour. It is important to emphasize that this term does not only refer to war trauma, but also to other developmental or traumas experienced in adulthood by the child's parents and ancestors, which remained repressed and "unprocessed" (Badurina et al., 2021).

According to Hill (2017), transgenerational trauma can negatively affect families as a result of:

- unresolved emotions and thoughts about the traumatic experience,
- a negative repetitive pattern of behaviour that includes beliefs about parenting,
- untreated or poorly treated substance abuse or mental illness,
- weak parent-child relationship and inadequate emotional attachment,
- complicated personality traits or personality disorders, and
- a firm attitude that things should stay within the family.

6.3.3. Financial Instability

Parental unemployment and low financial income can lead to insufficient quality living conditions for a child's healthy physical and psychological development; frustrations in adolescents due to the perception of their own inequality in relation to others; perceived but also real social exclusion, due to the lack of opportunities to join a peer sports or art group.

6.3.4. Exposure to domestic and community violence among young people

Various problems faced by parents of young people in Bosnia and Herzegovina, such as unemployment, PTSD and other mental health difficulties, often lead to increased exposure of adolescents to family violence, which significantly impairs the mental health of adolescents.

Adolescents from Bosnia and Herzegovina are also exposed to violence in the community. Research on the exposure of children and adolescents to violence in the community is current, and the interest in this issue is fuelled by the knowledge that exposure to violence in the

community as a victim, witness or perpetrator has negative consequences on their physical and mental health. Violence in the community includes any violence that takes place in a public place (Bowen - Brown, 2008), i.e. it excludes domestic violence and violence in the workplace (Cicchetti, 2016). Violence in school is sometimes different from violence in the community, but it is most often seen as a part of, or as a separate form of violence in the community. In general, adolescents belong to an age group characterized by a risk of exposure to violence in the community. A study in the USA showed that 17.6% of children and adolescents are direct victims of attacks in the community (Finkelhor - Turner - Omrod - Hamby - Kracke 2009; Cicchetti, 2016; according to Omersoftić, Zvizdić, 2019). It is still necessary to work on sensitising the population, as well as experts who work with children to report even the smallest forms of violence and to act intersectorally in treating families where violence occurs.

6.3.5. School Environment-related Risk Factors

School is an integral part of every child and represents, in addition to the family system, one of the most important systems in children's and adolescents' mental and psychosocial development. Since children spend most of their time in school, it seems logical that all those who work with children should be concerned with what schools are like and how children feel in them.

The aforementioned research included specific aspects of the quality of school life, which show that close to 60% of children often feel afraid of school, and almost every other child does not feel safe at school, while close to 60% of children do not feel that they belong to their school at all (Badurina, 2013, 2016; according to Badurin et al., 2021).

Nowadays, risk is defined as the probability that future problems will decrease in the balance between the competencies of young people and children (resilience) and their riskiness (Bašić, 2001).

Williams, Ayers, Arthur (1997; according to Bašić, 2001) list the most common risk factors in the development of behavioural disorders in children and young people. Among others (genetic or biological, individual and peer-, family- community-related risk factors), as an important risk factor for the emergence of behavioural disorders and problems, they mention school-related factors, namely:

- school failure,
- poor academic achievement,
- disciplinary problems, and
- insufficient attachment to school.

The authors Kafedžić, Bjelan-Guska et al. (2019) point out that elementary school is a place where different forms of child behaviour can be recognized, i.e. risk factors that exist in the child's environment, and where it is possible to influence the reduction or removal of risk factors, i.e. prevent the development of problems in children's behaviour. In addition, the school environment plays an important role in achieving and maintaining the mental health of children and adolescents. School is recognized as a protective factor for many health problems. On the other hand, factors that have a bad effect on mental health are peer violence, lack of acceptance from peers and lack of support from parents/guardians and teachers. The same authors list risk factors for the emergence of socially unacceptable behaviour and behaviour problems that can be recognized in the school environment:

- the student is defiant and in constant resistance to school rules,
- the student is constantly (unjustifiably) absent from class,
- the student is violent (verbally, physically and relationally) towards peers,
- the student endangers peers (or other persons) in the digital environment (cyberspace…),
- the student passively witnesses and records violence (among peers),
- the student physically confronts the teacher
- the student very often accuses others of his/her bad actions (neutralisation...),
- the student is prone to self-harm (auto-aggression...),
- the student shows strong outbursts of anger at minimal stimuli,
- the student constantly violates school rules,
- the student initiates and/or participates in fights,
- the student intentionally destroys public property in and around the school,
- the student appropriates other people's things at school,
- the student consumes cigarettes and/or alcohol,
- the student consumes drugs,
- the student (during classes) spends time in cafes or betting shops,
- the student brings dangerous objects to school that can hurt his/her peers,
- the student strays and/or begs, and
- the student expresses xenophobic attitudes and/or practices hate speech (Kafedžić et al., 2019).

6.4 Development of Resilience in Young People

Resistance or resilience can be defined as the effect of the interaction of risk factors in combination with positive forces (protective factors) that contribute to an outcome that represents a healthy adaptation. In order to develop long-term resilience in children from high-risk environments, it is necessary to ensure emotional care and warmth, openness and acceptance, independence with supervision, orientation towards achievement and the development of appropriate values. The ecological multidimensional approach to looking at risk factors and protection in the development of behavioural disorders (Raić, 2016) represents a model that can help in assessing the strengths and weaknesses in the ecological system as well as in planning preventive and treatment actions.

6.4.1. Satisfying Basic Needs

The fundamental prerequisite of the resilience development is the satisfaction of the basic existential needs of the child. Social policy measures, but also child protection under the family law and other interventions of the social protection system play a key role in ensuring the satisfaction of the child's basic needs.

Adolescents' needs in relation to others

Every child has relational needs, i.e. needs for contact, which he/she is often unaware of and unable to communicate to adults or his/her peers. That is why children make changes in their behaviour to show that they lack the attention or love of parents, acceptance of peers, understanding of teachers, educational support in the sense of help in mastering school material or clear structure by adults.

When relational needs are unsatisfied, children show changes in behaviour, such as withdrawal, aggressive behaviour, lower school performance, disobeying school rules, and as a result, they may become victims or perpetrators of violence in the school environment.

Richard Erskine, a clinical psychologist and eminent expert in the field of psychotherapy, in the book he published with his associates defines 8 needs that people have in relation to others (Erskine et al., 1999; Erskine, 2015; Badurina et al., 2021):

1. The need for security

Security is the organic experience that our physical and emotional vulnerabilities are protected. Counselling work with children should therefore include an empathetic awareness of the need for security in the relationship as well as a reciprocal response to that need. This

presupposes a response that includes respect and unashamed acceptance of children's vulnerability (Erskine, 2015; Badurina et al., 2021).

2. The need for validation, affirmation, and significance

This need refers to the existence of another person who will validate, affirm and accept all our relational needs as natural. This is achieved through real contact with the child and genuine interest in the child, rather than mere presence.

3. The need for acceptance from a wise, reliable and protective other person

This is a fundamental need because every child needs to rely on parents, older brothers and sisters, teachers and mentors. It is the need for a significant other from whom we receive protection, encouragement and information (Erskine, 2015; Badurina et al., 2021).

4. The need for community - sharing experience

This need is manifested through the desire to be in the presence of someone who is similar, who understands because he or she has had a similar experience. It is the feeling of going through the same path together with someone who is "like me" (Erskine, 2015; Badurina et al., 2021).

5. The need for self-definition (Who am I?)

Self-definition is a relational need to know and express one's uniqueness and to gain recognition and acceptance from others.

6. The need for having an impact on the other person

It is an individual sense of competence in a relationship that results from the effectiveness of attracting the attention of another person, the influence that could benefit other people, and the influence of changing the feelings or behaviour of another person (Erskine, 2015).

7. The need for having the other initiate

Initiative refers to the incentive to make interpersonal contact with another person. It is looking for the other person in a way that recognizes and gives importance to him or her in the relationship (Erskine, 2015; Badurina et al., 2021). If excessive passivity is noticed in an adolescent, it is possible that one of the causes of such behaviour may be that this need was not met in an earlier phase of life.

8. The need for expressing love

This need is a very important component of a relationship. Love is usually shown through silent gratitude, affection or when we do something for another person. The importance of the need to show love – whether from children to parents, siblings or teachers, or from a client to a therapist – is often overlooked in psychotherapy practice (Erskine, 2015; Badurina et al., 2021).

6.4.2. Social Network and Substantive Acceptance

The second level of prerequisites for the resilience development is substantive acceptance and a quality and supportive social network. Substantive acceptance of the child as a person is crucial for his/her balanced psychosocial development. Accepting a child gives him/her the message that he/she is loved, that he/she is valuable as a person, that he/she can turn to an adult, no matter what happened. If significant people in the child's environment do not react to some unacceptable behaviour, the child may experience it as something contrary to acceptance, which is indifference. If a family is functioning well, it will provide adequate acceptance to its members, but for many reasons, many families are not ready to provide this to their members. It is therefore important to develop support that will help the family and the child to overcome difficulties.

6.4.3. Experience of Personal Effectiveness

Experiencing personal effectiveness is not just knowing what to do and being motivated to do it. Effectiveness is the product of the ability to organise social, cognitive and emotional skills and contribute in a coordinated manner to the achievement of various goals. A skill that is important for the development of a child's sense of effectiveness and empowerment is called a social skill. Social skills refer to a number of specific skills, from effective parenting skills to communication skills of children and parents and the like. It is important to enable all children to acquire such skills because they make it easier for them to get involved in various activities that expand their social network, but also to more easily face the demands of the environment. Work on the development of social skills in a child presupposes work on his/her environment and thus can influence the development of a sense of effectiveness. A child will best acquire social skills from an adult who accepts him/her as a person.

6.4.4. Effective Coping with Stress

Coping implies the individual's activities to change the currently disturbed relationship with the environment, either by changing one's own behaviour or by changing unfavourable aspects in the environment. There are many coping strategies that a child can use in difficult life situations - seeking social support, fantasizing and daydreaming, expressing feelings, active problem solving or humour. It is important that the child develops various coping strategies and that, depending on the situation, he can effectively use one of them. For example, humour is more than a defence mechanism or an escape from unpleasant reality. It gives us a lot of strength and can be related to resilience in many ways. We need to encourage a climate in the family or school where there is laughter and jokes. In order to be successful in this, one needs to create a climate of trust, since without a climate of trust, humour can become very aggressive.

6.4.5. Self-concept and Self-esteem

A "healthy" person knows oneself, accepts oneself and loves oneself. Such a person is capable of taking responsibility for the consequences of his/her actions. Self-concept refers to the image that an individual has of himself/herself as a social, emotional and physical being. Self-esteem is the awareness of who and what we are, independent of what we know and can do. It is key to developing compassion and caring for others. When a child does not accept himself/herself, it is difficult for him/her to accept the opinion of another child, and this is the basis of frequent mocking or rejection, as well as aggressive behaviour. Therefore, affirmation, confirmation of one's own worth, is one of the prerequisites for the complete development of a child, mutual acceptance in groups of children, and constructive resolution of conflicts between children (Ajduković, 2000).

Protective factors are all those internal and external forces that help the child to bear risks better or that mitigate risks (Fraser, 1997; according to Bašić, 2000). Both protective and risk factors are found in the areas of individual characteristics of a child or young person and in the areas of the social environment where young people live (Bašić, 2000).

Some foreign authors, including Artur, Hawkins et al. (2002; according to Meščić, Blažević, 2007), list the following protective factors, the presence of which reduces the risk of behavioural disorders:

- individual (positive/resilient temperament, problem-solving skills, prosocial behaviours),

- family (good relationship with parents and connection with family, agreements with family, stable family),
- school (motivation/positive attitude towards school, good relationship with teachers, high-quality school, clear school rules regarding behaviour and responsibilities),
- peers (involvement in positive activities, good relationships with peers, parental approval of friends) and
- community (economically stable communities, safe environment, neighbourhood connection and social cohesion) (Meščić Blažević, 2007).

Strengthening the aforementioned protective factors already in early education contributes to the empowerment of children and their environment, and this is precisely the point of primary prevention. In this way, the resilience and ability of young people to resist the various pressures and challenges they are exposed to during adolescence are developed. There is no doubt that the school, along with the family, has crucial importance in the development and socialisation of each individual, and accordingly, it offers a broad set of opportunities for the application and implementation of various pedagogical strategies for the prevention of behavioural disorders in young people. Pedagogical prevention refers to all educational and social procedures, measures and activities aimed at preventing the emergence and development of behavioural disorders. Pedagogical prevention includes early detection of behavioural disorders and timely and adequate provision of help and protection. Pedagogical prevention is also based on the concept of strengthening protective factors, and empowering and meeting the basic psychological needs of adolescent students.

There are three key aspects of support for the development of resilience in children (Hooper, 2012; according to Badurina et al., 2021):

1. a strong sense of personal security, trust in others, by providing optimal conditions of a safe haven where the child feels recognized, accepted and loved as he/she is;
2. strengthening the child's self-confidence with support to make him aware of: intrapsychic support system (personal strengths, potentials and abilities, weaknesses, awareness of feelings, thoughts and behaviours and the ways in which he/she most often responds to the environment, emotional and social competences); interpersonal support system (relationship with parents, relationship with family members, teachers, friends, peers, school environment and active support from the community);
3. awareness of a sense of meaning, active participation and responsibility for oneself and others, which lead to growth and success.

7. Theoretical Concepts of Prevention and Promotion in Mental Health Focused on the Population of Young People Aged 14 to 18

7.1.Theoretical Principles of Prevention and Promotion in Mental Health

There is no doubt that the leading public health challenges that marked the 21st century on a global level, such as poverty, environmental and social consequences of urbanisation, and increased exposure to risk factors for the onset of chronic diseases, also influenced the trend of increasing mental health disorders.

The promotion of mental health in the community requires an intersectoral approach, with the active participation of relevant institutions of the government sector, non-governmental organisations and citizens' associations, with the aim of systematic and continuous measures of monitoring and prevention of risk factors and strengthening mental health, well-being and quality of life in all population groups.

Prevention of risk factors and strengthening of protective factors, and promotion of mental health includes integrative strategies that create living conditions and an environment that enables and supports healthy lifestyles.

In order to define the theoretical principles of interventions in the improvement of mental health, it is necessary to emphasize the difference between the concepts of prevention and promotion, which are often used as synonyms by professionals and the general public. However, although these are mutually complementary activities, there are differences in the content and concept of action, whereby promotion activities are aimed at improving health and quality of life, and prevention activities at disease with a focus on disease prevention measures.

Promotion in Mental Health

The transition of health on a global level has also left its mark on the evolution of conceptual approaches to health promotion contained in international documents. Thus, of the traditional approaches that consider the promotion of mental health as activities aimed at strengthening the mental health and well-being of the population and individuals and reducing the incidence of disease, according to contemporary authors, the promotion of mental health is the closest to the term ‘positive mental health’ and includes measures that strengthen the valuation of mental health in the perception of the general health of the individual, the family and the community as a whole, i.e. strengthening the knowledge and skills of individuals and

population groups to support and strengthen positive emotional and cognitive capacities as preconditions for mental health.

Conceptual framework of prevention and promotion in mental health

The modern concept of prevention and promotion in mental health implies the integration of interventions in health and other sectors in the implementation of three major strategic goals:

- preventive re-orientation of services at all levels of health care;
- prevention and reduction of diseases and promotion of mental health;
- developing services in the community that support re-socialisation and integration and reduce inequalities in health for vulnerable population groups.

According to the WHO, every government's investment in the prevention and promotion of mental health is extremely important for the long-term and sustainable development of the community by advocating:

- perception of prevention, as well as investment in health;
- active participation of the community in the development of an environment that enables and supports choices for healthy living;
- health services designed in such a way that they must adequately respond to diseases, but also strengthen the possibilities of health promotion;
- enabling people to promote their health and be active partners to healthcare professionals in disease management;
- decision-makers at all levels of government have the responsibility to develop sound public policies and ensure intersectoral interventions for their implementation.

In accordance with the recommendations provided in relevant documents, with the aim of mobilisation and active participation of the community, systemic intersectoral interventions to reduce mental health disorders and diseases are integrated into four strategic courses: **monitoring, prevention, promotion and education**.

Monitoring includes:

- improvement of records of mental health disorders and diseases in the health statistical system in accordance with internationally recommended indicators;
- development of the registry of mental health disorders and diseases;
- continuous implementation of population surveys related to all aspects of mental health.

Prevention includes:

- inclusion of mental health protection and promotion content in the preventive examinations content for all population groups and in all life cycles;
- development and availability of systemic programmes for prevention and withdrawal from addiction diseases (smoking, alcohol, drugs and psychotropic substances) associated with mental health disorders and diseases;
- inclusion of mental health protection and promotion content in the teaching content of preschool and educational institutions of all levels;
- supporting the work of self-help groups and other services in the community for people suffering from mental disorders, psychosocial difficulties and other population groups at risk.

