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GUIDELINES ON MENTAL HEALTH PROMOTIVE AND PREVENTIVE INTERVENTIONS FOR ADOLESCENTS

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Contents

Working group for adaptation of the Guideline

"Mental Health Promotive and Preventive Interventions for Adolescents"

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Mental Health Promotive and Preventive Interventions for Adolescents

I.Introduction

1.1 Adolescents Mental Health

Adolescence is a period of rapid development of life, where individuals experience physical, social and psychological changes, a stage in which the brain is very sensitive to environmental impact, a potential period for health promotion and prevention of interventions that affect development and health.

Creating a supportive environment that enables good maintenance of mental health for adolescents is very necessary and important at this stage of life.

Promoting strategies to support adolescents' mental health to improve their well-being, so that they are able to realize their potential and participate meaningfully in their communities is very important and necessary at this stage of life cycle.

Main facts

- Globally, one in seven adolescents' 10-19- year-olds experience a mental disorder, which accounts for 13% of the global burden of disease in this age group.
- Depression, anxiety and behavioural disorders are among the leading causes of illness and disability in adolescents.
- Suicide is the fourth leading cause of death among 15- 19-year-olds.
- The consequences of failing to address the factors that affect adolescents' mental health extend into adulthood, impairing both physical and mental health and limiting the chances of having a satisfying life[1].

Adolescence is a unique and formative time. Physical, emotional, and social changes, including exposure to poverty, abuse, or violence, can make adolescents more vulnerable and affect their mental health.

1 https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health

Protecting adolescents from adversity, promoting socio-emotional learning and psychological well-being, and ensuring access to mental health care is a key factor in their health and well-being during adolescence and adulthood.

Globally, it is estimated that 1 in 7 [14%] of adolescents, aged 10-19 years, have difficulties, which are reflected in mental health, however, these difficulties remain largely unrecognized and untreated.

Adolescents are particularly vulnerable to social issues, discrimination, stigma [affecting readiness to seek help], educational difficulties, risky behaviour, poor physical health and human rights violations

1.2 Mental Health Determinants

Adolescence is a crucial period for developing social and emotional habits, important for mental well-being, including healthy sleeping habits, exercising regulary, developing coping skills, solving interpersonal problems, etc.

Protective and supportive environments in the family, at school, and in the wider community are also important.

Multiple factors affect mental health. The more risk factors adolescents are exposed to, the greater the potential impact risk on their mental health.

Factors that can contribute to the onset of stress during adolescence include: exposure to adversity, peer adjustment, and exploration of identity.

Media influence and gender norms can exacerbate the disparity between an adolescent's lived reality and their perceptions or aspirations for the future. Other important determinants include: the quality of their home life and relationships with peers.

Violence [especially sexual violence and bullying], serious socio-economic problems are recognized risks to mental health.

Some adolescents are at greater risk because of their living conditions, stigma, discrimination, exclusion or lack of access to quality support and services.

These include adolescents with chronic illnesses, autism spectrum disorders, developmental delays, or other neurological conditions; pregnant adolescents, adolescent parents or those in early marriages, forced orphans, ethnic minority adolescents or other discriminated groups.

1.3 Behavioural disorders

Behavioural disorders: are more common among younger adolescents than older adolescents.

Behavioural disorder [involving symptoms of destructive or challenging behaviour] occurs among adolescents 10-14 year-olds with a percentage [3.6%], and adolescents 15-19 year-olds with a percentage [2.4%].

Behavioral disorders can affect adolescents' education and can result in criminal behavior.

Attention Deficit Hyperactivity Disorder [ADHD], characterized by difficulty concentrating, overactivity, and acting without consequences, occurs among [3.1%] of 10-14 year-olds and [2.4%] of 15- 19 year-olds [2.4%].

1.4 Eating disorders

Eating disorders: such as anorexia nervosa and bulimia, commonly emerge during adolescence and young adulthood. Eating disorders involve abnormal eating-related behaviours and preoccupation with food, accompanied in most cases by concerns about weight and body shape. Anorexia nervosa can lead to premature death, often due to medical complications or suicide, and has a higher mortality rate compared to other mental disorders.

1.5 Suicides and self-harm

Suicide: is the fourth leading cause of death in older adolescents [15-19 years old]. Risk factors for suicide are numerous and include the harmful use of alcohol, abuse in childhood, stigma against help-seeking, barriers to accessing care and access to means of suicide.

Digital media, like any other media, can play a significant role in educating and preventing suicidal behaviours.

1.6 Risk behaviours

Risk behaviours: that start during adolescence such as: the use of various substances can seriously affect the mental and physical well-being of a teenager.
The use of tobacco and cannabis are additional concerns. Many adult smokers had their first cigarette prior to the age of 18.

Cannabis is the most used drug among young people with about [4.7%], mainly users are young people aged 15-16 years [2018 study]. Violence is a dangerous behaviour that can increase the likelihood of injury and involvement in crime or death.
Interpersonal violence ranks among the leading causes of adolescent death mainly affecting males [older adolescent boys, 2019 study].

1.7 Promotion and prevention

Mental health promotion and prevention interventions [MH], aim to strengthen an individual's capacity to regulate emotions, enhance alternatives to risk-taking behaviours, build resilience for managing difficult situations and adversity, to promote educational messages in supportive social environments and networks.

These programs through the use of different platforms require access to many Institutional levels such as: MoH, NIPHK, PHC, CAMHC, MHC, HCI, Schools, Communities using different strategies to reach adolescents, particularly the most vulnerable.

1.8 Early detection and treatment

It is crucial to address the needs of adolescents with mental health problems. Respecting the rights of children in line with the United Nations Convention on the Rights of the Child and other human rights instruments are key for adolescents' mental health[2].

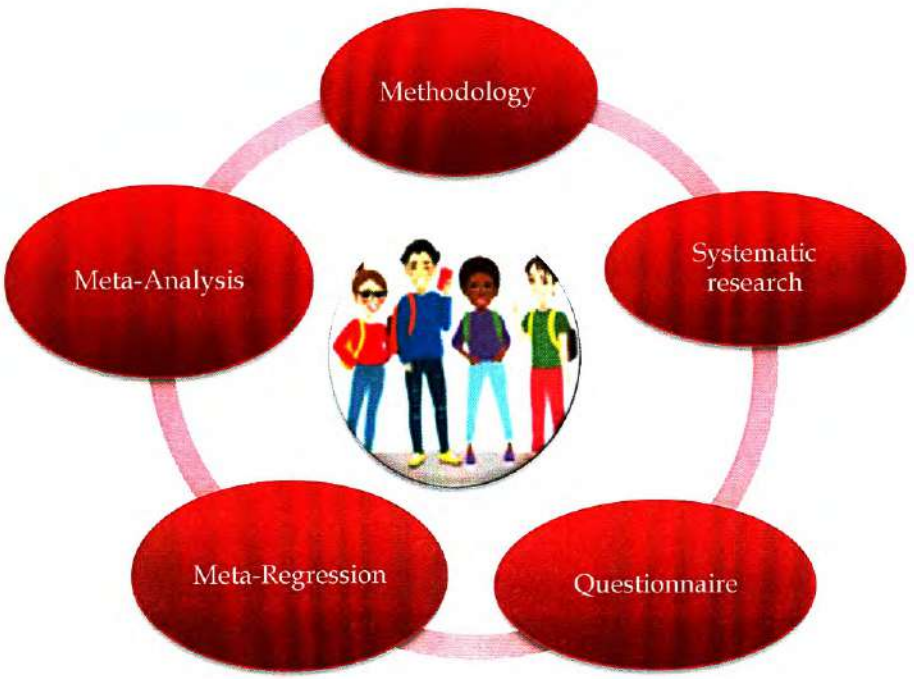
2https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health

II. METHODOLOGY

This guide was drafted by a multidisciplinary and multiprofessional working group appointed by the Ministry of Health-Republic of Kosovo / MoH.