Promotion includes:

- informing and educating the public with the aim of improving knowledge and attitudes, reducing stigmatisation and inequality related to all aspects of mental health;
- strengthening intersectoral cooperation between health and other sectors, NGOs and the media in the implementation of mental health promotion campaigns;
- inclusion of mental health promotion in the intersectoral interventions, such as healthy schools, healthy workplaces, centres for healthy ageing, and mental health centres;
- support for re-socialisation, integration and employment programmes for persons with mental and psychosocial disabilities.

Education includes:

- affirmation of the importance of the mental health segment in the undergraduate programmes and continuous medical education of health workers and associates;
- development of multidisciplinary mental health education programmes for professionals in health and other sectors;
- development of multidisciplinary guides for the prevention and promotion of mental health.

Mental health and the development of diseases and disorders related to mental health are determined by the action of multiple and interactive factors such as knowledge and attitudes, lifestyles and behaviour, and the participation of social factors such as education, employment, working conditions, housing. Moreover, there is no doubt that in addition to the proper organisation of health care as a fundamental basis for the promotion of mental health in the

community, the degree of development of a social climate that respects and protects basic human, political, socio-economic and cultural rights is of great importance.

7.2 Significance of Promotion and Prevention in Preserving Mental Health

Positive mental health is "a state of emotional and social well-being in which an individual is able to realize his/her own potential, cope with normal life stresses, work productively and successfully, and is able to contribute to the community in which he/she lives" (WHO, 2001). Lack of positive mental health is a threat to public health, quality of life and stability in society.

Promotion and prevention of mental health represent a proactive approach, which supports positive mental health and resistance/resilience to the onset of illness. Promotion activities are focused on the determinants of health, while prevention is focused on the causes of disease. In practice, these areas overlap and a single intervention, such as activities aimed at improving social ties between people, has both promotional and preventive characteristics.

Prevention is defined as "interventions undertaken before a disorder occurs" to prevent its development. The historical, public health concept of disease prevention divides prevention into primary, secondary and tertiary.

Primary prevention aims to prevent the occurrence of diseases and reduce the incidence of disease to the lowest possible level and is primarily aimed at healthy people.

A good example of primary prevention in controlling infectious diseases is vaccination. When talking about primary prevention in the field of mental health in children and adolescents, the full meaning of the proverb „better safe than sorry“ comes to the fore. Primary prevention in childhood usually means eliminating or at least reducing the consequences of a developmental disorder. "Satisfactorily healthy" psychological growth and development of a child primarily depends on the inherited constitution, dynamics within family interactions, transgenerational trauma transmission or behavioural patterns, and hereditary burden.

It is easier to establish rational prevention if the factors associated with developmental disorders are well understood (Offord and Bennett 2002).

Secondary prevention includes early diagnosis and treatment of the disease, where success is assessed by prevalence. It refers to the identification of "potential" patients with mental illnesses, i.e. patients in the early stages of the disease, in order to prevent the development of a manifest illness through timely intervention and thus stop its progression and preserve lifespan as well as the quality of life.

The goal is to reduce the number of already established cases. It rests on the identification of persons at risk who are currently asymptomatic as well as persons showing sub-clinical symptoms of the disease. People at risk then undergo interventions aimed at preventing the onset of the disease or reducing the intensity or duration of symptoms.

It is important that interventions aimed at prevention include general risk and resistance factors (factors common to many diseases) as well as disease-specific factors.

Tertiary prevention aims at suppressing and limiting the consequences of the disease and the occurrence of relapses and re-establishing abilities that are threatened or lost due to the disease. Its effectiveness is assessed by the disability of the patient in a given population (Vlajković, 2003).

Another way of conceptualizing preventive strategies is based on **a risk-benefit point of view**. Prevention of mental disorders focuses on reducing risk factors and improving protective factors related to mental health. Effective prevention requires a multisectoral approach, partnership, consultation, commitment and community involvement.

According to the target groups they are aimed at, the types of primary preventive interventions can be classified into: universal, selective and indicated. The first two fall under preventive interventions "*sensu stricto"*, while indicated preventive interventions fall under the category of early intervention (Commonwealth Department of Health and Aged Care, 2000)).

- **Universal** – those that are aimed at the population or entire population groups that are not identified on the basis of individual risk, with the aim of improving the overall mental health of the population. Examples of universal preventive interventions are: building connections and a sense of belonging, hope for the future and coping strategies among students, good prenatal care, bullying prevention programmes in schools, reducing risk factors associated with mental disorders such as low control and high levels of stress at workplaces.

- **Selective** - those that are aimed at individuals or population groups that are at increased risk of developing problems and disorders. Selective preventive interventions aim to reduce the risk in the target population group. Examples: school programmes aimed at young people at risk of depression, support for children whose parents suffer from mental disorders, psychosocial support for people suffering from chronic physical diseases, social support programmes for older people in socio-geriatric institutions as prevention of depression, programmes for people who have experienced adverse life events, such as the loss of a loved one or divorce.

- **Indicated** interventions are aimed at individuals and population groups at high risk, who show minimal but noticeable early signs and symptoms of mental problems and disorders. Examples: programmes for parents of pre-school children who exhibit aggressiveness and uncooperativeness, programmes for school children who exhibit behaviour problems, early intervention programmes in the prodromal phase of the first psychotic reactions (Commonwealth Department of Health and Aged Care, 2000). Effective early interventions require work "on the ground", where services are actively looking for people in need. These services should be provided in places where people live, work, study and spend their free time, rather than wait for them to come and seek help in "traditional" health and psychiatric services. Research has shown that adolescents particularly avoid traditional health services (Rickwood & Braithwaite, 1994). Mental health and other health services are only one of the strategic places for early intervention. Schools are ideal places for early detection of initial signs and symptoms of mental problems and disorders, and school children and adolescents are in a period of life where early interventions are of great importance (Fallon & Bowles, 1999). Services for the treatment of addiction to psychoactive substances and (juvenile) delinquency can also be important places for early intervention, where people at high risk are present.

8. Suicidality and Suicide in Adolescents and Suicide Prevention

8. 1 Key Facts on Suicide (WHO, WFMH)

- 800.000 people globally die by suicide each year.
- Every 40 seconds someone loses their life by suicide.
- There are many more people who attempt suicide (20x).
- Previous suicide attempt is the most important risk factor.
- Second leading cause of death among 15-29-year-olds.
- 79% occur in low- and middle-income economies.
- Ingestion of pesticides, hanging, and the use of firearms are among the most common methods of suicide worldwide.
- A tragedy that affects families, communities and entire regions and has long-term consequences for the people left behind.

- A serious public health problem.
- They can be prevented by timely, often inexpensive and evidence-based interventions.
- Effective responses at the level of economies require a comprehensive multi-sectoral suicide prevention strategy.

Who is at risk?

Suicide as a phenomenon is "ancient" and universal. Suicide is generally a rare event, but not in high-risk groups, e.g. in patients with depression or schizophrenia, it is around 15%, while in those who have attempted suicide it is even higher (the suicide rate is 100 times higher in the year after the attempt).

Classic definitions of suicide contain three components: the intention of self-destruction, an act that is life-threatening and will have a fatal outcome (death). In the absence of the third component, we are talking about a suicide attempt. In the absence of the second and third components, we are talking about suicidal intent, the most dangerous type of suicidal thoughts

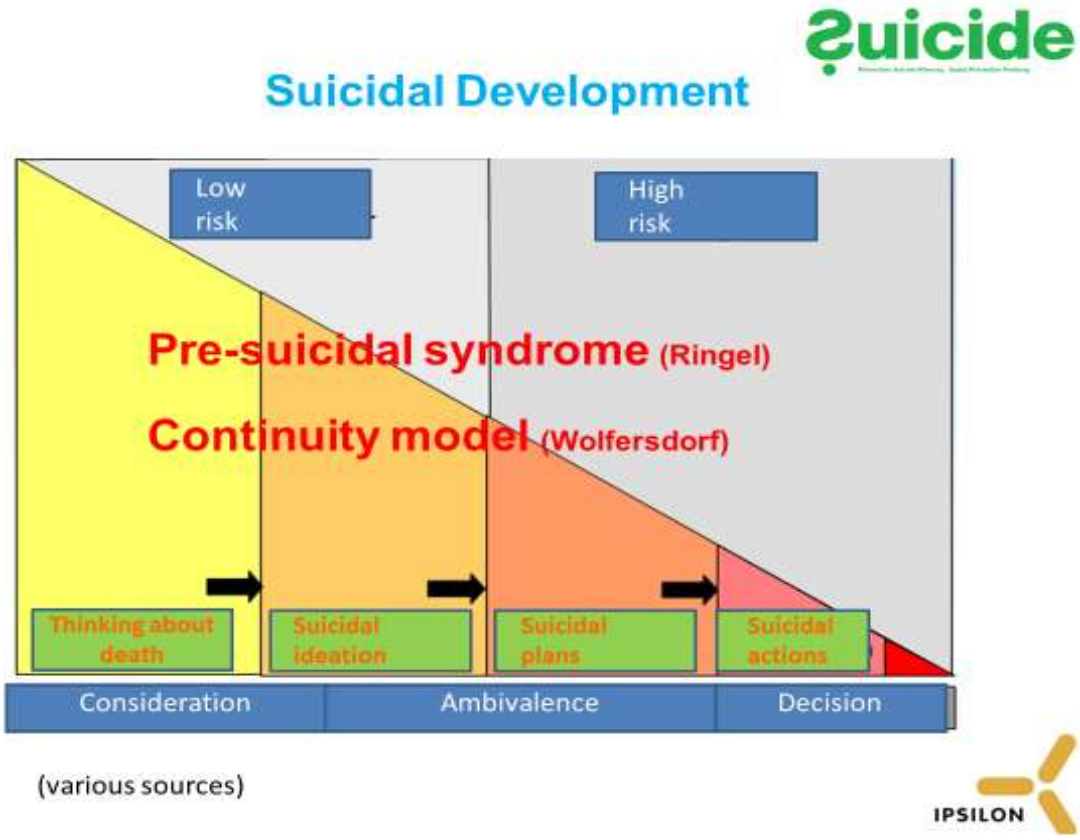

Figure 1. Suicidal development

Suicide = a global phenomenon, which is greatly influenced by socio-demographic and socio-economic factors (Emile DURKHEIM, 1897: suicide "Anomie" = disintegration of family structures, social isolation). WHO, 1984: Different suicide rates in different economies can be

explained by differences in the quality of social and health structures, socio-economic factors, access to lethal means, and neuro-biology plays an important role.

Suicidal behaviour is not a 'normal' reaction to stress or a necessary consequence of a serious mental illness. It is a complex behaviour that has different causes that are determined by: biological factors, psychological factors and cultural factors (Rhimer, 2007).

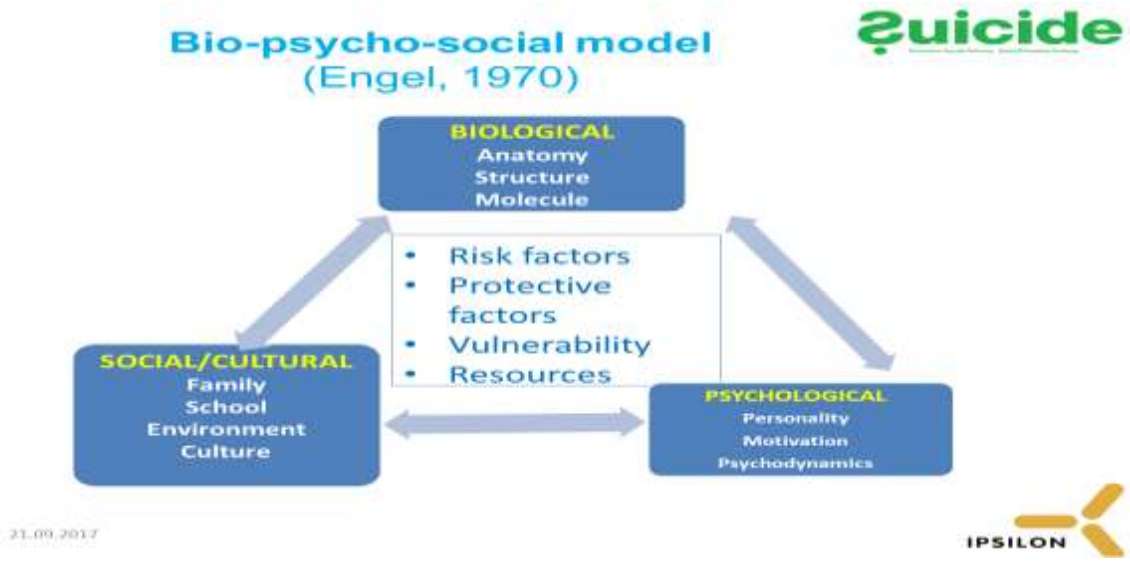

Figure 2. Bio-psycho-social model

Indications of suicidality and "presuicidal syndrome", (Ringel**)**

1. Increased limitation (attitudes, activities, values, etc.)
2. Accumulation of aggression, self-aggression
3. Suicidal ideation (first actively sought, then passively imposed)
4. in children and young people: declining achievement, irritability, escape

Many suicides occur impulsively in moments of crisis when the ability to deal with life's stressors is interrupted (e.g., financial problems, relationship breakdown, or chronic pain and illness). The experience of conflict, disaster, violence, abuse or loss and feelings of isolation are strongly associated with suicidal behaviour. Suicide rates are also high among vulnerable groups experiencing discrimination (e.g. refugees and migrants, LGBTI people, indigenous peoples, prisoners, the elderly). Stigma, particularly that associated with mental illness and suicide, means that many people who are considering or have attempted suicide do not seek or get the help they need. To date, only a few countries have included suicide prevention among their health priorities, and only 38 governments report having a comprehensive suicide

prevention strategy. Raising community awareness and breaking down taboos is important for economies to make progress in preventing suicide.

History of suicide prevention

- Biblical: "musical therapy" (David's lyre playing for Saul)
- Mid-19th century: Beginning of efforts to prevent suicides - among prison guards in France!
- "Samaritans" (GB, from 1935)
- "Care for people tired of life" (A, from 1955)
- Telephone consultation – Extended hand

Suicides and suicide attempts can be prevented.

A number of measures can be taken at the level of the population, populations and individuals:

- reducing access to means (e.g. pesticides, firearms, medicines);
- media reporting in a responsible manner;
- school interventions;
- introducing policies to reduce the harmful use of alcohol;
- early identification, treatment and care of people with mental disorders and drug addicts, people with chronic pain and acute emotional problems;
- training of health professionals for assessment and management of suicidal behaviour;
- monitoring people who have attempted suicide and providing support in the community.

Suicide prevention requires coordination and cooperation between multiple sectors, including health and other sectors such as education, labour, police, agriculture, justice, defence, politics and the media.

Population-oriented strategies:

- Reduce access to dangerous means (guns, drugs...)
- Labour and unemployment policies
- School programmes
- Public education
- Media coverage
- Attention to disinhibiting substances

High risk-oriented Strategies (risk groups or individuals):

- Detection and treatment
  - depression and primary care
  - suicide attempts
  - schizophrenia and mental health services - coordinated care
- Crisis intervention
- Improved access to mental health departments and services
  - training of health professionals
  - training of prison staff and prisoners

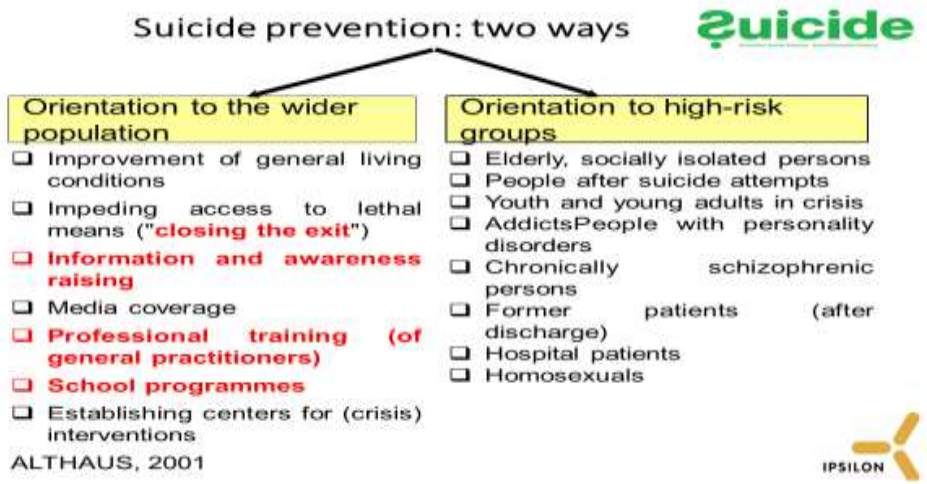

Figure 3. Suicide prevention: two ways

8.2 Suicidality and Suicide in Adolescents and Young People

Worldwide, suicide is among the top five causes of death for young people aged 15 to 19, and in many economies it ranks first or second as the cause of death in this age group. Therefore, the prevention of suicides among children and adolescents is a high priority, and schools are an excellent place for the development of appropriate preventive actions.