The Working Group has reviewed adolescent mental health guidelines published in the last three years with consistent, high-evidence recommendations that provide evidence-based recommendations for psychosocial interventions to promote positive mental health and to prevent mental disorders in adolescents, and has decided to adopt the latest WHO guideline, "Guidelines on Mental Health Promotive and Preventive Interventions for Adolescents"[WHO 2020].

Systematic reviews for data collection have been made in accordance with the methodology. The studies presented in this guide were conducted using the AMSTAR tool, which is a tool developed for the critical evaluation of systematic reviews that integrates areas related to risks from bias and reporting.



III. Definition

Adolescence [3]: is the stage of life between childhood and adulthood, from 10 to19 years old. It is a unique stage of human development, involving rapid physical growth and sexual maturation combined with emotional, social and cognitive development.

It's an important time to lay the foundations for good health.

Adolescents: are individuals in the age group 10-19 years.

Caregivers: refers to those persons who are responsible for children's care and may include mothers, fathers, grandparents, brothers, sisters and others within the extended family network as well as other carers outside the family network.

Community: can be defined as a network of people who share similar interests, values, goals, culture, religion or history - as well as feelings of connection and care among its members.

Mental Health: is an integral and essential component of health. Mental health is a state of well-being in which an individual realizes his or her abilities, can cope with normal life stresses, can work productively, and is able to contribute to his or her community.

Mental health and psychosocial support: is a compound term used to describe any type of local or external support aimed at protecting or promoting psychosocial well-being.

Mental Health Care: refers to services dedicated to the treatment of mental health and the improvement of mental health in persons with mental disorders or problems.

Mental Health Status: refers to a wide range of disorders that affect an individual's cognition, emotions and / or behaviours and interfere with an individual's ability to learn and function in the family, at work and in society.

In many circumstances, many of these conditions can be prevented and/or successfully treated such as: mental and substance use problems, severe psychological distress, people with intellectual disabilities, and people at risk for suicide.

Mental Health Promotion: includes actions that improve psychological well-being. This may include creating an environment that supports mental health.

Mental Health Services: are services that provide effective mental health interventions.

Prevention: in mental health aims to reduce the incidence, prevalence and recurrence of mental health disorders and the disability associated with them. May include universal prevention, targeted or indicated prevention strategies.

[3] https://www.who.int/health-topics/brain-health

Psychosocial: means the interconnection between psychological and social processes interaction constantly influencing each other.

Psychosocial disturbance: refers to unpleasant feelings or emotions that may have an impact on a person's level of functioning and ability to participate in social interactions. It is a psychological disorder that interferes with a person's daily activities. Sadness, anxiety, distraction, disruption in relationships and some symptoms of mental illness are manifestations of psychological distress.

Psychosocial interventions: promoting mental health, helping adolescents learn techniques that positively impact their social behaviours, thoughts, feelings, and interactions.

Suicide: is death caused by harmful behaviour, self-directed with intent to cause death.

Intentional self-harm: means self-inflicting painful, destructive, or damaging actions but without the intent to die

Referral: is the process of directing a client to another service provider in cases where the client seeks help that is beyond the expertise or scope of work of the current service provider.

Resilience: is the ability to overcome difficulties and adapt positively after challenging or difficult experiences. Children's resilience is related not only to their innate strengths and coping skills, but also to the pattern of risk and protective factors that affect their social and cultural environments.

Well-being: is the ability to overcome difficulties and to adapt positively after challenging or difficult experiences.

3.1 Questions 

The following questions are elaborated referring to the available evidence and information aggregated from the conducted studies.

I. **Should interventions,** positive psychosocial thinking for all adolescents be considered to improve access to positive mental health thinking, prevent mental disorders, self-harm and suicide, and reduce risky behaviours?

2a. Should psychosocial interventions be considered for adolescents exposed to difficulties [specifically violence], to improve their mental health positive thinking and to prevent mental disorders, self-harm and / or other dangerous behaviours?

2b. Should psychosocial interventions be considered for adolescents exposed to difficulties [specifically, extreme poverty], to improve their mental health and to prevent disorders, self-harm and / or other dangerous behaviours?

2c. Should psychosocial interventions be considered for adolescents exposed to hardships [specifically humanitarian emergencies] to improve their mental health and prevent mental disorders, self-harm and / or other dangerous behaviours?

3. Should psychosocial interventions be considered for adolescents and pregnant adolescents, parents to promote their mental health and prevent mental disorders such as self-harm and / or other dangerous behaviors?

4. Should psychosocial interventions for adolescents living with HIV / AIDS be considered to improve their mental health and prevent mental disorders, self-harm and / or other dangerous behaviours?

5. Should psychosocial interventions for adolescents with emotional problems be considered in order to prevent mental disorders [including progression to diagnosable mental disorders] and to prevent self-harm and / or other dangerous behaviours?

6. Should psychosocial interventions for adolescents with disruptive / contradictory behaviours be considered to prevent behavioural disorders, self-harm, and / or other dangerous behaviours?

IV. Recommendation

4.1 First Recommendation [I] -A

Recommendation A

Recommendation A

Psychosocial interventions should be provided for all adolescents. These interventions have a positive effect on mental health, as well as on the prevention and reduction of suicidal behaviours, mental disorders [such as depression and anxiety], aggression, disruptive and antagonistic behaviours, and substance use.

Strength of recommendation: → **Strong.**

Security of evidence: → **Low.**

Important notes: Based on the available evidence, interventions should cover education / learning, social and emotional care, which may include components such as: emotional regulation, problem solving, interpersonal skills, awareness, determination and stress management.

Rationale: The studies conducted were subject to the risk of prejudice due to the difficulty of intervention.

However, a strong recommendation was made despite the low reliability of the evidence thanks to the relative consistency of the study results, from the fact that the significant benefits significantly outweighed the potential harms. In addition, considerations about values, feasibility and cost-effectiveness further supported the recommendation.

Interventions in schools may be easier to implement and less likely to cause stigma compared to interventions that require investigation.

In schools, interventions can help reach a larger number of adolescents and address a wide range of risk factors, providing a basis for promoting mental health and preventing risky behaviours.

4.2 Second Recommendation [II] –B

Recommendation B

Recommendation B 

Psychosocial interventions should be provided for adolescents affected by humanitarian emergencies.

These interventions are particularly helpful in preventing mental disorders [depression, anxiety, and stress-related disorders] and can be considered to reduce substance use in these populations.

Strength of recommendation:  **Strong** for reducing symptoms and / or preventing mental disorders [depression, anxiety, and stress-related disorders]. Conditional on substance use.