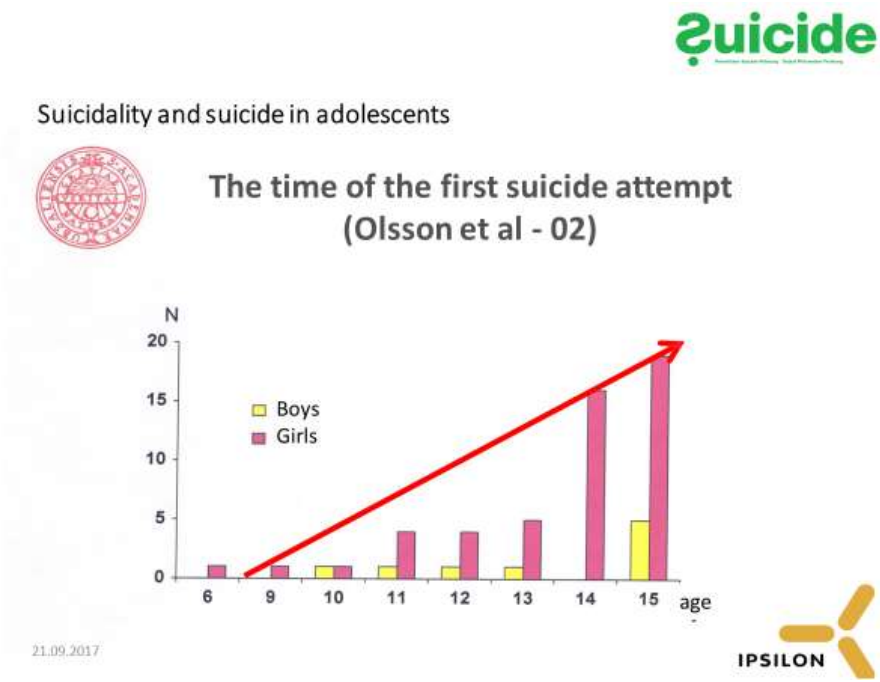

Figure 4. Suicidality and suicide in adolescents

Boys are much more likely to die by suicide than girls; one of the reasons may be that they resort to violent methods of committing suicide, such as hanging, firearms and explosives, more often than girls. However, in some economies suicide is more common among 15- to 19-year-old girls than among boys in the same age group, and the proportion of girls using violent methods has increased over the past decade.

Having suicidal thoughts from time to time is not abnormal. They are part of the normal development process in childhood and adolescence, as well as work on existential problems and attempts to understand life, death and the meaning of life. General risk factors for suicidality in adolescents include: identity defined still to a small extent (generally, in the psychological and sexual sense); increased impulsivity, emotional lability, as well as malleability (Werther effect: Imitation, Suggestion, "Suicide cluster"); the ability to control is (still) limited; unfixed (social) perception.

Surveys show that more than half of high school students report that they have thought about suicide (McKey PW, Jones RW, Barbe RH., 1993). Other authors state that suicidal thoughts are present at a certain age: 20-24% in young people, ages 12 to 17 (Nock, 2008); 14.4% Germany, on average in fifteen-year-olds (Brunner, 2007); 37.9% Austria, on average among fifteen-year-olds. (Dervic, 2007).

The results of the SMASH study, Michaud et al., CH 2002 show that the prevalence of suicidal thoughts in the age group 16-19 is 5%(m) - 20% (female), while suicide attempts are 4% (m)

- 8% (f). Young people should discuss these topics with adults (McGoldrickn & Walsh, 1983). Suicidal thoughts become abnormal and pose a serious risk in children and adolescents when they realize that these thoughts are the only way out of their difficulties. At that point, there is a serious risk of attempted suicide or suicide.

In some cases, it may be impossible to determine whether some deaths caused by, for example, automobile accidents, drownings, falls, and illegal drug overdoses, were unintentional or intentional (Litman, 1989). Adolescent suicidal behaviour is thought to be underreported, as many of these deaths are incorrectly classified as unintentional or accidental. They show subtle manifestations of self-destructive and risky behaviour and while some of their deaths may be caused by unintentional actions, others are intentional actions resulting from the pain of living (Holinger & Klemen, 1982)). Only 50% of adolescents who attempted suicide sought hospital care after the suicide attempt. Generally speaking, boys commit suicide more often than girls. However, the rate of suicide attempts is two to three times higher among girls. Girls develop depression more often than boys, but it is also easier for them to talk about their problems and ask for help (Jilek-Aall., 1988). Boys are often more aggressive and impulsive, and often act under the influence of alcohol and drugs, which probably contributes to the fatal outcome of their suicidal actions.

Protective factors

The main factors that provide protection against suicidal behaviour are:

- **family patterns**: good relationships with family members; family support,
- **cognitive style and personality**: good social skills; confidence in oneself and one's own achievements; seeking help when difficulties arise; openness to other people's experiences and solutions; openness to new knowledge,
- **cultural and sociodemographic factors**: social integration, e.g. through participation in sports, religious institutions, clubs, etc.; good relations with schoolmates; good relationships with teachers and other adults; support from relevant people.

Risk factors and risky situations

Suicidal behaviour under certain circumstances is more common in certain families than in others, due to environmental and genetic factors.

- **Cultural and sociodemographic factors:**

The risk is low socioeconomic status, poor education and unemployment in the family. Immigrants can also be classified in this group, because they often experience not only emotional and language difficulties, but also a lack of social networks, previous war injuries

and psychological torture. Children and adolescents who do not have cultural roots have more pronounced identity problems and do not have a model for conflict resolution. Gender and identity issues related to sexual orientation are also risk factors for suicidal behaviour. Children and adolescents who are not accepted in their culture, by their families and peers, or by schools and other institutions have serious problems with acceptance and insufficient support models for optimal development.

- **Family pattern and adverse life events during childhood:**

Destructive family patterns and traumatic events in early childhood adversely affect youth, especially when they have been unable to cope with the trauma (Sudak, Ford, Rushforth, 1984). Family dysfunction aspects include: parental psychopathology, particularly mood disorders and other psychiatric disorders (Gould et al., 1989); abuse of alcohol and other psychoactive substances, or antisocial behaviour in the family; family history of suicide and suicide attempts.

Heritability of suicidality

Degree of kinship:	**Risk of suicide:**
• Maternal suicide	5 times more often
• Paternal suicide	2 times more often
	(AGERBO et al., 2002)
• Identical twins	~ 6 times more often
• Fraternal twins	~ 4 times more often
	(HEATH et al., 2002)

- first degree relative: > 2x
- Estimated "overall" heritability: 43% (McGuffin et al. 2001)

Violent and abusive family (including physical and sexual abuse of a child); poor parental/guardian care, poor communication within the family; frequent arguments between parents/guardians, with tension and aggression; divorce, separation or death of parent/guardian; frequent moves; very high or very low expectations from parents/guardians; lack of time for parents/guardians to observe and address the child's emotional stress and negative emotional environment characterized by rejection or neglect; family rigidity (Carris, Sheeber, Howe., 1998), adoptive or foster family. Suicidal youth often come from families with multiple problems where the risks are cumulative.

- **Cognitive style and personality**

The following personality traits are often observed during adolescence but are also associated with suicidal risk (although available research evidence for any specific trait is generally sparse and often equivocal): unstable mood; angry or aggressive behaviour; antisocial behaviour; high impulsivity; irritability; rigid thinking and coping patterns; poor problem-solving ability; inability to grasp reality; tendency to live in an illusory world; fantasies of grandeur alternating with feelings of worthlessness; feelings of inferiority and uncertainty that may be masked by open manifestations of superiority, rejection or provocative behaviour towards schoolmates and adults, including parents; uncertainty about gender identity or sexual orientation (Garofolo et al., 1998)); ambivalent relationships with parents, other adults and friends.

- **Psychiatric disorders**

Suicidal behaviour is most prevalent in adolescents with the following psychiatric disorders:

Depression

A combination of depressive symptoms and antisocial behaviour has been described as the most common precursor to teenage suicide (Spruijt, de Goede, 1997), (Weissman et al.; 1999). Several studies have shown that up to three-quarters of those who end up taking their own lives show one or more symptoms of depression, and many suffer from full-blown depressive illness (Schaffer & Fisher, 1981). Students suffering from depression often present with somatic complaints, such as headaches and stomach aches, leg or chest pains (Wasserman, 1998). Depressed girls have a strong tendency to withdraw and become quiet, despondent and inactive, while depressed boys have a tendency to disruptive and aggressive behaviour and require a lot of attention from teachers and parents. Aggression can lead to loneliness, which itself is a risk factor for suicidal behaviour. Although some depressive symptoms or depressive disorders are common in suicidal children, depression is not a necessary concomitant of either suicidal thoughts or suicide attempts (Vandivort & Locke, 1979). Adolescents can kill themselves without being depressed, and they can be depressed without being suicidal.

Anxiety disorders

Studies have shown a consistent correlation between anxiety disorders and suicide attempts in men, while a weaker association was found in girls.

Alcohol and drug abuse

People who use psychoactive substances are quite common among children and adolescents who commit suicide. In this age group, it was determined that one out of four suicidal patients consumed alcohol or drugs before committing suicide (Pommereau X. Quand, 1997).

Eating disorders

Due to dissatisfaction with their body, many children and adolescents try to lose weight. Between 1% and 2% of teenage girls suffer from anorexia or bulimia (very often also from depression), and the risk of suicide in anorexic girls is 20 times higher than for young people in general. Recent findings show that boys can also suffer from anorexia and bulimia (Wasserman, 1998).

Psychotic disorders

Although few children and adolescents suffer from severe psychiatric disorders, such as schizophrenia or manic-depressive disorder, the risk of suicide is very high among those affected.

Previous suicide attempts

A history of single or repeated suicide attempts, with or without the aforementioned psychiatric disorders, is an important risk factor for suicidal behaviour.

Current negative life events as triggers of suicidal behaviour

Expressed susceptibility to stress, along with the mentioned cognitive style and personality traits (due to inherited genetic factors, but also family patterns and negative life stressors experienced in early life), is usually observed in suicidal children and adolescents (Beautrais et al., 1997). This vulnerability makes it difficult to cope adequately with negative life events and reactivates feelings of helplessness, hopelessness and despair that can lead to suicide attempts or suicide (De Wilde et al., 2001).

Risky situations and events that can cause suicide attempts or suicide

Situations that can be perceived as harmful and injurious to personal dignity (without necessarily being objective); family disturbances; separation from friends, girlfriends/boys, etc.; death of a loved one or significant other; breaking up a love relationship; interpersonal conflicts or losses; legal or disciplinary problems; peer group pressure or self-destructive peer acceptance; bullying and victimisation; disappointment with school results and failure to learn; high demands at school during exam periods; poor financial circumstances; unwanted

pregnancy, abortion; infection with HIV or other sexually transmitted diseases; severe physical illness; natural disasters.

How to identify students at risk?

Any sudden or dramatic change that adversely affects adolescent behaviour should be taken seriously (Cohen-Sandler, Berman, King., 1982), such as: lack of interest in usual activities, an overall drop in grades, misbehaviour in the classroom, unexplained absences or absences, excessive smoking or drinking of alcohol or drug abuse (including cannabis), incidents that led to police involvement and student violence. These factors help to identify students at risk for mental and social disorders who may have suicidal thoughts that eventually lead to suicidal behaviour (Zenere & Lazarus, 1997). If any of these signs are recognized by a teacher or school psychologist/pedagogue, the school team should take action to conduct a thorough assessment of the student, as they usually indicate problems, and the outcome can, in some cases, be suicidal behaviour.

Suicide risk assessment

When assessing suicide risk, school personnel should be aware that problems are always multidimensional. **Previous suicide attempts** are one of the most significant risk factors. Young people in trouble tend to repeat their actions. Another major risk factor is **depression**. The diagnosis of depression should be made by a physician or child/adolescent psychiatrist, but teachers and other school personnel should be aware of the range of symptoms (Weissman et al., 1999), which are part of the depressive illness. The difficulty of assessing depression is related to the fact that the natural transition phase of adolescence shares some characteristics with depression (Marcelli, 1998). Adolescence is a normal state during which characteristics such as low self-esteem, despondency, problems with concentration, fatigue and sleep disturbances appear. These are also common features of depressive illness, but there is no cause for alarm unless they are persistent and increasingly severe. Compared to depressed adults, young people tend to eat and sleep more. Depressive thoughts can be normally present in adolescence and reflect a normal developmental process, when a young person is preoccupied with existential questions. The intensity of suicidal thoughts, their depth and duration, the context in which they arise and their persistence are what distinguish a healthy young person from one at suicidal risk. Another important task is to identify **risky situations and adverse life events**, which activate suicidal thoughts and thus increase the risk of suicide.

8.3 Prevention of Suicidality in Adolescents

General prevention

The most important aspect of any suicide prevention is the **early recognition of children and adolescents in distress and/or at increased risk** of suicide. Many experts share the view that it is unwise to teach young people explicitly about suicide. Instead, they recommend replacing suicidality issues with a positive approach to mental health (Malley, Kusk, Bogo, 1994). Whenever feasible, the best approach to school-based suicide prevention activities is teamwork involving teachers, family doctors and nurses, school psychologists/pedagogues, and social workers, working in close collaboration with community mental health services (mental health centres, psychiatric clinics/hospital wards).

Strengthening the mental health of teachers and other school staff is very important. For them, the workplace can be challenging and sometimes even violent. Therefore, they need informative material that improves their understanding of their own psychological burden, as well as the psychological burden of students, but also access to psychological support to alleviate stress at work (Smith, 1986).

Strengthening students' self-esteem protects children and adolescents from psychological problems and enables them to adequately cope with difficult and stressful life situations (Erikson, 1994). Various techniques can be used to strengthen the positive self-esteem of adolescents, such as:

- positive life experiences that will help create a positive identity and that increase the chances of young people for greater future self-confidence (Papenfuss et al., 1983),
- children and adolescents should not be constantly pressured to work harder and better,
- it is not enough for adults to say they love the child, the child must feel loved,
- children should not only be accepted, but also nurtured, as they are.

Empathy encourages autonomy and is important for building adolescent self-esteem and confidence. Self-esteem of adolescents depends on the development of their physical, social and professional skills (Weissman, Fox, Klerman, 1973). For high self-esteem, it is necessary for young people to ultimately establish independence from family and peers, to be able to connect with the opposite sex, to prepare for professional occupation and self-support and to establish a functional and meaningful philosophy of life. The introduction of life skills training, first through visiting experts, and later as part of the regular curriculum has proven to be an effective strategy. The educational system should also promote the development and consolidation of students' sense of identity.

It is important to establish a relationship of trust with adults. Children and adolescents should be taught to take their feelings seriously and encouraged to confide in their parents and other adults (teachers, school psychologists, doctors or nurses, friends, sports coaches, religious advisors).

Preventing bullying and peer violence at school is very important in order to create a safe environment.

Provision of information on support and treatment services should be ensured by publicizing telephone numbers, such as crisis hotlines (e.g. blue line) and telephone numbers of health services (family medicine, mental health centres, adolescent wards in psychiatric hospitals , non-governmental organisations) making them accessible to young people.

Preferred interventions when suicidal risk is identified

Recognizing a suicidal crisis and red flags:

- Suicidal statements in the narrow sense
- Previous suicide attempts
- Psychiatric diseases in the narrow sense (addiction problems, depression, psychotic disorders, eating disorders)
- Isolation
- Severe negative life events
- Early loss of parents
- Male sex
- Additionally, in children and young people: behavioural anomalies (poor grades, skipping school, running away), physical symptoms of unclear origin (sleep disorders, headache, lack of appetite, pronounced fatigue, etc.).

In most cases, young people at risk of suicidal behaviour have communication problems, which is why the first step in suicide prevention is **to establish dialogue and confidential communication**. Lack of communication results in silence, increased tension, and lack of dialogue, often due to the adult's fear of provoking the adolescent to commit suicide by discussing his suicidal thoughts. The existence of ambivalence can also result in avoidance of dialogue when unresolved emotional problems of adults who are in contact with suicidal children and adolescents can surface. Discomfort in adults is sometimes so great that the ultimate reaction to suicidal adolescents is verbal or non-verbal aggression. It is important to understand that the teacher should not be alone in this communication process, and learning how to achieve good communication is fundamental. Dialogue should be created and adapted to each situation and it implies, above all, recognition of children and adolescents and their

need for help. Adolescents at risk of suicide often lacked confidence in their relationships with their families and peers during their upbringing, which they experienced as an absence of interest, respect or even love. The hypersensitivity of the suicidal student is equally evident to verbal and non-verbal communication (body language). However, adults should not be discouraged by adolescents' anxiety or reluctance to talk to them, as avoidance is often a sign of distrust of adults. Suicidal adolescents also show marked ambivalence about whether to accept or refuse offered help, which affects the young person's behaviour and rapid changes from help-seeking to refusal, which can be misinterpreted by adults (WHO, 2000).