Security of evidence:  **Low**

Important Note: Ongoing support for adolescents exposed to humanitarian emergencies includes a wide range of psychosocial interventions that reflect the heterogeneous nature of experiences involved in emergency events. It is therefore important to carefully interpret the study findings. Available evidence suggests that stress management, relaxation strategies, and well-being are components of related interventions that result in effectiveness.

In the category of adolescents exposed to high levels of trauma, **trauma-focused cognitive-behavioural therapy [CBT] has been shown to have positive effects in reducing the symptoms of depression, anxiety, and stress.**

Rationale: The studies were subject to the bias of difficulties, interventions in self-reported outcomes, which are common in these types of interventions.

However, a strong recommendation was made for psychosocial interventions to reduce the symptoms of mental disorders, despite the low reliability of the evidence.

The reason was that the predicted clinically significant benefits outweigh the potential harms. Furthermore, important values, equality considerations, and feasibility suggest that mental illness prevention programs should prioritize adolescents exposed to humanitarian emergencies. Evidence supports the notion that all adolescents should benefit from generally offered psychosocial interventions. The high prevalence of mental disorders in adolescents

exposed to humanitarian emergencies, and the large treatment gap in those environments, make a case for the implementation of psychosocial interventions in this population even more compelling. However, it is important to consider the profile of adolescents and the degree of exposure, given the heterogeneity of experiences and circumstances.

4.3 Third Recommendation [III] –C

Recommendation C

Recommendation C 

Psychosocial interventions

It should be considered for adolescents, pregnant and adolescent parents, especially to promote positive thinking about mental health [mental functioning and mental well-being] and improving school attendance.

Strength of recommendation: → **Conditional.**

Security of evidence: → **Low**

Important Note: Based on the available evidence, cognitive and behavioural skills development programs may be considered for adolescents, pregnant, and adolescent mothers.

4.5 Fourth Recommendation [IV] –D

Recommendation D

Recommendation D

Induced psychosocial interventions

Should be offered to adolescents with emotional symptoms.

Strength of recommendation: → **Strong** for reducing symptoms of depression / anxiety and / or preventing mental disorders [depression and anxiety] and promoting positive mental health. Condition for improving school attendance.

Security of evidence: → **Very low**

Important Note: Based on the available evidence, group-based CBT may be considered for adolescents with symptoms / emotional.

Rationale: The reliability of evidence was often diminished because studies were subject to risk to promote mental health positive thinking approach in adolescents with emotional problems. This was despite the very low security of the evidence.

The reason is that the benefits outweigh the potential harms. Furthermore, considerations of significant values, capital and cost-effectiveness justify investing in interventions for this at-risk group, prejudice due to difficulties, interventions and reliance on self-reported outcomes, both elements of which are common in these types of study interventions. However, a strong recommendation was made to reduce the symptoms of depression and / or anxiety and / or prevent mental disorders [depression and anxiety].

Poor mental health among adolescents is a major risk factor reflected in physical and mental health problems later in life. Early intervention in adolescents who exhibit emotional problems has proven crucial in preventing mental health problems and optimizing health and life trajectories.

4.6 Recommendation five [V] –E

Recommendation E

Recommendation E  **Induced psychosocial interventions** should be provided for adolescents with disruptive / contradictory behaviors.

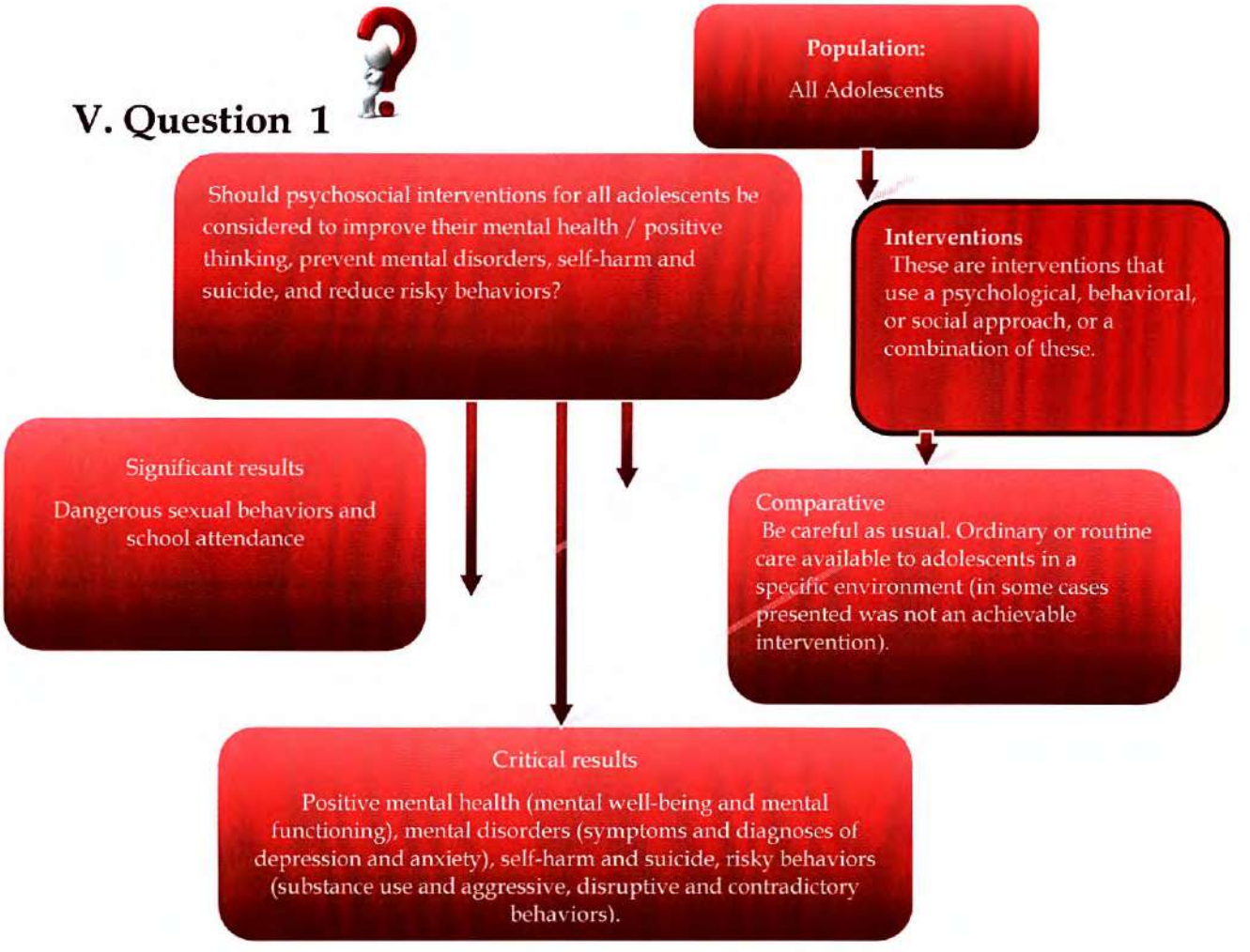
These interventions reduce aggressive, disruptive, and hostile behaviours, prevent mental disorders [depression, and anxiety], and promote positive thinking mental health. Interventions should be performed carefully to avoid increased substance use in adolescents with disruptive and antagonistic behaviours.

Strength of recommendation: ⇒ **Conditional**

Security of evidence: ⇒ **Very low**

Important notes: According to the available evidence, effective psychosocial interventions for adolescents at risk or diagnosed with behavioural disorders often include: training for parents, based on social learning approaches; and training in problem-solving cognitive and interpersonal skills for adolescents. They may also include multimodal interventions for adolescents and their parents, based on a social learning model.

V. Question 1



Universal preventive interventions are those that apply to all populations, regardless of their status.

The advantages of universal interventions are that they tend to be performed in environments where a larger part of the population is involved, such as schools.

Universal interventions offer the opportunity to target a wide range of risk factors at the same time, which is especially important in low-income countries where adolescents are outnumbered and experience a wider range of negative life events. An advantage of universal interventions is that high-risk adolescents are easily identifiable by their peers.

Recommendation A

Recommendation 

Psychosocial interventions should be provided for all adolescents. These interventions have a positive effect on mental health, as well as on the prevention and reduction of suicidal behaviours, mental disorders [such as depression and anxiety], aggression, disruptive and antagonistic behaviours, and substance use.

Strength of recommendation: **Strong.**

Security of evidence: **Low.**

Important notes: Based on the available evidence, interventions should cover education / learning, social and emotional care, which may include components such as: emotional regulation, problem solving, interpersonal skills, awareness, determination and stress management.

Rationale: The studies conducted were subject to the risk of prejudice due to the difficulty of intervention.

However, a strong recommendation was made despite the low reliability of the evidence thanks to the relative consistency of the study results, from the fact that the significant benefits significantly outweighed the potential harms. In addition, considerations about values, feasibility and cost-effectiveness further supported the recommendation.

Interventions in schools may be easier to implement and less likely to cause stigma compared to interventions that require investigation.

In schools, interventions can help reach a larger number of adolescents and address a wide range of risk factors, providing a basis for promoting mental health and preventing risky behaviours.

Additional considerations

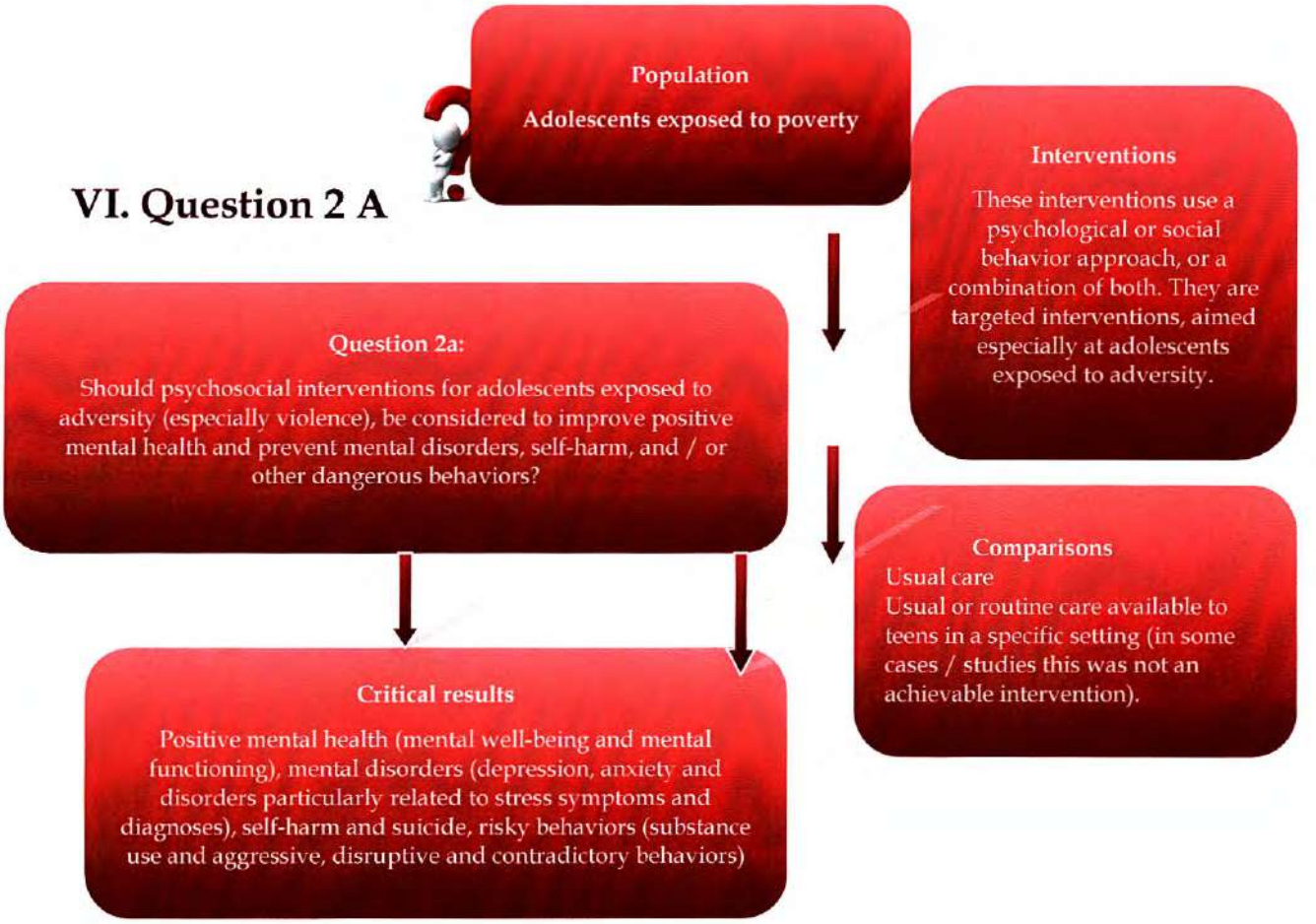
Considerations for implementation

These interventions can be implemented through various platforms [including digital platforms, community and health centers]. However, most of the interventions assessed in this review [70%] have been

implemented in schools.

It is important to use a multi-sectoral approach, involving a range of stakeholders [such as health, education, and others].

VI. Question 2 A



Background

Violence against children is a worldwide concern, about one billion children aged 2-17 have experienced some form of violence or neglect. Since 2010, the number of children and adolescents living in conflict zones has increased to 37%, while in the same period there has been an increase of 174% of serious violations verified against children.

There has been research on the negative effects of violence as a reflection on children's mental health outcomes, with an increase focused on adolescents.

Adolescents who have experienced violence can experience multiple symptoms including PTSD and depression. Furthermore, negative mental health outcomes can result from various types of exposure to violence, including intimate partner violence and domestic violence.

Violent childhood experiences, such as exposure to violence, can increase the likelihood of engaging in risky behaviors, with the earliest onset of alcohol use and use of other substances. Preventive efforts, including interventions, have been made by UNICEF, WHO and other partners who have played a critical role in preventing violence against children. However, there is a lack of data on successful interventions among populations, who have already experienced or faced violence.

It's Important

Prioritize interventions to promote the positive mental health of adolescents exposed to violence, as well as to prevent mental disorders, self-harm, and suicide, and to reduce risky behaviors among them.

However, no specific recommendation could be made for psychosocial interventions for adolescents exposed to violence, as there was no clear evidence of the effect due to the limited number of studies available for adolescents exposed to violence.