Training school staff through special courses and training to talk to each other and to students about life and death issues, improving their skills in recognizing anxiety, depression and suicidal behaviour and increasing their knowledge of available support are key tools for suicide prevention. School staff should know that early injuries during growing up, such as neglect and deprivation of a child, early losses and children without parents (war and expulsion), violence between parents, threats of death and suicide of parents, abuse and sexual abuse of children and "macrosocial fears" represent risk factors (WHO, 2000).

Important aspects for teachers

- observe,
- be available,
- listen,
- ask appropriate questions (Previous suicide attempts? Triggers? Emotional state? Reasoning ability? Alternatives?),
- help less skilled students with their school work,
- take care of absenteeism from classes,
- destigmatize mental illnesses and help eliminate alcohol and drug abuse,
- seek help from colleagues and other professionals.

Crisis intervention

- Accept suicidal behaviour as a red flag
- Try to understand the meaning and necessity of the crisis
- Create a conversational situation
- Building relationships
- Assessment of the situation
- Symptom relief
- Involvement of support persons
- Problem solving approach (Sonneck, 2000)

To be avoided:

- Too quick comfort
- "Warning"
- Generalisation
- Trivializing the problem
- Condemning and commenting
- Hearing, questioning, analysing
- Too fast activities ("activism")
-

Referral to mental health professionals, when risk is recognized, is of fundamental importance. Quick, authoritative and decisive intervention, active connection and referral of a young person to the health system (general practitioner, child psychiatrist or emergency room) can be life-saving. To be effective, health services for young people should be accessible, attractive and non-stigmatizing. Disturbed and/or suicidal students should be personally referred by the school staff, and received by a multidisciplinary team composed of doctors, nurses, psychologists, social workers and legal representatives whose task is to protect the rights of the child.

Restricting students' access to means of suicide (dangerous and lethal drugs, pesticides, firearms and other weapons, explosives, knives, etc.) in schools, parents' homes and elsewhere are very important life-saving measures. Since these measures alone are not sufficient, psychological support should be offered at the same time.

When suicide is attempted or committed, it is necessary to inform the school staff and students. Schools should have emergency plans on how to inform school staff as well as students and parents to prevent cluster suicides. The contagion effect results from the tendency of suicidal adolescents to identify with the destructive solutions they have adopted from students who have attempted or committed suicide (Centres for Disease Control, 1994). It is important to identify all potentially suicidal students, both in the same class and in other classes.

Summary: The future begins yesterday

- Early life experiences influence perception and behaviour
- Early traumatic experiences leave scars on personality development
- (Epi-)genetics shows that such experiences can make a person vulnerable to depressive reactions and suicidal behaviour

- • However, it also shows that resilience – and thus a successful life – is possible after all! (*Caspi et al., Science, 2003.)*

Messages to remember

- Thoughts about suicide are very common among young people, suicide attempts are common, and suicides are too common!
- The suicidal behaviour of an individual cannot be predicted with certainty. However, it is possible to spot the signals and take them as an opportunity to ask questions and help!
- Professionals must pay attention to the sudden changes that occur in a child, young person or young adult, in order to propose and implement useful interventions!
- **Suicide prevention is possible and works!**

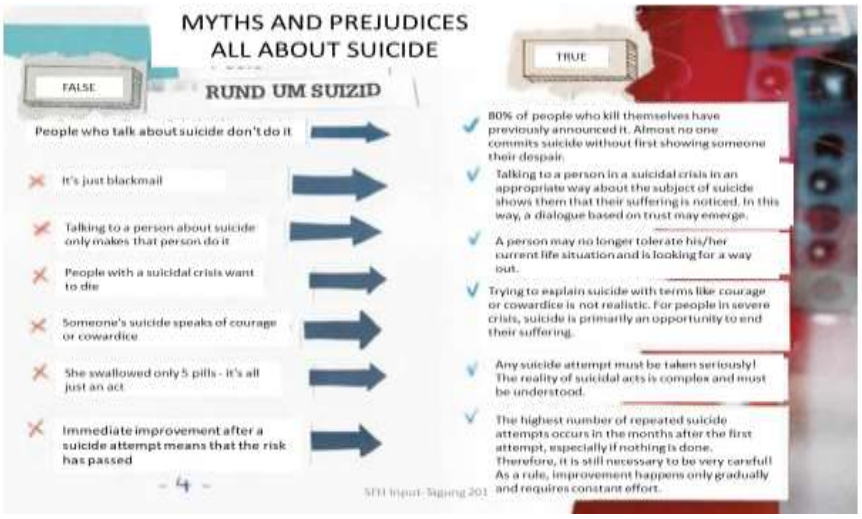

Figure 5. Myths and prejudices - All about suicide

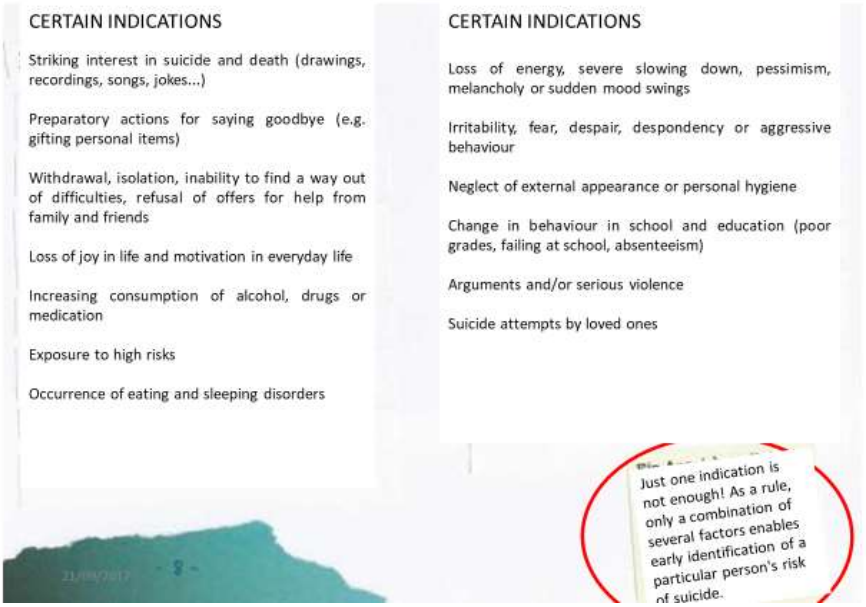

Figure 6. Certain indications for suicide

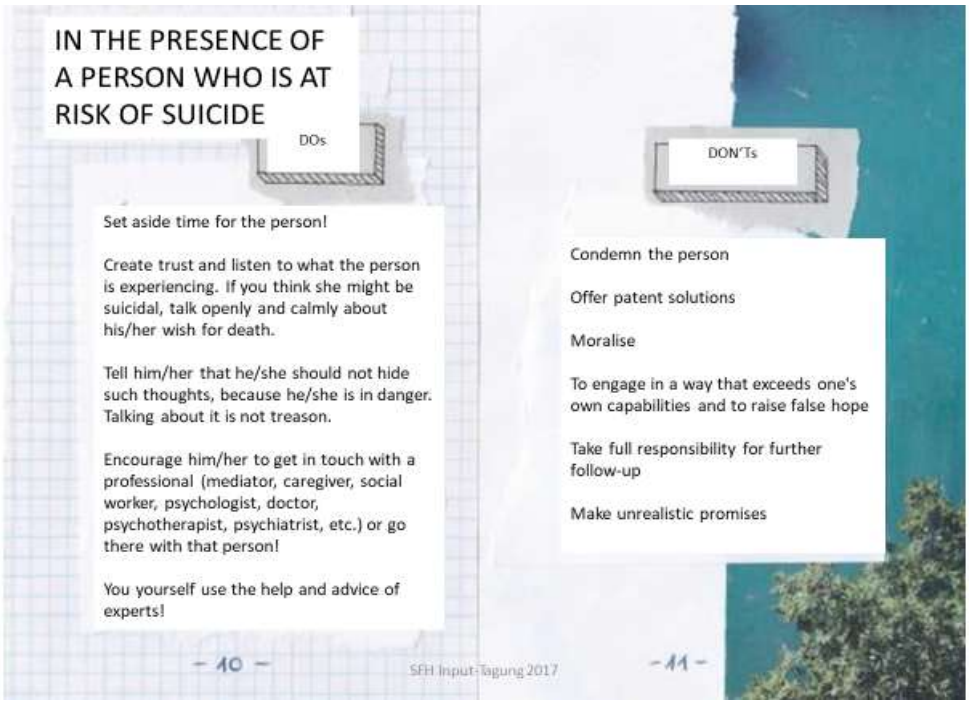

Figure 7. What to do in the presence of a person who is at risk of suicide

9. Instructions for Creating Programmes for This Age Group and Implementation Guidelines

9.1. Planning, implementation and evaluation of promotional and preventive programmes

9.1.1. Situation analysis - needs assessment, identification of key stakeholders and resources in the community

Before planning preventive programmes, it is necessary to make a **Situation analysis**, which includes a needs assessment, and identification of key stakeholders and resources. The situation analysis includes the analysis of demographic indicators and vital events, as well as the health characteristics of the population group for which we are planning an intervention. For this purpose, relevant information that can be obtained from statistical yearbooks, routine health statistics, epidemiological and other research is used. The assessment of the situation includes an overview of existing legislation, policies and strategies, legal mechanisms and management processes, and opportunities for potential partners. During the entire assessment process, it is necessary to record all the necessary data and information and include as many participants as possible for a better understanding of the situation (identify all stakeholders from the public, private and civil sectors, and analyse their goals, problems or needs in order to determine from whom we can expect support, who is against and who is neutral).

An assessment and identification of resources, i.e. existing advantages in the particular community (existence of non-governmental organisations, citizens' associations, self-help groups, landscaped surroundings with parks, etc.), is also to be carried out.

Stakeholders are all individuals, groups and organisations/institutions that influence the project and are affected by the project. These can be legal and natural persons and/or organised groups who are interested in the realisation and implementation of the project and who can influence the success of the process. Stakeholders can be actively engaged, i.e. all those who are directly involved in achieving the results and achieving the project's goals, and passively engaged, i.e. those who are affected by the project's results.

Prioritisation

It is necessary to ensure that the selected intervention is aimed at those population groups that really need it. In the process of determining priorities, it is necessary to take into account all the results of the previous analysis and give answers to several basic questions:

- What service/intervention is needed?
- Will the intervention or service that has been confirmed as effective meet the assessed needs?
- Is the intervention acceptable and appropriate for the public health system or the educational system?
- Is the intervention cost-effective?
- Is it ethically verified?

Defining objectives, strategy (choice of activities) and results of the programme

Objectives should reflect the adopted policy/strategy and accepted international standards. When setting objectives, it is necessary to clearly state the target population groups, geographic territory and locations that will be covered by the intervention and clearly quantify the expected improvements.

Overall objective defines the ultimate welfare and change to which we want to contribute, while the specific objectives represent a positive change in relation to the target group, i.e. the specific objectives of the programme that will be achieved in the course of the programme. Setting objectives is a very important process in planning and it is necessary to determine the criteria that such objectives should meet.

SMART objectives is an acronym for easier remembering the features of the objectives:
S – specific
M –measurable
A – acceptable / easily available
R – realistic, result-oriented
T – time bound and defined.

Strategy identification is performed by asking the question "What is needed to reach the set objective?" We use the references to find the most effective strategies up to that point and choose the best ones in terms of time, money, personnel, equipment.

Activities should be effective, but realistic and feasible for the given conditions.

Results are what we want to achieve, and activities are the way to achieve it.

Results represent concrete benefits, products and services as a consequence of successfully implemented activities. They should be measurable and realistically achievable, and they should all lead to the achievement of the objective.

Activity plan

The Activity Plan should contain an implementation plan and a timeframe:

- activities, what will be done?
- how will it be implemented/work methodology?
- who will work on the implementation: institutions, part of the institution, group, others?
- where will it be implemented?
- when will it be implemented - beginning, end, duration?
- how much does it cost - estimate, realisation?
- sustainability – how do we intend to achieve this?

Monitoring and Evaluation

Monitoring is the daily monitoring of activities during their implementation with the aim of checking whether the activities are carried out according to plan and on time. Monitoring identifies what is happening with activities without delving into the results of those activities. Some of the most appropriate monitoring tools and mechanisms are: field visits, project reports, reviews and analyses.

Evaluation is a systematic and objective evaluation of an ongoing or completed project, programme or policy and it aims to determine the relevance, effectiveness, efficiency and results of the project, programme or policy. It provides an answer to the question: What was expected, and what was achieved and to what degree?

Indicators and Logical Framework (Logframe)

Indicators are measuring tools used for monitoring the achievement of goals. Indicators should answer the questions: How will we know that we have achieved the goal?; What is it that will change?; How will we measure the change? Indicators should be clearly defined and focused on results and outcomes. They can be quantitative (expressed in numbers, percentages and rates) and qualitative. Properties of a well-defined indicator are: measurability, temporality, relevance and specificity.

Logframe is a goal-oriented approach to project planning and project management. It is a useful tool for planning, implementation, monitoring, evaluation and reporting. Where are we going?; How will we get there?; How will we know if we have arrived?; These are all questions that the logical framework as an analytical tool can answer.

Basic components of the logical framework:

1. inputs: resources intended for the programme or resources used by the programme,
2. activities: activities carried out by the programme in order to achieve the desired results/outcomes,
3. output: measurable product/results of programme activities,
4. outcome: benefits for clients, communities, systems or organisations - short-term, medium-term and long-term (impact),
5. external influences (assumptions and risks): various factors outside the system that influence its functioning.

Overcoming planning risks

Risk management is the process of identifying, assessing and responding to the occurrence of risks during programme implementation, monitoring and reporting. In every planning process, one should be aware of the possibility of risk. A risk is an event, condition or situation that, if it occurs, has a negative effect on the objectives of the programme. The types of risks that can occur during the entire project cycle are: financial risk, legal risk (e.g. changes in legislation), political risk (changes in management, organisational changes, strategies and policies), physical risk (natural disasters, fires, accidents), technical risk (IT security, infrastructure, software), security risk (facilities, documentation) and unspecified and other risks (human resources, knowledge, skills, interpersonal relations, etc.).

Planning risks can be overcome by creating a **risk management plan** that is to be developed within the programme planning process. The risk management plan is an integral part of the programme documentation, and is updated as necessary during the implementation. The entire project team and key stakeholders must be involved in risk identification process, and it implies the evaluation of factors from the environment, organisational, cultural and other specificities, i.e. all elements of the programme plan in its full scope. Special attention is paid to programme deliverables, assumptions, constraints, cost estimates, resource plan and other key programme documents. This is followed by the quantitative and qualitative risk analysis in terms of probability and the impact it can have on the programme, ranking it as low, medium or high risk.

The risk response strategy can be: identification of triggers/warning signals and the threshold for the occurrence of risk in order to avoid the risk through careful monitoring: risk mitigation

measures; changes to the activity plan to avoid risk: and finally conscious acceptance of risk, if it is beyond the control of the project team.

9.2 Guidelines and Instructions for Developing Programmes in the European Economies

During the WHO European Ministerial Conference dedicated to mental health in 2005, it was recognized that, in addition to treatment and rehabilitation, the promotion of mental health and prevention of mental disorders are a priority for member countries. Despite the increasingly present recognition of the importance of promotion and prevention at the political and declarative level, the situation is different when it comes to "putting words into action". In addition to the insufficient financing of mental health (which includes the financing of promotional and preventive activities) in many economies, mental health professionals often give promotional and preventive activities a lower priority in their work. Considering that the promotion and prevention of mental health implies a multisectoral approach, cooperation and coordinated work of a large number of interested parties, who come from different sectors, represent another challenge. In addition to challenges and areas that need to be developed, there are also numerous examples of good practices in many European economies. Programmes dedicated to the elimination of stigma and discrimination and consequent social exclusion, suicide prevention, prevention of psychoactive substance abuse (PAS) and other similar programmes are part of action plans for mental health and are implemented in numerous European economies.

Various sectors are involved in the implementation of these activities, such as health, social, educational, judicial, police, etc. The growing awareness of the significance of implementing policies to combat poverty and social inclusion as relevant for the prevention of mental disorders and the promotion of mental health is of great importance (Jane-Llopis & Anderson, 2006).

9.2.1 WHO Actions and Recommendations for Improving the Mental Health of Children, Adolescents and Young People (WHO/EURO, 2022)

The Pan-European Mental Health Coalition is a flagship initiative of the WHO Regional Office for Europe launched in September 2021 in response to requests to address the mental health challenges and disparities faced by communities across the WHO European Region, particularly in the wake of the COVID-19 pandemic. The Coalition functions as the operationalizing instrument of the **European Framework for Action on Mental Health (2021-**

2025) (EFAMH). The EFAMH offers a structure for the planning, implementation and tracking of mental health services, programmes and policies throughout the European Region by laying out the needs and objectives that, if met, would position mental health as a crucial facet of a healthy society. Coalition work is organised around six priority working packages, the completion of which corresponds to the successful implementation of the EFAMH.
One of the work packages includes the **mental health and well-being of children, adolescents and young people**.