There are WHO guidelines that provide guidelines for responding to: child abuse; sexual abuse of children and adolescents; intimate partner violence and sexual violence against women such as:

• WHO guidelines for the health sector response to child abuse. WHO, 2019. https://www.who.int/publicationsdetail/who-guidelines-for-the-health-sector-response-to-child-maltreatment.

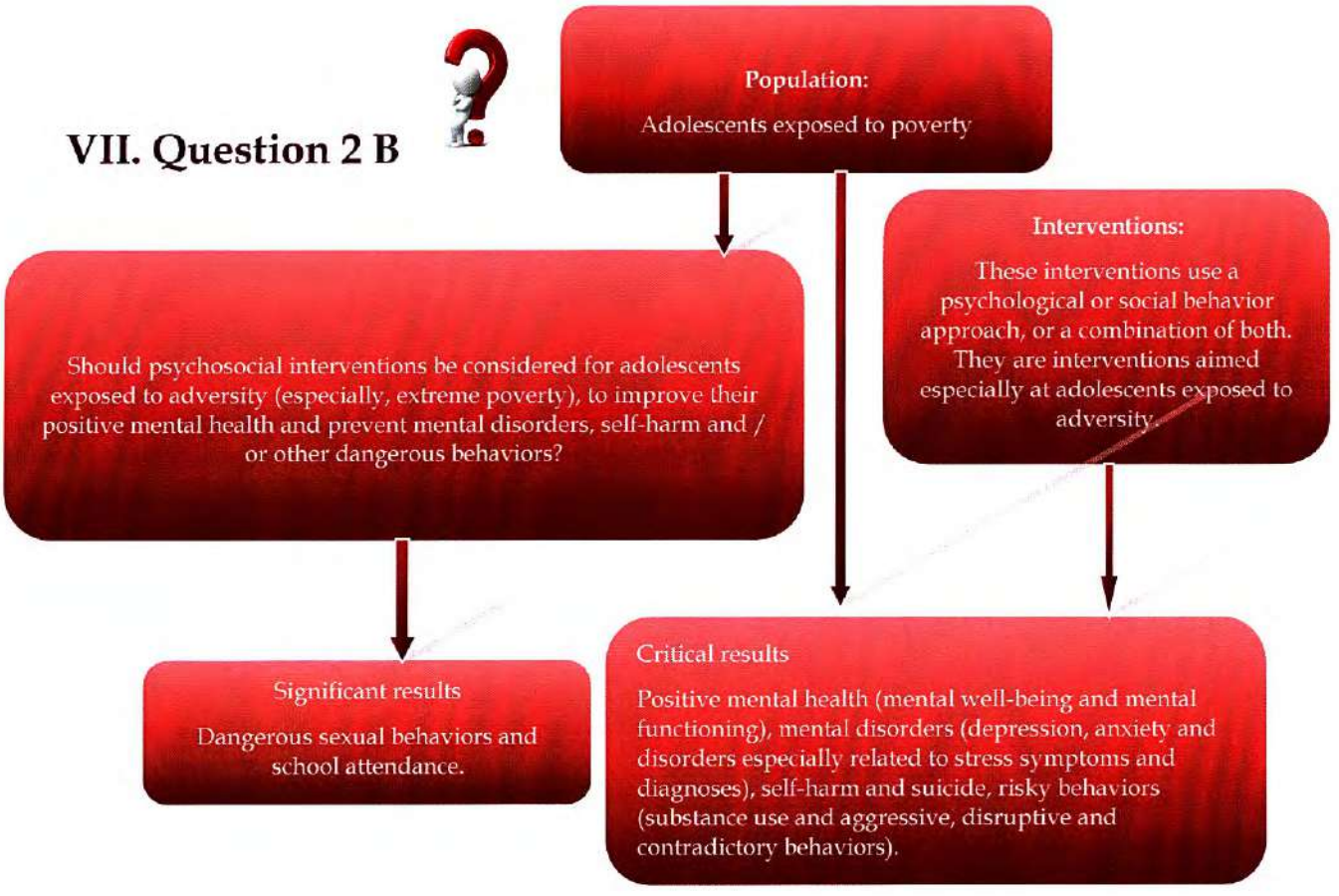
• Guidelines for responding to children and adolescents who have been sexually abused. WHO, 2017. https: // apps.

kush.int/iris/bitstream/handle/10665/259270/9789241550147-eng.pdf?sequence=1[37].

• Responding to intimate partner violence and sexual violence against women: WHO clinical guidelines and policies. WHO, 2013.

https://apps.who.int/iris/bitstream/handle/10665/85240/9789241548595_eng.pdf?sequence=1[35].

VII. Question 2 B



Background

Adolescence is a vulnerable transitional period of biological and psychosocial development. Exposure to poverty during adolescence can affect development, productivity, and health outcomes for adolescents throughout life.

Severe social conditions / poverty put adolescents at increased risk due to food insecurity, hunger, infectious diseases, and exposure to community violence, and school dropout, which limits employment opportunities associated with increased mental health problems, as well as involvement in risky behaviors, including substance use and risky sexual behaviors.

Thus, it is critical to invest in preventing mental health problems in this group. However, there are well-documented methodological challenges related to the evaluation of interventions for this group.

It's Important

Prioritize interventions to promote the positive mental health of adolescents exposed to poverty, as well as to prevent mental disorders, self-harm, and suicide, and to reduce risky behaviors among them.

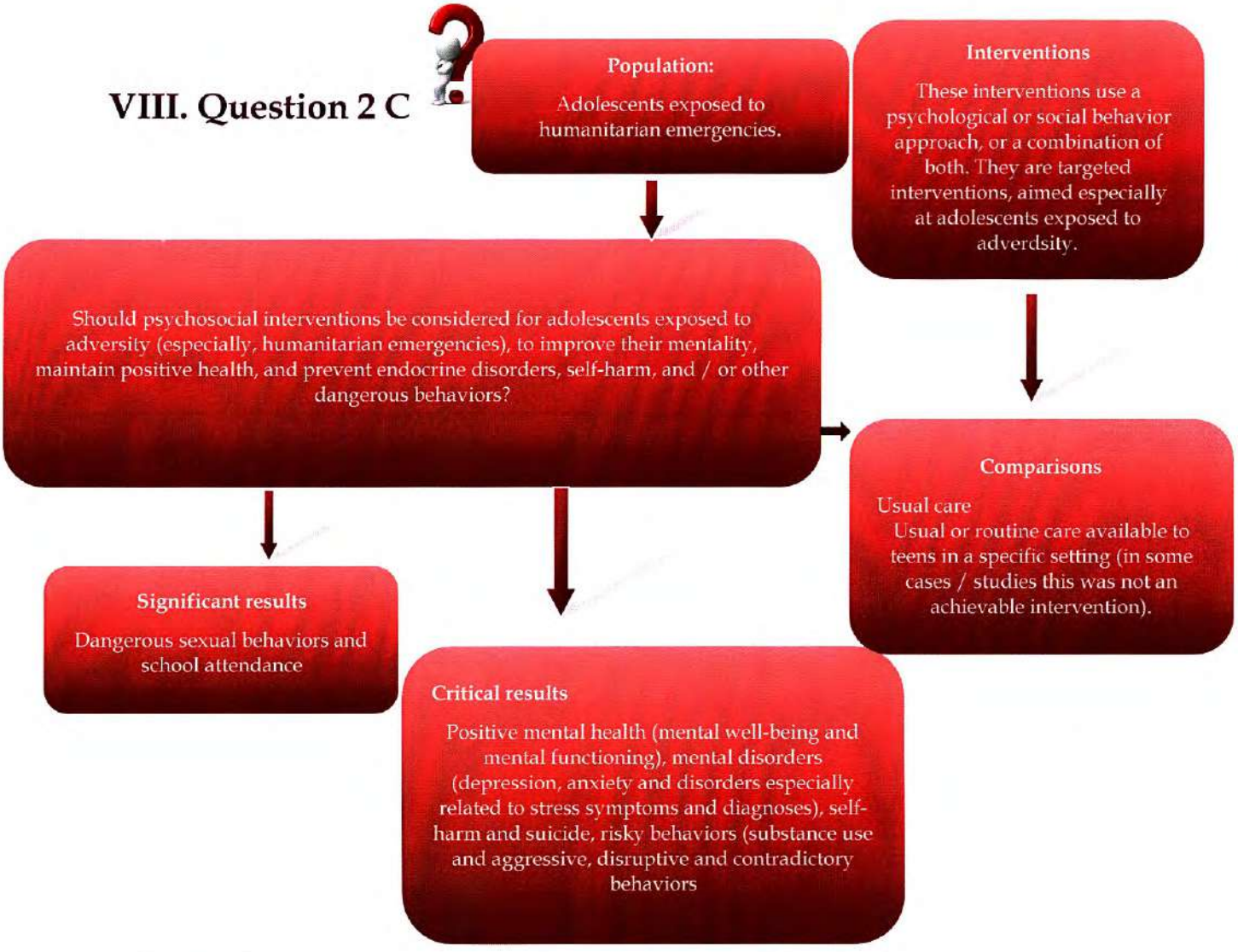
However, due to lack of evidence, it was not possible to provide any specific recommendations for psychosocial interventions to promote positive mental health among adolescents exposed to poverty.

Also, it was impossible to make recommendations for interventions to prevent mental disorders such as [depression, anxiety and stress-related disorders in particular], aggressive, disruptive and adversarial behaviors, substance use, self-harm and suicide in this population.

This was the challenge in identifying the full range of effects in studies on adolescents exposed to poverty.

Poverty as a risk factor for adolescent mental health outcomes is a complex, multidimensional issue that needs to be more widely conceived and defined in future research studies focusing on adolescents exposed to poverty.

VIII. Question 2 C



Background

Humanitarian emergencies involve a wide range of events, including situations arising from war, armed conflict, displacement, natural and man-made disasters, or industrial causes. Humanitarian emergencies have a major impact on a significant number of people.

For example, current estimates show that the number of internally displaced children due to armed conflicts is around 20 million.

Due to wars or other disasters, affected individuals may be exposed to trauma, loss and insecurity as well as may witness cruel acts that affect their mental state.

As such, mental disorders and psychosocial problems are prevalent within humanitarian settings to long-term concerns due to loss, trauma, and insecurity.

Moreover, armed conflict and other humanitarian emergencies can significantly disrupt the life trajectories of the individuals affected.

Adolescents are vulnerable to the negative effects of humanitarian emergencies on mental health.

The need for mental health services in these settings is evident. However, very often a large gap exists between the needs of affected individuals and the services available.

This is especially true for low- and middle- income countries [LMICs], with limited resources affected by conflict or natural disaster, and those expecting larger numbers of refugees.

Recommendation B

Recommendation B

Psychosocial interventions should be provided for adolescents affected by humanitarian emergencies.

These interventions are particularly useful in preventing mental disorders [depression, anxiety, and stress-related disorders] and may be considered to reduce substance use in these populations.

Strength of recommendation: Strong for reducing symptoms and / or preventing mental disorders [depression, anxiety, and stress-related disorders]. Conditional on substance use.

Evidence Security : Low

Important Note: Ongoing support for adolescents exposed to humanitarian emergencies includes a wide range of psychosocial interventions that reflect the heterogeneous nature of experiences involved in emergency events. It is therefore important to carefully interpret the study findings. The available evidence shows that stress management, relaxation strategies, and well-being care are components of related interventions that result in effectiveness.

In the category of adolescents exposed to high levels of trauma, trauma -focused cognitive-behavioral therapy [TNS] has shown to have positive effects in reducing the symptoms of depression, anxiety, and stress.

Reasoning: Studies were subject to the bias of difficulties, interventions in self-reported

outcomes, which are common in these types of interventions. However, a strong recommendation made psychosocial interventions to reduce the symptoms of mental disorders, despite the low reliability of the evidence.

The reason was that the anticipated benefits that are clinically significant outweigh the potential harms. Moreover, important values, equality considerations, and feasibility suggest that mental illness prevention programs should prioritize adolescents exposed to humanitarian emergencies. The evidence supports the notion that all adolescents should benefit from psychosocial interventions generally offered. The high prevalence of mental disorders in adolescents exposed to humanitarian emergencies, and the large treatment gap in those settings, make the case for the implementation of psychosocial interventions in this population even more compelling. However, it is important to consider the profile of adolescents and the degree of exposure, given the heterogeneity of experiences and circumstances.