Welfare and well-being of young people

Challenges

- COVID has impacted mental health and well-being of many young people, particularly in the areas of schooling, employment, and social connectedness, while also promoting significant anxiety/fear.
- Many countries lack policy that targets child and adolescent mental health and well-being.
- Investments have been made in poorly evidenced health promotion programmes, while well-evidenced programmes are not necessarily implemented or scaled.
- There is a lack of high-quality, culturally specific mental health data on youth mental health outcomes and interventions to support their mental health.
- Some economies show a disconnect between young people's awareness and desire for support and their ability to access support.
- Young people are not being meaningfully or consistently involved in decision-making that impacts their mental health and wellbeing.
- School staff are not trained or supported to deliver mental health promotion, prevention or literacy-promoting activities in schools.
- There are considerable inequities in mental health outcomes for youth, such as those not in education or employment; who have a developmental, intellectual or physical disability; or who have limited family support.

Goals

- Meaningfully engage young people in decision making that impacts their mental health and support countries/organisations that do this.

- Build capacity in schools to promote and protect the mental health of young people, supported by evidence-based interventions, practice guidance, training, curriculum development, monitoring/evaluation tools, and implementation infrastructure/support
- Extend promotion and prevention activities beyond schools by strengthening capacity in established community settings for youth (e.g. arts, sporting organisations), ensuring that the most vulnerable young people are not left out through knowledge generation that is culturally relevant and implementing in settings that reach vulnerable groups.
- Promote capacity of adults and families in supporting their own mental health to support that of their young people.

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Actions for consideration

- Develop indicators for youth mental health and well-being that can be used/ adapted across different settings.
- Develop standards/guidelines for teacher training, curriculums for pre-service training in mental health promotion, prevention, and literacy.
- Create a repository of good practices, evidence-based interventions for improved knowledge translation.
- Build capacity for young people, clinicians, and organisations to advocate for youth mental health policy.
- Raise awareness of the costs of poor mental health for young people and the co-benefits across sectors of addressing the structural drivers of poor mental health and well-being of youth.
- Conduct an investment case for mental health programme and system funding.

Quality of care for children, adolescents and young people

Challenges

- There is a lack of investment in qualified staff to provide mental health care for young people.
- Parents and children struggle to navigate the mental health care system, contending with high wait times due to increasing demand (particularly in primary care), services that are not tailored to young people, and a lack of access to integrated services.
- Treatment is often not effective enough, even when accessed.

- There are numerous barriers to seeking and accessing quality care for young people and their families, including stigma and the cost of accessing training and resources for evidence-based, manualized programmes and assessment tools.
- There is a lack of continuity of care for young people moving from childhood into adolescence. Similarly, maternal health is dealt with separately from infant, child and adolescent mental health.
- Children and adolescents with chronic physical conditions, intellectual, neurological and developmental disabilities and other comorbidities are excluded from care.
- Economies lack an essential drug list for child and adolescent mental health, and there is a lack of pharmaceutical studies for children and adolescents, which limits appropriate prescription.
- There is an overuse of screening tools in some contexts, especially in school settings, and school psychologists being underutilized in delivering psychological interventions. Screening at the expense of intervention uses up limited resources and creates further demands that cannot be satisfied.
- Inconsistencies in psychology training exist across the region (e.g. content, timing, registration requirements).
- The concept of “self-care” and the way it is communicated especially via social media is considered problematic and simplistic, placing the responsibility on individuals to improve their mental health.

Goals

- Increase investment in the mental health workforce, community- and school-based care, support for free or low-cost access to evidence-based treatments and tools.
- Expand access to integrated, accessible “one-stop shop”-style mental health services for young people and their families, based on a transdisciplinary approach and appropriate diagnostic classification systems for children and adolescents. These services should be acceptable and accessible for all young people, especially the most vulnerable, addressing cultural and linguistic diversity, refugee and migrant youth and young people with co-morbidities.
- Ensure affordable/low-cost treatment for children, adolescents and young people, including those with intellectual and developmental disability.
- Ensure that young people are supported through key transitions including out of the education system and through child, adolescent and adult service systems.

Actions for consideration

- Develop guidance on the implementation and available options for interventions and programming dependent on context.
- Conduct monitoring and evaluation of programmes and services to inform service planning and improvement.
- Engage young people and youth representatives in all aspects of the development of this working package, including in the creation of a communication and media strategy.
- Draft a regional blueprint for how child, adolescent and youth services should be organised and provided based on context, population, workforce and resources.
- Build a repository of good practice and service models across the European region.
- Draft a situation analysis tool to collect relevant data for sharing and identifying gaps in service availability, accessibility, quality and workforce.

9.2.2 Examples of Preventive Policies and Programmes in the European Economies:

9.2.2.1 Programmes for School Children

Children spend a lot of time in schools, and that is why schools are ideal places to influence the behaviour, mental health and development of children and adolescents. There are initiatives to implement a holistic school approach, such as the programme in Bulgaria, where "teachers are sensitized to children's emotional health issues, as well as initiatives in the school and environment that eliminate hostile and potentially traumatic experiences, as well as counselling programmes for children with specific phobias and similar problems for their parents as well." Similar programmes are implemented in many other economies. Programmes that promote healthy schools are also active in promoting mental health, e.g. "The Austrian network of health-promoting schools aims to promote the somato-psycho-social health of pupils and students, teachers and parents and gathers 120 schools. Health centres provide a lot of information, guides and programmes covering a variety of topics, including those related to mental health." In Ireland, programmes that include emotional health are a compulsory part of the school curriculum, after primary school. Programmes for the prevention of peer violence and abuse in schools are present in many economies. In many French schools, an adapted American programme to reduce violence in schools is being applied with great success. An evaluation of the "Olweus bullying prevention program" in Norway showed a 42% reduction in self-reported victimisation of school bullying and a 55% reduction in violence against others. In some other economies, such as Malta, the promotion of mental

health is integrated into school curricula and "all children aged 11 to 15 have a minimum of 1 hour per week dedicated to personal social development, where they are empowered to build the skills needed to be responsible members of society, to successfully integrate into peer groups and face everyday stressful life situations." In some economies, there are programmes for the early detection of mental problems in schools (e.g. for eating disorders, anxiety disorders, depression and abuse of psychoactive substances). In Luxembourg, educational courses for teachers and staff were introduced in schools to increase awareness of mental health problems in schools, drug abuse prevention, suicide prevention and early recognition of mental health problems.

9.2.2.2 Depression, Anxiety and Suicide Prevention Programmes

Depression is the second leading cause of disability in the European Union, and the prevalence of anxiety disorders is also very high. Depression increases the risk of suicide, which in Europe is a greater cause of death than traffic accidents, murder or HIV/AIDS. Half of the European countries have policies and programmes to prevent depression, anxiety disorders and suicide. For example, in Bulgaria, suicide prevention includes "the capacity to assess suicidal behaviour by specialists and family doctors, public awareness and the link between mental illness and suicide." Hotlines for people in crisis are present in seven countries, e.g. in Sweden, where they provide support to people in suicidal crises, or in Belgium, where there is electronic help for family doctors, through an info phone and an interactive curriculum for suicide prevention, with the aim of promoting their expertise in depression and suicide prevention. In many economies, such as Norway, there are initiatives aimed at limiting access to means of suicide, such as guns, drugs and poisons. A combination of several activities seems to have contributed to the reduction of suicides, such as those undertaken in Norway, Denmark and Finland. For example, Denmark has reduced its suicide rate by 60% over the past 25 years, probably thanks to a combination of several policies and programmes, including reducing access to suicide attempt resources, better health and psychiatric treatment after suicide attempts, increased social and cultural stability in society, a greater focus on general prevention, increased access to telephone counselling and psychiatric emergency services.

9.2.2.3 Programmes to Combat Poverty and Social Exclusion

Poverty is a major risk factor for mental disorders leading to depression and associated mental health problems. Poverty also leads to social exclusion, as well as mental disorders. Almost two-thirds of economies have comprehensive policies and programmes to reduce

poverty and social exclusion. Reducing economic difficulties by implementing measures such as supporting families at risk and the homeless or developing a general action plan against poverty, such as in Latvia.

9.3 Programmes in Different Environments

Depending on the place where they take place, the programmes can be divided into several categories: home, school, workplace, primary care/family medicine, psychiatric hospitals and clinics, institutions for the elderly, clubs, churches, recreation centres, etc., programmes on the Internet (Jane-Llopis & Anderson, 2006).

The messages sent by the media are of particular importance because they can have a great influence on the attitudes and behaviour of the population. "It is necessary to implement media campaigns aimed at positive changes in the community's attitudes about mental health and mental disorders and to increase the basic knowledge of the media about mental health beforehand. In any case, the media should be used as one of the components of a multi-strategic approach to achieve changes in the attitudes and behaviour of the population" (Mental Health Development Strategy of Republic of Srpska (2009-2015).

In the Canton of Fribourg, Switzerland, the main preventive activities are focused on programmes such as healthy eating, the importance of physical activities (outdoors), tobacco addiction and programmes for children and adolescents. Promotion and prevention programmes are mainly financed from the federal budget, which is distributed to the cantons that implement the programmes. Programmes are implemented in cooperation with cantonal organisations that have a mandate to implement the program. The cantons draw up their cantonal plans for health prevention, not specifically for mental health, which is valid for all segments of prevention. They are formulated as principles rather than programmes. The federal fund receives, for example, funds from the tobacco industry and these funds are directed to sports projects at the cantonal level, and the canton should also invest part of its funds.

9.3.1. Prevention in the family environment

Preventive interventions in the family environment can be classified according to participating members and parts of family interventions that are more difficult to change.

Interventions for parents are aimed exclusively at changing specific parenting practices such as disciplining children or effective communication and may involve only parents. Interventions for the development of family skills are usually broader in scope and include educating parents to improve and strengthen parenting skills, educating children in personal or social skills, as well as directly teaching and practising skills together with families. Here, the emphasis is not exclusively on the area of parenting, but the intervention also focuses on how parents and children influence each other and how they function together as a family.

Parenting skills development programs are sometimes implemented in the same community in combination with other interventions as part of a broader, more comprehensive prevention strategy (for example with school-based interventions). Such strategies are often applied in society due to many different micro and macro factors that influence the use of addictive substances among young people. Some evidence suggests that such a combination of approaches is effective in reducing substance use within the population.

Some interventions are intensive, such as family therapy that changes early problematic behaviours so that they do not escalate into substance use and more serious behavioural problems. There are various signs that the family may benefit from such an intervention. Sometimes they are reflected in aspects of family life, such as violence, and sometimes in the behaviour of young people outside the family environment, for example in school or in the community. Intensive family interventions, such as family therapy for youth who have already begun to show certain difficulties, can also have a significant impact on childhood and adolescence.

Depending on the age of the children in the family, the patterns of family interactions and parenting strategies also differ. Therefore, interventions for families with children of different ages will need to include teaching about different parenting and family processes. Outcomes of family programs are also linked to developmental stages. Outcomes associated with earlier stages relate to health, well-being and prosocial behaviour. In childhood and adolescence, an additional visible effect will be the reduction or prevention of problematic behaviour such as the use of addictive substances. Figure 8 shows effective strategies (black), goals (red) and positive outcomes (blue) of interventions implemented from birth to adolescence. The theory underlying interventions in the family environment claims that influencing family processes, such as parenting, will positively influence healthy behaviour in young people and prevent the development of behavioural difficulties. The family exerts one of the most important micro-influences on the development of an individual's personal characteristics, which can ultimately lead to disorders and the use of addictive substances. The family is an important context for

development and if the family is not functioning well, children are more likely to have difficulties.

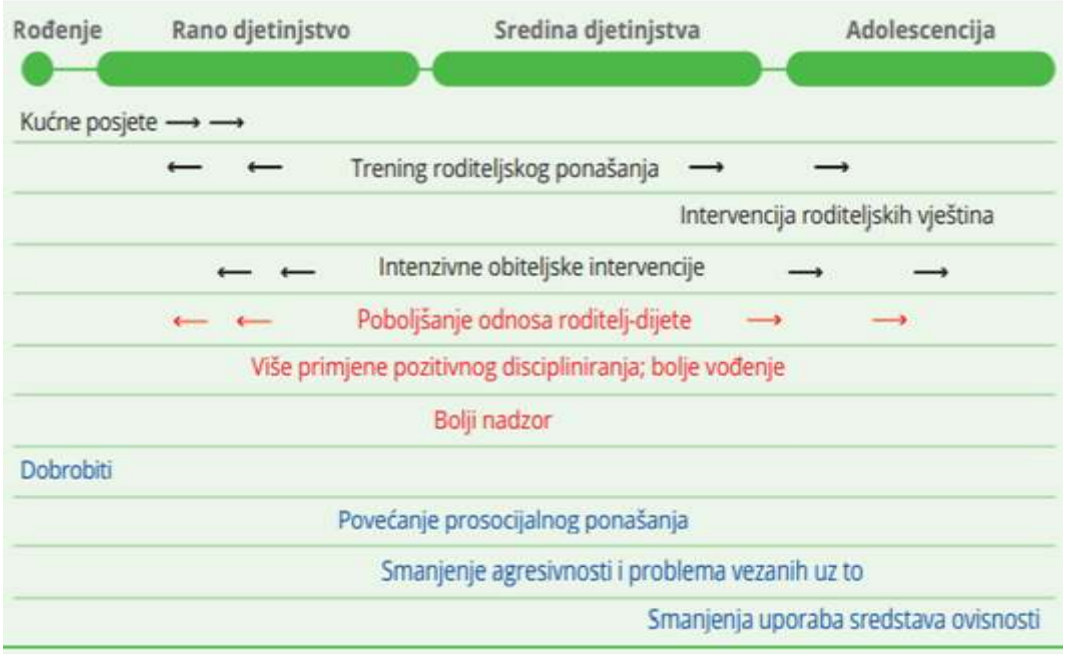

Figure 8. Preventive interventions in families according to developmental stages

Some of the most important family factors affecting children and youth development are listed below.

- Good relationship between parents and children.
- Effective behaviour management strategies.
- Communicating values promoted by the family.
- Involvement in children's lives.

The programmes intended for our age group, which have shown effects in solving family relationships, are:

EFEKT is an intervention that the Xchange registry rates as "useful". It is a universal preventive intervention for young people between 13 and 16 years of age. Its goal is to prevent the use of alcohol among adolescents by changing the attitudes of their parents. Parents are encouraged to communicate zero tolerance for alcohol. Information is given to parents at parent meetings at the beginning of each semester and through regular letters sent to them throughout the school year. Parents are also sent catalogues with information about activities organised in the community, so that their children can get involved in them and spend their free time constructively.

Functional Family Therapy is an indicated preventive intervention for young people at risk, aged 11 to 18. In the Xchange registry, it is rated as "probably useful". The programme aims to reduce involvement in crime or delinquency with the aim of preventing the use of addictive substances and maintaining good relations between participants and parents. The target change in the area of parenting skills, youth cooperation and comprehensive behaviour (cognitive, emotional and behavioural) is based on the prepared profiles of specific risk and protective factors of each family.

Triple P – the positive parenting programme is a preventive strategy focused on parenting and family support, designed to prevent more severe behavioural problems, emotional problems and developmental difficulties in children, by strengthening the knowledge, skills and confidence of parents. The Triple P intervention has not yet been included in the Xchange, but the Blueprints registry rates it as "promising". Although there are several versions of the program, five key principles of positive parenting form the foundation of the programme and refer to specific risk and protective factors known to predict positive developmental and mental health outcomes in children. Those key principles are: (1) ensuring a safe and supportive environment; (2) creating a positive learning environment; (3) application of assertive discipline; (4) realistic expectations; and (5) parent self-care.

9.3.2. Prevention in school environment

The two main environments for prevention of substance abuse for children and adolescents are family and school. Indeed, many children spend more time in school environment than with both parents, or parents in general. The advantage of schools is the opportunity to implement intervention with all children (as universal population) and not only with those falling in risk groups (selective population) or vulnerable individuals (indicated population). All children may benefit from universal interventions in schools since all are exposed to some level of risk. Furthermore, messages we deliver to all youth in the school may be accepted without stigma as the interventions do not rely on identification and possible singling out of youth that have already started consuming addictive substances. In addition, isolating high risk young persons into a closed group (Poulin, 2001) has proven to increase their risky behaviour. Schools differ by size and system, however almost in all economies schools are tasked to prepare children and youth to become fully integrated members of their family, work environment and society in general. However, schools and education accomplish much more than that. By analysing data from education systems and economic indicators, World Bank's 2007 Policy Report (Hanushek and Wößmann, 2007) determined that "There is

strong evidence that the cognitive skills – rather than mere school attainment – are powerfully related to individual earnings, to the distribution of income, and to economic growth.

Cognitive skills are described as student's ability to:

- privately reflect, solve problems in reasonable and thoughtful way, either individually or in cooperation with others;
- reflect, conceptualise and solve problems using unknown information or new procedures;
- conclude and find solutions by analysing relations amongst the given problems, issues or conditions.