Additional considerations

Research considerations

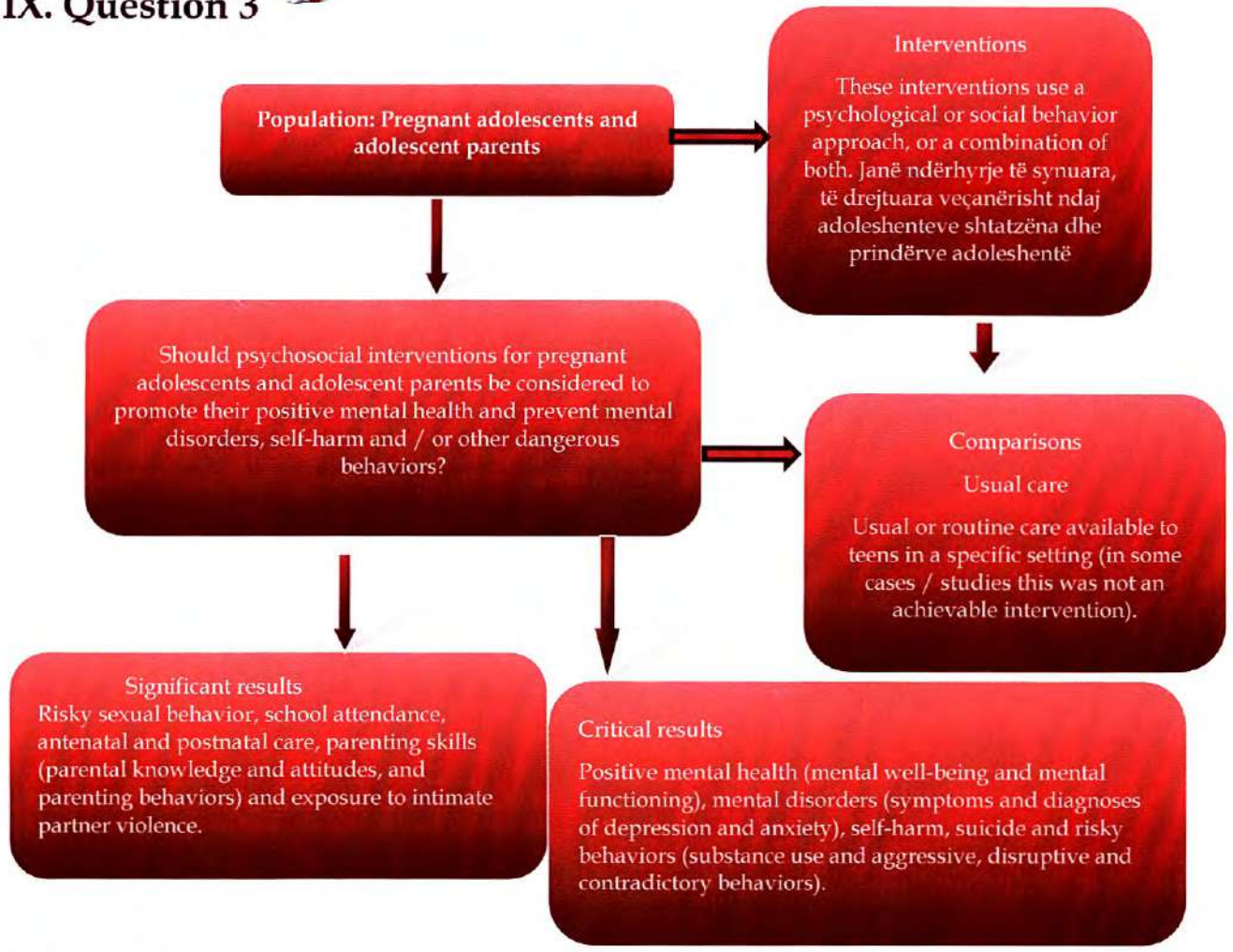
There is a need for a greater focus, focus on research studies in the field of self-harm and suicide. It is especially important to pay attention to the way and ethics of research in these contexts.

Considerations for implementation

In most countries facing humanitarian crises, programmers and researchers have limited access to affected populations.

It is particularly important to consider specific weaknesses [age and gender] within these contexts.

IX. Question 3



Background

Approximately 19 million girls, under the age of 20, are born each year in poor environments. As teens are the fastest growing age group worldwide, the number of pregnancies between them expected to increase in the next decade. While some pregnancies are planned, two-thirds of pregnancies may be unwanted.

Adolescent pregnancy is more common in environments with low socioeconomic status, school dropout, unemployment, and exposure to violence and substance use.

While poverty and vulnerability increase the risk of pregnancy and early parenting, adolescent parenting can lead to many risk factors.

Moreover, pregnant adolescents face additional health and psychosocial risks. Teenage mothers experience higher rates of physical complications and mortality, compared to older women, and is more likely to give birth to babies with lower weight. Pregnant and postpartum adolescents

are more likely to experience mental health problems, such as depression, compared to older mothers.

It has been found that adolescents find it difficult to estimate the amount of support they will receive after giving birth, leading to increased stress and postpartum depression. Moreover, depression in this group is associated with school dropout, harsh parenting, use of alcohol and other substances, and recurrent pregnancies.

Recommendation C 

Psychosocial interventions

It should be considered for adolescents, pregnant women and adolescent parents, especially to positively promote mental health [mental functioning and mental well-being] and improve school attendance.

Strength of recommendation: Conditional.

Evidence Security: Low

Important remarks: Based on the available evidence, cognitive behavioral skills development programs considered for adolescents, pregnant women, and adolescent mothers.

Background

Participants' settlements constituted the most common distribution environment [n = 7, 41.2%], with three other studies [17.6%] conducted in one health center and two [11.8%] in a school setting. Two other studies [11.8%] conducted in a community setting.

Three interventions performed through a combination of these environments. The most common type of implementer in the studies was the secular health worker [n = 7].

A study was submitted digitally and using pamphlets, thus disseminating to staff. Mental health professionals meanwhile conducted three [17.6%] other studies. Professionals who were not mental health specialists performed two interventions, while mental health professionals and lay workers performed two more.

Six of the studies showed the length of time spent implementing the training. This ranged from 1 to 500 hours, with an average of 38 hours. Over half of the interventions were delivered to individuals [n = 10, 58.8%] while three were performed within a group or using an individual combination. One study used videos and pamphlets. Overall, 15 studies showed the total

contact time of the intervention. Of those studies that reported contact ranged from 4 to 43 hours with an average of 18 hours of intervention.

However, five [29.4%] studies had a long follow-up, ranging from 6 months to 2 years after birth.

This was a specific feature of the interventions for pregnant teens and parents, without being reflected in other adolescent mental health interventions.

Less than one third of the studies [n = 5, 29.4%] explicitly involved adolescents in the development of the intervention; 10 studies [58.8%] adapted their intervention approach to suit individual needs and preferences