Like family, school is one of the micro environments and a key institution that shapes children's development and their pro-social attitudes and behaviours. There are many and complex interactions amongst biological, personal, social and environmental characteristics impacting human behaviour. Those interactions shape values, beliefs, attitudes and behaviours of children and youth, and are of particular importance for physical, emotional and social environment, both from childhood to adolescence and from adolescence to adulthood. School may impact the way in which children and youth perceive acceptability and unacceptability of different positive and negative behaviours. Hence, interventions in school environment may impact individual vulnerability to the risk of occurrence of specific behaviours, in particular use of drugs. Preventive interventions implemented in school environment may be of interest to universities or higher education institutions. Students are often at risk of substance abuse. At that age they move from their home to an environment with greater independence and are expected to control a number of behaviours related to health and social relations. In addition, certain substance are more accessible, and a culture which supports use of drugs may prevail in student organisations and at parties. Though it is in particular important to create and maintain the positive school environment, schools also have an important role in prevention of substance abuse in at least three additional areas:

- behavioural approaches – this means prevention or at least postponement of the use of drugs by young people by attempting to develop values, standards, beliefs and attitudes against the use of drugs and education to efficiently resist peers inciting the use of drugs;
- environmental preventive interventions – this means to develop and consistently implement sound and clear policies regarding the use and sale of all addictive substances, including alcohol and tobacco in the area around schools and at school events;

- reducing adverse effects related to substance abuse – schools may treat the students using drugs with sensitivity and compassion and refer to counselling and support services (and if a treatment is needed) and thus help them reduce or stop using drugs. Surveys of preventive interventions in school environment determined their successfulness in improving school success and preventing early school leaving (Gaspar, 2011) – and these are the main two academic goals. Therefore, prevention coordinators must be able to provide arguments that it is in the best interest of the school and its students to find time for implementation of substance abuse prevention.

Programmes in school environment provide opportunity to cover a large number of young people in one place during the period of their intensive cognitive, emotional and social development, and schools are places where social networks are being developed, including models that impact the behaviour through integration with their peers and grownups as models (teachers, professors, pedagogues, etc.). Development of physical and mental health of youth leads to improvement of study habits, academic success and long-term responsible attitude towards work. Well-organised programmes in schools may lead to prevention of risky behaviour, development of academic achievements and reduction of unemployment and subsequent tendency to antisocial behaviour. Education and conversation with young people, teaching and non-teaching staff may provide significant information regarding the issues and problems at school level, including guidelines regarding development of promotional and preventive activities. Thus far experience as regards systematic approach to development of health and mental wellbeing in school environment single out the need for implementation of programmes aimed at improving health and wellbeing of youth based on identified school environment needs and through close cooperation with teachers and non-teaching staff. These programmes are a step from individual approach towards development of adjusted school programmes focused on the needs of young people in school environment. The World Health Organisation (WHO) approach is focused on **development of healthy schools** that continuously strive to strengthen capacities and conditions aimed at health lifestyle and improvement of health. This approach includes: improvement of school programmes and environment, and active engagement of family and entire community. Numerous surveys determined that traditional approaches to prevention and promotion at school, focused only on education, are of limited reach and that systemic programmes with long-term effects should include a wider community and parents, and be focused on **development of healthy school environment and healthy lifestyles**. School programmes should be focused on development of life skills and safe environment which will contribute to positive development and a feeling of being more connected with the family, school staff and local community institutions. Many mental health programmes focused on development of **academic, social and emotional**

skills have a significant impact on the reduction of the number of children leaving school, including reduction of risky forms of behaviour.

According to their main approach, the aim of promotional and preventive programmes in school environment may be:

1. training in social skills – studying and acquiring life and social skills through adjusted plans and programmes,
2. overall school environment; i.e. holistic approach to development of a healthy and positive environment focused on the overall school environment, working with parents and community towards development and improvement of stimulating school environment,
3. selective prevention programmes – interventions amongst the groups of young people of higher risks, strengthening their life skills and reducing the risks of development of mental disorders or suicide.

Training focused on **developing social skills** is designed to provide opportunity to young people to acquire new models of behaviour which can improve communication, assertiveness, develop resilience to negative impact of peers, enable establishing social relations successfully, etc. Though large number of similar programmes also focused on reducing substance abuse, the mentioned approaches are used when developing social skills which encourage self-confidence, resilience and promotion of protective factors positively impacting the health. The approach to education which is based only on passive lectures will not lead to long-term effects; hence it is necessary to work on developing practical workshops with interactive exercises which will facilitate development and acquiring social skills with the aim of improving healthy lifestyles and better social and emotional relations.

Training in social skills is based on structured and organised approach to learning, and the major portion of this training is focused on developing behavioural components that serve the individual to acquire skills important for their successful independent and social functioning. The main mechanisms used in the process of social skill training are identification of problems, setting the goals, role playing, positive and negative feedback, model learning, exercising, homework, etc.

Likewise, primary prevention programmes in school environment may include activities inspired by cognitivist and humanistic approach which combine **resolving life crises while at the same time developing individual capacity and skills** in order to change the relations towards oneself and others.

Life skills programme, developed by Hopson and Scally (1981), is based on a presumption that life skills may be learnt and that during the process the person develops their self-consciousness and accepts responsibility for themselves and their life. The programme focused on learning life skills is primarily designed for young people and students. The most appropriate place for its implementation is school environment while employing workshop-based techniques (drama club, discussion group, and the like). This promotional and preventive work model is based on a specific approach where through personal experience people develop and discover their strengths and learn how to better live and better live for themselves and for others, at the same time developing life values that prefer changes, freedom, responsibility and non-stereotype assessment of life opportunities.

Among the main skills needed for life the following are singled out:

1. skills needed for development and wellbeing - ME,
2. skills needed for successful communication with others – ME and YOU, ME and OTHERS
3. skills needed in the community or in other life situations – ME and COMMUNITY, SPECIFIC SITUATIONS.

The main life skills according to the above mentioned segments defined by Hopson and Scally (according to Thones and Green, 2004 Health Promotion: Planning and Strategies. London: Sage Publications. p. 237):

- ME: reading and writing; how to find information; constructively reflecting about the problems and solving them; positive attitude towards oneself; how to set one's goals and priorities; how to make effective decisions.
- ME and YOU: constructive communication; resolving conflicts; establishing and developing relations; how to give and receive.
- ME and OTHERS: assertiveness; how to support others: how to cooperate within a group; constructively expressing feelings, etc.
- ME and COMMUNITY, SPECIFIC SITUATIONS: skills needed for education; skills needed for work; skills needed for home; skills needed in free time; skills needed in community (e.g. how to develop and present one's political beliefs).

The approach which targets the entire school goes beyond individual programme and is focused on a wider school environment, organisational structure and local community. Wider environmental approach enables participation of students, school staff, school management, parents and wider community with the aim of connecting then and creating better relations

between students and school staff. The mentioned programs are focused on school ambience, values, rules and action plans, for example, issue of violence, conflict resolving and issue of diversity of students in a school. The overall objective of the school approach is development of partnership with parents, community and institutions which are linked to the school in order to provide and ensure availability of systemic services to students, if there is a need for support.

The main characteristics of the programmes focused on development of healthy schools address four main areas including: improvement of health in immediate surrounding, promoting health of students and school staff, improvement of relations in the school and between the school and community.

- **Promoting health in immediate surrounding** refers to improving and developing an environment which is encouraging and healthy for learning, life and work, including physical (play area, lighting, heating, ventilation, water supply) and organizational (management, safety measures).
- **Promoting health of students** is achieved through support to teachers to spend more time on topics of relevance to healthy lifestyle through a holistic approach and using appropriate learning techniques. Topics most often proposed include: health as a positive concept, health of social environment, first aid and self-help, relations between people and genders, sexual health and unwanted pregnancy, HIV and other sexually transmitted diseases, mental health, exercise and physical health, and consumer education. It is also very important to use appropriate learning techniques which will enable active involvement of youth in the process of acquiring knowledge through role playing, discussions in small groups, case studies, team work and community actions. One of the important goals of healthy schools in to enable young people to solve problems in their life circumstances and be active in the society.
- **Promoting healthy school staff** is an important component which enables development of healthier working conditions, specialised services and programmes aimed at improving physical, physiological and social potential of the teaching staff.
- **Improving relations in the school and between the school and community** is implemented by strengthening cooperation amongst all members of school community (students, teachers, parents, administrations, etc.) and encouraging cooperation between the school and community as a whole.

According to the results of several evaluations from different European economies, the scientifically-based preventive intervention programmes presented below had promising outcomes. Selection of these programmes is based on the scores of the Register of European

Monitoring Centre for Drugs and Drug Addiction – Xchange. They are provided as an inspiration for further search of interventions appropriate to your context.

Unplugged programme (implemented in Croatia under the name “Imam stav”) is a school-based prevention programme that incorporates components focusing on developing critical thinking, decision-making, problem solving, creative thinking, effective communication, interpersonal relationship skills, self-awareness, empathy, coping with emotions and stress, normative beliefs, and knowledge about the harmful health effects of drugs. The curriculum consists of 12 one-hour educational units taught once a week by teachers who have previously attended a 2.5-day training course, Xchange register rates Unplugged as successful, which means it will probably be effective in different contexts.

The Good Behaviour Game (GBG) is a classroom-based behaviour management strategy for primary schools that teachers use along with the standard curriculum. GBG has been rated as “probably useful” in Xchange register which means that though there are survey findings confirming its effectiveness, additional surveys need to be carried out in Europe to be certain of this. This approach includes the entire class, teams and rewards to socialise children to the role of student and reduce aggressive ad disruptive behaviour in classroom, which is a risk factor of adolescent and adult drug abuse, including antisocial, violent and criminal behaviour. In GBG classrooms, the teacher assigns all children to teams that are balanced with regard to gender; aggressive, disruptive behaviour; and shy, socially isolated behaviour. Basic rules of behaviour are displayed visibly and reviewed. When GBG is played, each team is rewarded if team members commit a total of four or fewer infractions of the classroom rules during a game period. During the first weeks of the intervention, GBG is played three times a week for 10 minutes each time, during periods of the day when the classroom environment is less structured and the students are working independently of the teacher. Game periods are increased in length and frequency at regular intervals; by mid-year, the game may be played every day. Initially, the teacher announces the start of a game period and gives rewards at the conclusion of the game. Later, the teacher defers rewards until the end of the school day or week. Over time, GBG is played at different times of the day, during different activities and in different locations; the game evolves from being highly predictable in timing and occurrence with immediate reinforcement to being unpredictable with delayed reinforcement, so that children learn that good behaviour is expected at all times and in all places.

KiVa is a programme against bullying, with encouraging scores from Finland, and is being implemented in Estonia too. This programme targets school-age children aged 5 to 11 years and uses universal and indicated strategies. It strives to increase prosocial behaviour and emotional wellbeing of children. KiVa programme has not been included in Xchange register

yet; however, Blueprints register rates it as “promising”, meaning that high-quality research has confirmed its effectiveness.

Miroljubivi Partneri **(Peaceful Partners) programme to prevent bulling** was implemented as part of the first phase of Mental Health in Bosnia and Herzegovina project (PMZ Bosnia and Herzegovina, 2010-2014) and was based on social and emotional approach to help students learn skills of conflict resolution, cooperate mutually, prevent verbal and physical violence, and respect differences and integration of different social groups (ethnical, religious, cultural, socio-economic). The programme offered young people an opportunity to recognise if they are victims of bulling and whether they know if their rights have been at risk, creating a baseline for providing specific assistance to bullied children. The programme is designed to prevent stigmatisation of bullied children. Students, as direct programme beneficiaries, were active and creative during the project implementation, while teachers noticed that students quickly started applying the acquired knowledge in their spontaneous mutual communication.

Škola za Život **(School for Life) preventive programme** is targeting secondary school students to provide support to adolescent development. The programme has been implemented at 2 levels, extensive and intensive. The comprehensive plan included all students of the school while intensive plan included smaller group of students that met once a week. As part of the extensive approach at the school level, a billboard was placed with its contents changing on monthly basis, usually in a form of a comic. The students responded to the contents/billboard topics with letters which they placed in a special box, discussions in a smaller group or drawings/graphical representation of the contents of a specific topic. During the school year, different topics were featured on the billboard, including love, friendship, tolerance, relations with parents, etc. Two types of messages were communicated via P.A. during the lunch break: ‘school for life’ messages and ‘messages to school for life’. These messages become a type of communication amongst the students who in such a way responded to the billboard contents, shared their experiences from the small group discussions and sent messages to one another. During the week, small group of students would meet to discuss the topic presented on the billboard for the given month. The work within the group was implemented based on the principles of psychotherapy. Selective programmes targeted students and groups of young people at greater risk, whether it being life circumstances or greater exposure to stress. The programmes often target children at risk and are organised through cooperation of school staff, health workers and parents to implement activities that will ultimately contribute to development of problem-solving or cognitive skills that enable prevention of anxiety, depression or suicide amongst young people. Though many risk factors may contribute to development of mental disorders, there are also

many potential protective factors that may be supported through targeted activities. The mentioned factors may include individual potential of a child, their relations with parents, family, peers and other social support networks. The assessment of children's needs should provide a basis to define difficulties which should be addressed, including positive aspects that need to be strengthened.

10. Overview of existing preventive programmes focused on this age group in Bosnia and Herzegovina, implementation experiences and lessons learned

The table below provides examples of preventive programmes implemented by key partners and focused on adolescents which were piloted and/or implemented over the past decade in Bosnia and Herzegovina.

The overview provides the programme's main determinants: targeted population, authors, evaluation results and lessons learned, and examples of best practice.

The objective of this overview of thus far successfully implemented programmes in Bosnia and Herzegovina is to make them available to all stakeholders in Bosnia and Herzegovina and the region for the purpose of promotion of continuous preventive activities with young people and replication of quality programmes in the coming years.

Table 1: Overview of successfully implemented promotional and preventive programmes in Bosnia and Herzegovina for young people aged 14 to 18 years

Programme Title	Implementation Timeline	Implementation Locations	Programme Target Groups	Authors (institutions, NGO and individuals)	Programme evaluation results	Lessons Learned
Inicijativa Mladića **(Young Men Initiative – YMI): Promoting Healthier Lifestyles and Decrease of Interpersonal Violence amongst Youth in Bosnia and Herzegovina by Challenging Gender Stereotypes III**	2014-2023	Bosnia and Herzegovina (Sarajevo, Mostar, Banja Luka) and other cities in Bosnia and Herzegovina in cooperation with youth organisations	Youth Teachers and school staff	IPD in partnership with CARE Balkans and Youth Power Mostar and Perpetum Mobile Banja Luka. Supported by Swiss Government and CARE Germany, Austrian Development Agency and	Effects of education under the Programme Y methodology and Be a Man Club activity: 1. Changes in attitude towards violence and adoption of attitudes leading to lower tolerance towards various forms of violence 2. Reducing the occurrence of physical violence 3. Reducing the occurrence of digital violence 4. Reducing the occurrence of sexual violence 5. Increasing the level of gender equitable attitudes	1. Program Y is a science-based educational curriculum tailored to the specific needs of young people that enables young people to cope independently and with adequate skills with the challenges of growing up, making decisions that are of best

				Oak Foundation from Switzerland.	6. Increased percentage of young people who would stop violence they are witnessing 7. A larger number of young people who would seek help 8. Increased knowledge about violence, health and healthy lifestyles More information available at: https://youngmeninitiative.net/bs/resursi/	interest to their health. 2. Quality education according to the Programme Y methodology, if implemented with systemic support and in a supportive environment, can lead to a change in attitudes and behaviours of young people, motivate them to care about their own health and health of their peers, encourage perseverance in making decisions

						that are in the best interest of their health. 3. Programme Y leads to a reduction in physical violence, an increase in gender equality, an increase in tolerance, a reduction in the incidence of digital violence, and an increase in the percentage of young people who would stop the violence they are witnessing. 4. Teaching staff and the professional

						public involved in the audit and implementation of Programme Y recognize the methodology as a quality and important educational programme.
Ko zapravo pobjeđuje? **(Who Actually Wins)** **(Youth gambling prevention programme)**	2022 – 2023 (implementation will continue in next years)	Sarajevo Canton	Secondary school students (first and second grade), parents and teachers	NARKO-NE Association for Addiction Prevention	Evaluation results have shown the efficiency of the programme in increasing and strengthening protective factors which increase student's level of proper knowledge about gambling and gambling industry and reduce cognitive distortions related to gambling.	The programme was replicated from Croatia which has a similar problem with betting shops; programme evaluation showed its successfulness in Bosnia and Herzegovina too.

						Programme contents and materials have been tailored and facilitated learning. Given the need to address this topic, it is necessary to involve larger number of schools from Sarajevo Canton, including those from around Bosnia and Herzegovina.
Seeking professional help in school			Adolescents /second grade od secondary school	Belma Žiga	/	/

and community						
Nature and determinants of sexting amongst adolescents and youth: Cross-cultural research by SextYouth	February 2021	Croatia, Bosnia and Herzegovina	The Manual includes description of educational workshops for adolescents, teachers and parents/guardians	Arta Dodaj Kristina Sesar Mónica Ojeda Pérez Rosario Del Rey Ashton Gerding Speno Dominika Howard Krešimir Prijatelj Nataša Šimić Marko Odak	/	/
Programme M/Promotion of Gender	from 2008 to 2010	Zagreb, Sarajevo, Banja Luka,	Professors, experts in working with young people	CARE International	/	/

Equality, and Promoting Healthier Lifestyles of Young Men, Questioning Masculinity as Social Construction, and Strategy for developing necessary life skills of young men during growing up		Prokuplje and Belgrade	and other professionals working with young men; this manual is an important contribution to those providing support to healthy development of young people.	SZ Balkan with partners		
School Peer Violence Prevention Programme	2010	Banja Luka	Teaching staff and school's non-teaching staff, young people	Prof. Ivana Žečević *Zdravi da ste* Citizen's Association	The results obtained show that students estimate that peer violence has decreased by 6.5% at the level of both schools. It is important to note that, in case of prevention programmes impacting changes in behaviour,	In addition to improving the quality of communication, the benefit of this programme includes

					significant statistical data on their impact may be expected only after several years.	education of children and teachers about forms of violent behaviour, which is an added value in violence prevention.
Mental Health Project in Bosnia and Herzegovina /MHP in Bosnia and Herzegovina designed two two-year programmes: Psychotherapy Counselling for Children and Adolescents in Community	2019-2021	Bosnia and Herzegovina	52 professionals (W43, M9) of which 21 psychologists from Federation of Bosnia and Herzegovina and 31 professionals from Mental Health Centre teams from Republic of Srpska; End beneficiaries – children and	IPD/MHP in Bosnia and Herzegovina Federation of Bosnia and Herzegovina: prim.dr. Goran Čerkez, prim.dr. Marina Bera, dipl. iur. Adisa Mehić, prof. dr sc. Kristina	ACHEMBACH-ASEBA questionnaire was used to evaluate recovery and was completed by educators and teams covering the sample of 143 beneficiaries for Bosnia and Herzegovina, Federation of Bosnia and Herzegovina/99, Republic of Srpska/44 beneficiaries of services in child and adolescent therapy, by gender: 50% M, 50% W and age (up to 8 years of age 19%, 9-14 years of age 34% and above 15 years of age 46%).	Sustainability of the service and production of new practitioners, where needed, was provided through development of programmes and regulations on 2-year training in working with/ psychotherapy counselling of children and

Mental Health Centres in Federation of Bosnia and Herzegovina, and Education programme for Working With Children and Adolescents in Mental Health in Republic of Srpska, in cooperation with Medical Schools in Zenica and Banja Luka that were contracted for programme implementation.			young people, and their parents	Sesar, dr. sc. Mirela Badurina, prof. dr Vera Daneš, Mr. sci Irina Puvača, prof. dr. Dubravka Kocijan-Hercigonj, prof. dr. Gordana Buljan-Flander, prof. dr. Mirjana Graovac, dr. med., dr. sc. Vesna Hercigonja Novković Republic of Srpska:	Re-evaluation showed significant recovery across all diagnoses/difficulties. The largest recovery was seen with attention difficulties, aggressive behaviour and depression/anxiety and reticence.	adolescents on mental health in both entities, and implementation was provided through Medical Schools in Zenica and Banja Luka. It was once again demonstrated that the largest success in implementation is attributed to intensive process of monitoring the training and commitment of training managers, including of project implementers, to

				LJiljana Ivančić, dr. Milan Latinović, prof. dr. Mira Spremo, prof. dr. Nada Vaselić, dr. Ranka Kalinić, mr. sc. Tatjana Marković Basara, Violeta Banić, Sanja Gidumović, mr. sci Irina Puvača		supervision and control of quality.
Increasing Adolescent Wellbeing through Strengthening	2017/2018 2019/2020	18 local communities 18 MHC	Secondary school second-grade students, MHC professionals	Public Health Institute in cooperation with Mental Health	**2017.** The programme included total of 875 students, of which 480 female and 395 male. The Programme was implemented in total of 41 classes. Each	Improved cooperation between Public Health Institutes and MHC in the

Protective Factors in School Environment		40 secondary schools and 1518 students	Teachers/psychologists and other school staff, Parents	Centres and Cantonal level Public Health Institute Donor Mental Health Project in Bosnia and Herzegovina/ IPD	community participated with four classes while Zenica had 5 classes (one was voluntarily included in the programme). **2019.** The programme included total of 643 students, of which 383 females and 260 males. The Programme was implemented in total of 32 classes, and each community participated with 4 classes.	area of preventive work in schools. Improved capacities of Public Health Institutes, MHC for development, implementation and evaluation of preventive programmes.
Establishing Banja Luka University Psychological Counselling	2022 -	Banja Luka, Faculty of Philosophy, Department of Psychology	Professors and Faculty of Philosophy teaching staff, Psychotherapists – licenced and undergoing training, students	Mental Health Project in Bosnia and Herzegovina, IPD and Faculty of Philosophy of Banja Luka University	By establishing such counselling, students would receive free of charge and adequate psychological support and treatment through an organised approach, including opportunity to acquire adequate knowledge, encouraging personal development and strengthening own potentials,	

					contributing to promotion of the importance of mental health.	
Preventing Gambling Addiction with Focus on Strengthening Protective Factors in School Environment	Mostar 2017 Žepče 2018	Mostar (3 grades in 3 primary schools); Žepče (16 homeroom classes of 7th and 8th graders)	Students, MHC Mostar, MHC Žepče, School staff	Mental Health Project in Bosnia and Herzegovina /IPD	Total of 309 students (153 M and 156 F) were involved in Mostar. Total of 226 students (F 112 and M 114) were involved in Žepče.	Results of this prevention and promotional research project could be used as a basis for development and implementation of other similar projects given that it has been noted that the issue of gambling, which is observed in early adolescence, impedes family, school, personal and social functioning of a young person, i.e.

						renders more difficult achievement of expected development outcomes, which in long-term, in addition to serious personal and family consequences, is seen as a cost for the economy itself. Therefore, this requires continuous work on developing critical attitudes towards games of chance, and development of responsible behaviour of

						children and adolescents in this area.
***Zbog tebe, zbog nas* (For You, For of Us) interactive prevention programme for secondary school children.**	2021-2022	8 local communities (Banja Luka, Prnajvor, Foča, Istočno Sarajevo, Tuzla, Bosanska Krupa, Sarajevo Novi Grad, Vogošća and Stolac), 8 Health Centres/MHC and 8 secondary schools: Catering,	- secondary school students - school staff - MHC staff - parents - cantonal level ministries of education of Federation of Bosnia and Herzegovina - Bosnia and Herzegovina Federation Ministry of Health - Ministry of Health and Social Protection of Republic of Srpska	Mental Health Project in Bosnia and Herzegovina, Institute for Population and Development (IPD)	- Improved intersectoral cooperation and preventive activities in the area of mental health with education sector - Programme training material successfully tested -23 professionals completed ToT (W=22, M=1), of which 14 professionals from MHC and 9 persons from secondary schools. - Programme successfully implemented twice, covering 350 students (W 191, M 159) from 8 secondary schools. - Programme participants extremely satisfied, professionals additionally motivated to implement the	- MHC and representatives of selected schools trained by IPO and implemented preventive programme to become ToT instructors at regional level for MHC/schools in their environment and for their selected schools/psychologists, pedagogues, social workers.

		Trade and Tourism School Banja Luka, PI *Gimnazija* Prnjavor, Secondary School Stolac, Secondary School Centre Foča, Chemical School in Tuzla, PI Secondary School 28 JUNI, *Treća gimnazija* Sarajevo and PI *Opća gimnazija*	- Ministry of Education of Republic of Srpska		programme in the next academic years. - Students evaluate newly acquired knowledge of functional ways of overcoming youth problems and difficulties very positively, including better emotional literacy. - Programme participants informed about the availability of resources (MHC) in local communities where they can seek help/counselling. - Programme is applicable (piloted) to students of ninth grade of primary school.	- Programme is to be implemented with nine grade students (primary school). - Bringing together several schools to jointly implement the programme – 2 partner schools that would jointly implement the project and thus enable children to meet, exchange experience and learn about the richness of diversity (schools from the two entities).

		Bosanska Krupa.				
***Miroljubivi partneri* (Peaceful Partners) peer violence prevention programme**	2012-2013		Primary school students (420) teaching staff, school pedagogues. Project team trained staff of 4 MHC (Ključ, Bugojno, Novi Grad, Brčko), during the programme implementation they trained and supervised teaching staff and school pedagogues in 10 primary schools in 4 local	Mental Health in Bosnia and Herzegovina Project, I phase, XY Association/IPD	Evaluation results indicate the benefit of implementation of such a programme amongst the students, including school staff, students and their parents; satisfaction with programme contents. Students that participate in the programme recognise different situations which are by nature violent and now considered as such while they were previously considered not so violent. The biggest change can be observed as regards the perception of sexual violence (with 83.9% of respondents) relative to the baseline value (65.3% respondents). The change could be observed in the perception of	

			communities, teaching staff and pedagogues implemented the programme by working directly with students (420) over the course of one school year. Before and after programme implementation students have been tested using USN-School Bulling Questionnaire.		verbal violence as foul language, and students are now largely recognising name-calling as violent behaviour (87% of respondents) compared to the baseline (65.3% of respondents). The baseline survey shows that physical violence (91.9%) is largely recognised as violence which does not differ much from the final survey (95.2%). However, the change is evident in the understanding of the term violence which is now viewed differently and not only from the perspective of physical contact. The survey results are consistent with the results of a comprehensive survey carried out by Republic of Srpska Ombudsman for Children (2012-13) on significant presence of all types of peer violence in primary	

					and secondary schools and great need for preventive actions in schools.	
***Slon u sobi* (Elephant in the Room) Creating and distributing psychoeducational material on the impact of COVID-19 pandemic on mental and physical health, including main recommendations for self-protection of mental health using KBT techniques**	2020	Bosnia and Herzegovina	Internet /FB and Instagram	IPD/MHP in Bosnia and Herzegovina and Domino	During this period, written material was prepared and adjusted, containing 30 self-help techniques which will be published on #slonusobi platform. Online motivational counselling sessions with citizens (indicator: 50 interviews conducted). Thus far statistics show that all notifications reached more than 500 persons (as agreed through indicators).	

Medica project Visoko for students, teachers and parents	1998-2005	Visoko	Connecting students, teaching staff and parents. The activities were implemented in individual groups within several 3-hour sessions.	Swiss Embassy as part of *Deze*, evaluated by dr. David Becker, German Psychologist	Training plan and programme combined with actual experience was focused on communication, assertive communication, conflict, stress, trauma and violence.	Project demonstrated considerable benefit.
Inspirational Cards project			Inspirational cards in schools in different subjects, used by language professors when analysing literary works and drawing important lessons for students. Also used for homeroom classes to initiate communication and get closer to students.	Nermina Vehabović Rudež	Proven by positive assessment by teachers and students, including university students as university professors also use them.	

Working with children and young people, including teachers through Interpersonal Relations Centres	2007		Working with children and young people, including teaching staff through Interpersonal Relations Centres in schools, which are an integral part of schools and where students learn communication skills, conflict solving skills, solving conflicts among peers, etc.		This activity proposal is described in TPO Foundation Manual „Prevencija vršnjačkog nasilja: Jačanje kompetencija nastavnika u radu sa djecom“ (Peer Violence Prevention: Strengthening Teacher's Competencies in Working with Children), page 137	
***Ovdje i sada* (Here and Now) virtual crisis interventions**	2020	Bosnia and Herzegovina	Practitioners from Social Welfare Centres, Mental Health Centres and education institutions in	BHiDAPA	Strengthening professionals in using virtual/telephone crisis interventions in working with children and young people. Professionals strengthened with different psychological and	

			Bosnia and Herzegovina		therapy techniques they were able to use online or by telephone to protect mental health of children and young families during Covid-19 pandemic.	
The first educational programme in integrative child and adolescent psychotherapy and counselling	From 2015	Bosnia and Herzegovina	Mental health practitioners	BHiDAPA	In 2016 in Antwerp, educational programme became an equal member of European Interdisciplinary Association for Therapeutic Services with Children and Young People – EIATSCYP and the first European accredited training programme in integrative child and adolescent psychotherapy and counselling. In 2017, Bosnia and Herzegovina got the first 9 European licenced child and adolescent psychotherapists. In 2018, BHiDAPA opens the first Interdisciplinary Therapy	The Programme proved to be essential for our society which is in great need of strengthened professionals to work with children and adolescents.

					Centre for protection of children, young people and families in Bosnia and Herzegovina.	
Safe Internet Centre	From 2010	Bosnia and Herzegovina	Children, teaching staff, parents, citizens	MFS-EMAUS, UNICEF, Save the Children	Platform, free online assistance to victims of violence for parents, children and citizens.	Established in cooperation with international organisation Insafe – European network of awareness-raising centres promoting safe and responsible use of internet and mobile devices amongst children and young people.
***Plavi Telefon* (Blue Telephone)**	From 2013	Bosnia and Herzegovina	Children and adolescents	UNICEF, Nova Generacija	Providing online counselling support to children and adolescents and a platform to report violence.	Number of calls increased during and after the pandemic.

				Association Banja Luka		
Secondary Prevention Programme focused on unacceptable forms of behaviour and protection of students within *Pravda za svako dijete* (Justice for Each Child) programme	From 2016 to 2020	Sarajevo Canton, Una-Sana Canton, Canton 10, Republic of Srpska	Primary schools	UNICEF, CPRC	Early detection and prevention of children at risk and provision of professional treatment, establishing referral mechanism in the community to provide psychological and social support to children and families.	The programme was introduced in the system through secondary legislation and is very sustainable. The programme facilitates establishing a single database at the level of Bosnia and Herzegovina which would collect numerical data on violence against and amongst children, including method and form of

						professional assistance provided at the level of Bosnia and Herzegovina.
Peer Violence Prevention	2010	Bosnia and Herzegovina	Primary schools in Bosnia and Herzegovina	Save the Children	Published curriculum for homeroom classes for first throughout ninth grade.	
Online support to mental health of teachers and students	Covid-19 pandemic period	Bosnia and Herzegovina, diaspora	Teaching staff and students, schools in Bosnia and Herzegovina and diaspora	COI Step by Step	Providing psychological support in crisis period.	
Trauma-oriented peace work in Bosnia and Herzegovina	2022	Bosnia and Herzegovina	Teaching staff, students (1500)	Progres Association	Creating trauma-sensitive schools and civil society organisations.	Teachers recognising and reacting to student's trauma.
Justice for Every Child – programme in judiciary	2011 -2020	Bosnia and Herzegovina	Children afoul of the law, children witnesses and victims of crimes	UNICEF	Improving children's access to justice at the level of Bosnia and Herzegovina.	The programme contributed to better implementation of the Law on

						Protection and Treatment of Adolescents in Criminal Proceedings; advocating and employing of psychologists at courts and prosecutor's offices.
Socialisation with Right	2017-2018	Federation of Bosnia and Herzegovina, Brčko District	Students from 26 primary and secondary schools	PH International	Help to all stakeholders in their seeking to strengthen the rule of law and reduce juvenile delinquency rate in Bosnia and Herzegovina.	
Hate Speech Prevention in Online Media Environment	2022	Brčko District	Education of all categories of society focused on children and youth (more than 200 students of senior grades of primary	Association of Psychologists of Brčko District of Bosnia and Herzegovina,	Establishing dialogue within the local community amongst representatives of media, legal and executive power, and of public information monitoring authorities, and prevention of hate speech through education	Empowering young people to report hate speech; it was noticed that large number of students was a

			school and secondary school students).	Government of Brčko District of Bosnia and Herzegovina, Professional and Administrative Affairs Department	of all groups of society, focusing on children and young people.	potential victim of hate speech on internet and that large number of students uses such speech in online environment.

11. Final thoughts/Conclusions:

Unlike previous practices which focused principally on diagnostics and treatment of people with mental disorders, today much more attention is paid to promotion of mental health and prevention of mental disorders.

The community in general should be constantly developing resources which improve and protect mental health of population and reduce risk factors for development of disorders.
This handbook presents specificities of adolescence period – youth aged 14 to 18, which in practice includes students of senior grades of primary school and secondary school students, including protective and risk factors existing at that age which may impact the mental health of adolescents. Furthermore, it includes instructions for implementation of preventive programmes for young people of this age group, including examples of some of the successful programmes implemented in parts of Federation of Bosnia and Herzegovina or Republic of Srpska which, based on their successful outcomes and results, may be replicated in other parts of Bosnia and Herzegovina.

The outcomes of mental health promotional and preventive initiatives are usually not visible in the first several years after their implementation as it takes time for the attitudes to change and to new patterns of behaviour of citizens and activities of the institutions to be established. The results of surveys of problems and needs of children and youth in Bosnia and Herzegovina are presented in this handbook, which may serve as a basis for governmental and non-governmental institutions to focus their programmes purposefully. Based on thus far implementation of programmes focused on youth, multi-sectoral approach to prevention has proved to be extremely successful and efficient. The truth is that it is easiest to implement programmes at the school level - in an environment where children spend large portion of their time. However, schools alone cannot dismiss risk factors or strengthen protective factors unless health and social systems and security sector are not involved too. Monitoring and development of secondary legislation based on programme piloting, and continuous training and supervision of experts involved in the programme implementation make the programmes sustainable.

Community actions may be focused on processes which aim to improve social resources at large and which are linked to physical and mental health, not focusing narrowly on mental health. (E.g. reduction of smoking, reducing social isolation, combating poverty, improvement

of educational process, fostering healthy lifestyles, humanisation of work and living environments, respecting human rights, etc.).

The importance of bottom-up approach has been emphasised when action involves many stakeholders and challenges as regards grouping initiatives at Bosnia and Herzegovina Federation or Cantonal levels to define resources and priorities that might be supported.
Messages which media send are particularly relevant as they may have large impact on attitudes and behaviour of population. It is necessary to implement media campaigns focusing on positive changes in community attitudes concerning mental health and mental disorders preceded by improving the media's basic knowledge about mental health. In any case, media should be used as one of the components of multi-strategic approach to achieve changes in attitudes and behaviour of population.

This handbook strived to collect as much information as possible on the challenges faced by young people aged 14-18, including opportunities to overcome challenges and best practices to provide adequate psychosocial support to adolescents – care for their mental health.

12. Annexes: Examples of Best Practice

Example 1

12.1 Secondary prevention programme in Sarajevo Canton1

"Programme for recognising and protecting children from antisocial behaviour risk factors" is a secondary prevention programme of juvenile offenses aimed at recognising and supporting students of primary and secondary schools at risk of committing an act of violence or being victims or witnesses of some form of violence.[2] It resulted from an important project

[1] https://www.cprc.ba/_files/ugd/b112e0_34746b7a8146486bbf4a98f4b110ff57.pdf

[2] Ministry of Education, Science and Youth of Sarajevo Canton and Criminal Policy Research Centre (CPRC), supported by UNICEF, tested the "Programme for recognising and protecting children from antisocial behaviour risk factors" during two school years (2016/17 and 2017/18). In its first pilot phase (school year 2016/17) the programme included 13 schools in Sarajevo Canton (9 primary and 4 secondary schools) while its second phase covered all primary and secondary schools in Sarajevo Canton. After project piloting and use of the programme, it was renamed into "Programme of (secondary) prevention of anticosial behaviour and protection of students in primary schools in Sarajevo Canton". It is currently used only in primary schools in Sarajevo Canton, and preparations are ongoing to use it in secondary schools and in other cantons in Federation of Bosnia and

during the implementation of which a group of indicators was developed based on which teachers and non-teaching staff recognised certain risk factors with children and adolescents. The indicators were grouped into 8 factors: A: Difficulties in learning and behaviour; B: Relations with peers; C: Student-teacher relationship; D: Parent-student relationship; E: Parents' attitude towards school; F: Ability to deal with problems; G: Internalised behaviours; H: Antisocial behaviour. To protect student's privacy, the programme was coordinated by the school's administrative service authorised to care for mental health of children in school. The programme entails trained teaching staff that will be responsible to communicate verbally with the teacher or non-teaching staff if they notice some antisocial behaviour with children, after which, if needed, the teacher or non-teaching staff designs an individualised support plan for the child in cooperation with the parent and child. The aim of this plan is to jointly eliminate risk factors that exist in child's environment and strengthen protective factors through different interventions within the school or family. In the event when parents refuse to cooperate with the school despite assessment of the non-teaching staff of the existing risk, the school involves social services and an individualised care plan is developed for that child. If the school administrative service assesses that there is a greater risk for the child which requires clinical treatment or evaluation, non-teaching staff involves mental health centre in the given municipality with the parent's consent. Programme's methodology involves team approach of professionals involved in working with children to providing support to the child, and active role of the child and parent in creating and providing that support.

As indicated, health and social sectors were involved in programme implementation in addition to education sector. An inter-sectoral cooperation referral mechanism was designed to increase efficiency of the system response to recognised juvenile delinquency risk factors.

The overall programme has been regulated by secondary legislation: Rulebook on the method and form of implementation of educational support and professional treatment of students in primary schools in Sarajevo Canton and Rulebook on keeping records of antisocial behaviour and protection of students (Pleh, Omersoftić, 2020).

Herzegovina. More at: https://j4c.ba/blog/program-prepoznavanja-i-zastite-djece-od-faktora-rizika-2/ (page visited on 19 July 2020).

Example 2

12.2 Examples of a juvenile delinquency prevention programme for secondary schools

Month	Contents	Implementer	How is work organised and implemented
IX	Support to students at risk of antisocial behaviour	Subject teachers, homeroom teachers, school's Counselling Department staff, parents, students, Social Service officers.	Recognising students at risk of antisocial behaviour, identification of risk factors.
	Analysis of socio-economic structure and health status of first grade students in order to provide adequate support.	Pedagogue, psychologist and social worker	Analysis of data obtained from parent questionnaires. The questionnaire was designed to provide basic data on socio-economic and health circumstances of students in order to individualise the work and provide adequate support.
	Administrative service to fulfil children's needs	Pedagogue, psychologist and social worker in cooperation with homeroom teachers (visits to homeroom classes)	Introducing students of first throughout fourth grade with the types of support they may receive from School's Counselling Department, including manners of cooperation.
	Student's safety in digital environment	Homeroom teachers	Students of first throughout fourth grades will be introduced to protection measures for safe use of ICT and to characteristics of cyber violence.
	Improving school-parent cooperation	Parents, homeroom teachers, subject teachers, director, assistant director and school's non-teaching staff	General parent-teacher conference for first grades Parent-teacher conferences by grades Info meetings Consultations with teachers Cooperation with non-teaching staff Cooperation with school management
	Improvement of cooperation between school and parents of first grade students	Pedagogue, psychologist and school's social worker	Lecture for parents of first grade students: School-parent cooperation – partnership relations and continuity as precondition of student's success

	Cooperation of School's Counselling Department with homeroom and subject teachers	School's Counselling Department staff, homeroom teachers and subject teachers	At the beginning of school year, non-teaching staff will have discussions with homeroom teachers to be informed of social-economic, health and other circumstances of children for the purpose of potential individualisation of educational work and provision of adequate support. Initiating and participating in meetings of first grade department councils (and second throughout fourth grade department councils if needed) to introduce members to relevant information about those students with specific health/development and other issues which may impact their mastering the course materials and participation in educational process.
X	Support to students at risk of antisocial behaviour	Subject teachers, homeroom teachers, school's Counselling Department staff, parents, students and, if needed, professionals from Social Service, PI Education Centre, MHC and Sarajevo University Clinical Centre (KCUS).	Recognising students at risk of antisocial behaviour, identification of risk factors and provision of educational support or professional treatment (parent, student, homeroom teacher, school's Counselling Department, and professionals for other institutions beyond school, where appropriate)
	School-parent cooperation	Homeroom teachers, subject teachers director, assistant director and school's non-teaching staff	Info meetings Consultations with teachers Cooperation of school management and non-teaching staff with students' parents, if needed Home visits, where appropriate
	Strengthening student's competences	Pedagogue	A lecture for first grade students: Efficient Learning and Time Planning Methods and implementation within homeroom classes
	Violence prevention - Safe School – Zero-Tolerance for Violence	PI Education Centre Sarajevo Canton staff in cooperation with school's non-teaching staff and homeroom teachers	Lectures for first throughout fourth grade students: Education Centre staff will deliver lectures for first throughout fourth grade students

	Prevention of gambling	NARKO NE Association staff and homeroom teachers	Lecture for second grade students as part of homeroom class (1 class).
	Stop to Drugs	NARKO NE Association staff, counselling staff and homeroom teachers	Lecture for first grade students with the aim of preventing substance abuse (1 class)
	Cooperation between Counselling Department staff and homeroom teachers and subject teachers	School's Counselling Department staff, homeroom teachers and subject teachers	Counselling Department staff will continuously cooperate with homeroom teachers and subject teachers to exchange relevant information about students and parents and current events in classes, including taking adequate educational measures.
XI	Support to students at risk of antisocial behaviour	Homeroom teachers, subject teachers, school's Counselling Department staff, parents, students and, as needed, staff of Social Service, PI Education Centre, MHC and Sarajevo University Clinical Centre.	Providing educational support or professional treatment (parent, student, homeroom teacher, school's Counselling Department, and, as needed, staff from non-school institutions) to students with recognised risk factors.
	Oružje ne štiti, oružje ubija) (Weapons Do Not Protect, Weapons Kill)	**Ministry of Interior officers and homeroom teachers**	Lecture for fourth grade students (1 class)
	School-parent cooperation	Homeroom teachers, subject teachers, director, assistant director, school's non-teaching staff	Parent-teacher conference by grades Lecture for parents of first-graders Info meetings Consultation with teachers Cooperation of school management and non-teaching staff with students' parents, as needed
	Protection of psychophysical health of students	**PI Education Centre** staff and school's Counselling Department staff	**Lectures for students of first throughout fourth grade to encourage student's welfare, develop resilience and positive self-image.**
	Cooperation of Counselling Department staff with homeroom teachers and subject teachers	School's Counselling Department staff, homeroom teachers and subject teachers	Counselling Department staff will continuously cooperate with homeroom teachers and subject teachers to exchange relevant information about students and parents and current events in classes, including taking adequate educational measures.

XII	Support to students at risk of antisocial behaviour	Subject teachers, homeroom teachers, school's Counselling Department staff, parents, students, and where needed, staff of Social Service, PI Educational Centre, MHC and Sarajevo University Clinical Centre.	Educational support or professional treatment to students with recognised risk of antisocial behaviour (in line with the Student Support Plan).
	School-parent cooperation	Homeroom teachers, subject teachers, director, assistant director and school's non-teaching staff	Info meetings Consultations with teachers Cooperation of school management and Counselling Department staff with students' parents.
	Cooperation of Counselling Department staff with homeroom teachers and subject teachers	School's Counselling Department staff, homeroom teachers, subject teachers, director and assistant director	Counselling Department staff will continuously cooperate with homeroom teachers and subject teachers to exchange relevant information about students and parents and current events in classes, including taking adequate educational measures.
	Preventing Trafficking in Human Beings project	Homeroom teachers and school's Counselling Department staff	Lecture for **third grade students**: **What is Trafficking in Human Beings** (forms, how to recognise it, environment risk factors, risk factors related to persons themselves)" – 1 school class.
	Preventing Trafficking in Human Beings project	First, second and fourth grade homeroom teachers	**What is Trafficking in Human Beings** – 3 school classes during which students will explore through ToRs what is trafficking in human beings and how to prevent it.
I	Strengthening Student Competences in Achieving Better Performance in Learning and Behaviour project	Homeroom teachers, school's Counselling Department staff, parents, students, subject teachers and, where needed, director and assistant director.	Group or individual work with parents and students who failed at midterm (three or more failed subjects), had a number of unjustified absences and/or poor conduct.
	Strengthening Teacher's Competences	Pedagogue and psychologist	Professional training for all teachers Curriculum Reform – Teaching and Grading Requirements

II	Support to students at risk of antisocial behaviour	Subject teachers, homeroom teacher, school's Counselling Department staff, parents, students, and where needed, staff of Social Service, PI Educational Centre, MHC and Sarajevo University Clinical Centre.	Educational support or professional treatment to students with recognised risk of antisocial behaviour (in line with the Student Support Plan).
	Student's Safety in Digital Environment	Ministry of Interior officials in cooperation with school's non-teaching staff and homeroom teachers.	Ministry of Interior officials will inform students of first throughout fourth grade of protective measures for safe use of ICT, characteristics of cyberbullying and the procedure to report it. (1 school class)
	Preventing Violence - Violence prevention - Safe School – Zero-Tolerance for Violence	Homeroom teachers	Topic for homeroom class (2 school classes) I – IV grades: Types of Violence and How to Prevent It – ToRs and presentations
	Combating Peer Violence Day in Sarajevo Canton	Homeroom teachers	1 school class (video and discussion)
	Pink T-shirts Day – Preventing Peer Violence	Homeroom teachers and Student's Council	1 school class
	School-parent cooperation	Homeroom teachers, subject teachers, director, assistant director and school's Counselling Department staff	Parent-teacher conferences Info Consultations with teachers Where needed, cooperation between school's management and non-teaching staff with students' parents Home visits, where necessary
	Cooperation between Counselling Department staff and homeroom and subject teachers	Department staff and homeroom teachers and subject teachers	Counselling Department staff will continuously cooperate with homeroom teachers and subject teachers to exchange relevant information about students and parents and current events in classes, including taking adequate educational measures.
	Strengthening Student Competences in Achieving Better Performance in Learning and Behaviour activity	Homeroom teachers, subject teachers, pedagogue, psychologist and social worker	Group and individual work with parents and students who failed at midterm (three or more failed subjects), had a number of unjustified absences and/or poor conduct.

III	Support to students at risk of antisocial behaviour	Subject teachers, homeroom teacher, school's Counselling Department staff, parents, students, and where needed, officers of Social Service, PI Educational Centre, MHC and Sarajevo University Clinical Centre	Educational support and professional treatment for students with recognised risk of antisocial behaviour.
	Protection of Psychological and Physical Health of Students	Homeroom teachers	**Homeroom class (3 school classes) of I-IV grades to foster wellbeing of students, development of resilience and positive image of oneself through project activities and presentations.**
	School-parent cooperation	Homeroom teachers, subject teachers, director, assistant director, and school's officers	Info meetings Consultations with teachers Where needed, cooperation between school management and Counselling Department staff with students' parents.
	Cooperation between Counselling Department staff and homeroom and subject teachers	School's Counselling Department staff and homeroom teachers and subject teachers, director and assistant director	Counselling Department staff will continuously cooperate with homeroom teachers and subject teachers to exchange relevant information about students and parents and current events in classes, including taking adequate educational measures.
	Occupational Guidance for Students project	**Pedagogue, school's social worker and homeroom teachers, psychologist**	**Lecture for fourth graders: Labour Market Needs and Registering as Unemployed Person;** Presentation: How to make a good CV and submit application Survey of students as part of 2 researches: Occupational Guidance – School Satisfaction (as part of homeroom classes).
IV	Support to students at risk of antisocial behaviour	Subject teachers, homeroom teacher, school's Counselling Department staff, parents, students, and where needed, staff of Social Service, PI Educational Centre, MHC and Sarajevo University Clinical Centre.	Educational support and professional treatment to students with recognised risk of antisocial behaviour. Monitoring achievement of objectives. Evaluation of support plans. Where needed, identification of students for whom the risk factors have just been recognised.

	Cooperation with parents	Homeroom teachers, subject teachers, director, assistant director and school's non-teaching staff	Info meetings Parent-teacher conferences Consultations with teachers Continuous cooperation with school's management and non-teaching staff
	Cooperation between school's Counselling Department staff and homeroom and subject teachers	School's Counselling Department staff, homeroom teachers, subject teachers, director and assistant director	Counselling Department staff will continuously cooperate with homeroom teachers and subject teachers to exchange relevant information about students and parents and current events in classes, including taking adequate educational measures.
	Occupational Guidance for Students project – Cooperation with Universities	**UNSA staff**, private university staff, homeroom teachers, subject teachers and school's non-teaching staff	**Presentation of universities to fourth grade students**
	Student's Satisfaction with School project and Occupational Guidance	**School's Counselling Department staff**	**Analysis of results: Occupational Guidance – Satisfaction with School**
V	Support to students at risk of antisocial behaviour	Subject teachers, homeroom teachers, school's Counselling Department staff, parents, students, and where needed, staff of Social Service, PI Educational Centre, MHC and Sarajevo University Clinical Centre.	Educational support and professional treatment to students with recognised risk of antisocial behaviour.
	School-parent cooperation	Homeroom teachers, subject teachers, director, assistant director and school's Counselling Department staff	Info meetings Consultations with teachers Where needed, cooperation of school's management and Counselling Department Staff with student's parents.
	Cooperation of Counselling Department staff with homeroom and subject teachers	School's Counselling Department staff and homeroom and subject teachers	School's Counselling Department staff will continuously cooperate with homeroom and subject teachers to exchange relevant information about students and provide support.
VI	Support to students at risk of antisocial behaviour	Subject teachers, homeroom teachers, school's Counselling Department staff, parents and students.	Evaluation of support plans

	School-parent cooperation	Director, homeroom teachers, assistant director, school's Counselling Department staff	Cooperation of director, assistant director, homeroom teacher and school's Counselling Department staff with parents – where needed.
	Presentation of research	School's Counselling Department staff	**Presentation of survey results: Occupational Guidance/Satisfaction with School at the Teacher Council meeting**

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