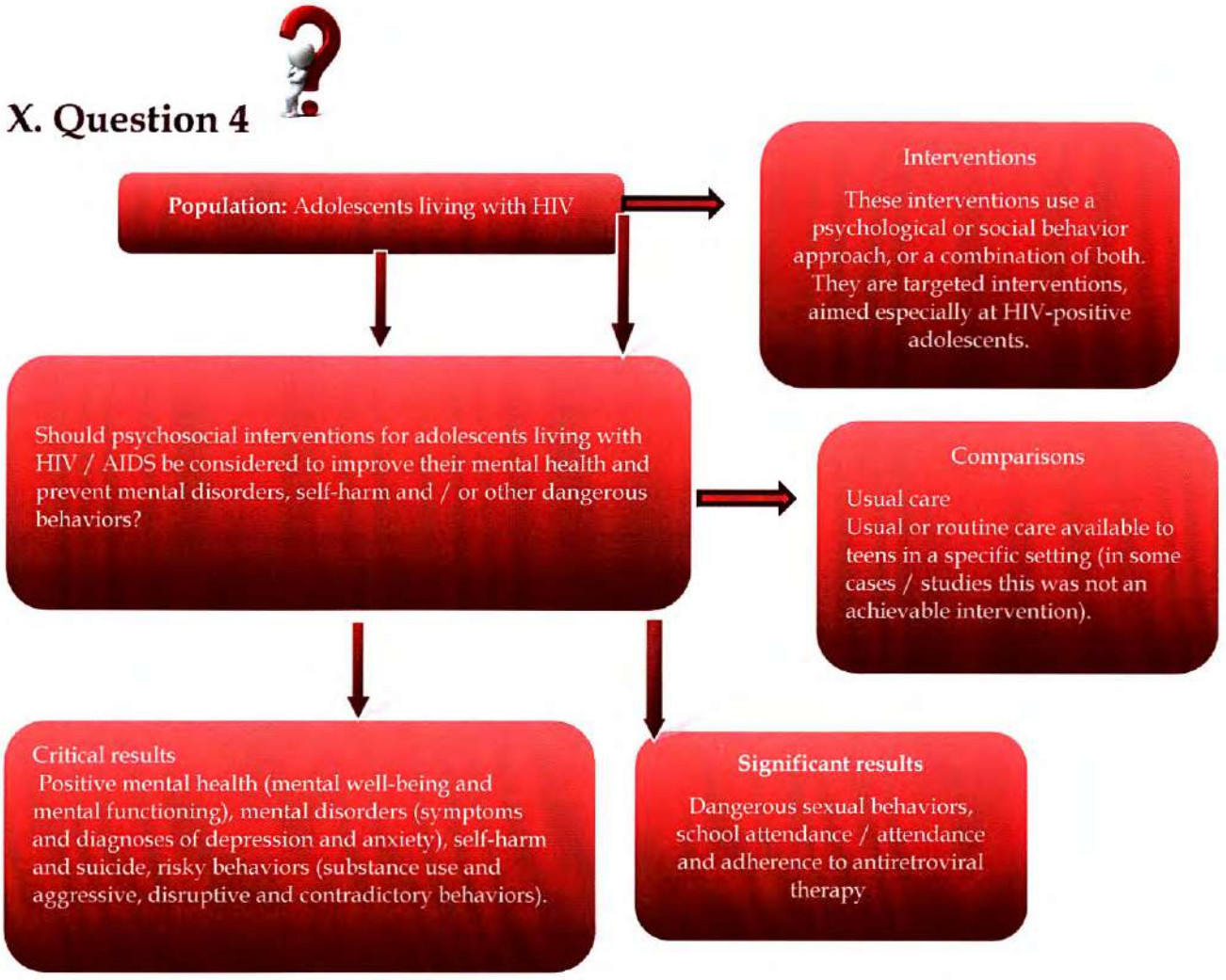
Results of Meta-Analysis

Results of Meta - Analysis	Time Points			
	Effect size	P-value	95% of confidence intervals	
Positive/ mental health	0.3549	0.0141 *	0.0952	0.6147
Mental Disorders [Depression & Anxiety]	0.1080	0.2145	-0.2953	0.0792
Self-harm and Suicide				
Aggression, disruptive and oppositional disorders				
Use of substances	-0.2682	0.2553	-1.0988	0.5624
Behaviors dangerous to sexual and reproductive health	-0.1661	0.5556	-2.6821	2.3499
Attendance at school	0.6350	0.0068 *	0.5489	0.7210
Adherence to antenatal and postpartum care	0.3118	0.5299	4.0408	4.6643
Parenting skills	0.0723	0.4703	0.1599	0.3045
Exposure to violence by intimate partner				

* P <0.05. Italics are only indicative, given the statistical estimation procedures used.

For positive mental health, school attendance, antenatal and postnatal care and parenting skills, a magnitude of positive effect indicates a beneficial effect. For all other results, the magnitude of the negative effect indicates a beneficial effect.

X. Question 4



Focusing on sexual reproductive health and the rights of women living with HIV, this section also covers some aspects of mental health, such as the impact of HIV diagnosis on mental health, high prevalence, difficulties of women who living with HIV as well as concerns about stigma, fear and discrimination.

These guidelines provide guidance on diagnosing HIV infection, using antiretroviral medications to treat and prevent HIV infection, and caring for people [children, adolescents, and adults] living with HIV.

The guidelines emphasize the fact that an HIV-positive diagnosis can have consequences for the mental health of the person living with HIV, which is manifested by an increased risk of depression or Self-harm /Suicide.

It also pointed out that mental health issues can impede adherence to antiretroviral therapy and that antiretroviral medications can cause side effects with an impact on mental health.

However, we have no recommendations for specific psychosocial interventions to mitigate the risks.

Consolidated guidelines for the prevention, diagnosis, treatment and care of HIV for key populations.

These guidelines propose a comprehensive package of HIV-based evidence-based recommendations for key populations, including men who have sex with men [MSM], injecting drug users, [PDI] people in prisons and other closed settings, female employees [PSF] and ransgender persons [TG].

The guidelines highlight mental health disorders [depression or psychosocial stress] as a potential concomitant disease to HIV, which may require preventive or managerial interventions.

However, no specific recommendations for psychosocial interventions presented to help mitigate the risks.

There are no relevant recent reviews by Cochrane on preventive psychosocial interventions to improve the mental health of adolescents living with HIV / AIDS.

A 2013 systematic review of the mental health of adolescents living with HIV provided little results describing the prevalence of psychiatric diagnoses in HIV-infected adolescents.

However, studies suggest that psychiatric disorders such as depression and anxiety are more prevalent among perinatally infected adolescents compared to uninfected adolescents.

A narrative review of mental health challenges among adolescents living with HIV highlighted the need to address proactively mental health issues for all HIV-infected youth, and to integrate such issues into general HIV care to adolescents.

Health care systems should also pay more attention to the way in which mental health support provided to integrate HIV management into care. This should assume a life course approach, taking into account the changes that occur from childhood to adolescence and adulthood.

The apparent lack of studies and support for the mental health needs of adolescents living with HIV / AIDS exposes a large gap in research and practice and calls for urgent, more cost-effective solutions.

Characteristics of the study

Only three relevant studies are identified: one in a high-income country [USA], one in a high middle-income country [South Africa] and another in a low middle-income country [Zimbabwe].
All three studies had similarities in the methodology used.

All studies used random control test, same design, had similar sample sizes [mean 77 participants; age group 10-22 years] as well as gender segregation -boys and girls involved [average 48.5% boys and 51.5% girls].

All evidence for enrolled participants collected from clinics. However, studies based in African countries enrolled participants aged 15 years and older, while the American study enrolled participants aged 14 years and older.

The South African study reported positive mental health and mental health disorders as a result, while the American study included these two results as well as the implementation of antiretroviral therapy as well as aggressive, disruptive, and contradictory behaviors.

The Zimbabwean study considered positive mental health and adherence to antiretroviral therapy. No studies have measured self-harm and suicide, substance use, risky sexual and reproductive health behaviors, or school attendance.

Implementation of interventions

The studies were conducted in health centers and used group forms, only one study was conducted individually in the homes of the participants. No study used any digital media or adapted their interventions according to participants' reactions. None of the studies specified the duration of the session.

Two studies had a similar number of sessions [six for the South African study and nine for the American study], while the third had weekly sessions over the course of a year. One study used secular workers another used both secular workers and mental health professionals, and one used conscience instructor.

Results of Meta-Analysis

Results of Meta - Analysis	Time Points			
	Effect size	P-value	95% of confidence intervals	
Positive /Mental health	0.6818	0.0956	- 02,968	1.6604
Mental Disorders [Depression & Anxiety]	0.2146	0.7611	-6.7059	7.135
Self-harm & Suicide				
Aggression, disruptive and oppositional disorders				
Use of substances				
Behaviors dangerous to sexual and reproductive health				
Attendance at school				
Adherence to antiretroviral therapy	3,223	0.4685	-33.8605	40.3065

The effects of desirability

The expected desirable effects are unknown. Similarly, the predicted side effects are unknown, as no significant effects were identified.

Securing evidence

The overall security of the evidence was very low. Two results had very low reliability of evidence [positive mental health and mental disorders], and two others had low reliability [compliance with antiretroviral therapy, aggressive, disruptive, and contradictory behaviors]. Outcomes related to self-harm and suicide, school attendance, substance use, and dangerous sexual and reproductive health behaviors were not measured.

However, improving mental health is a key part of SDGs [objective 3.4] and reducing suicide mortality is a key measure for indicator 3.4.2

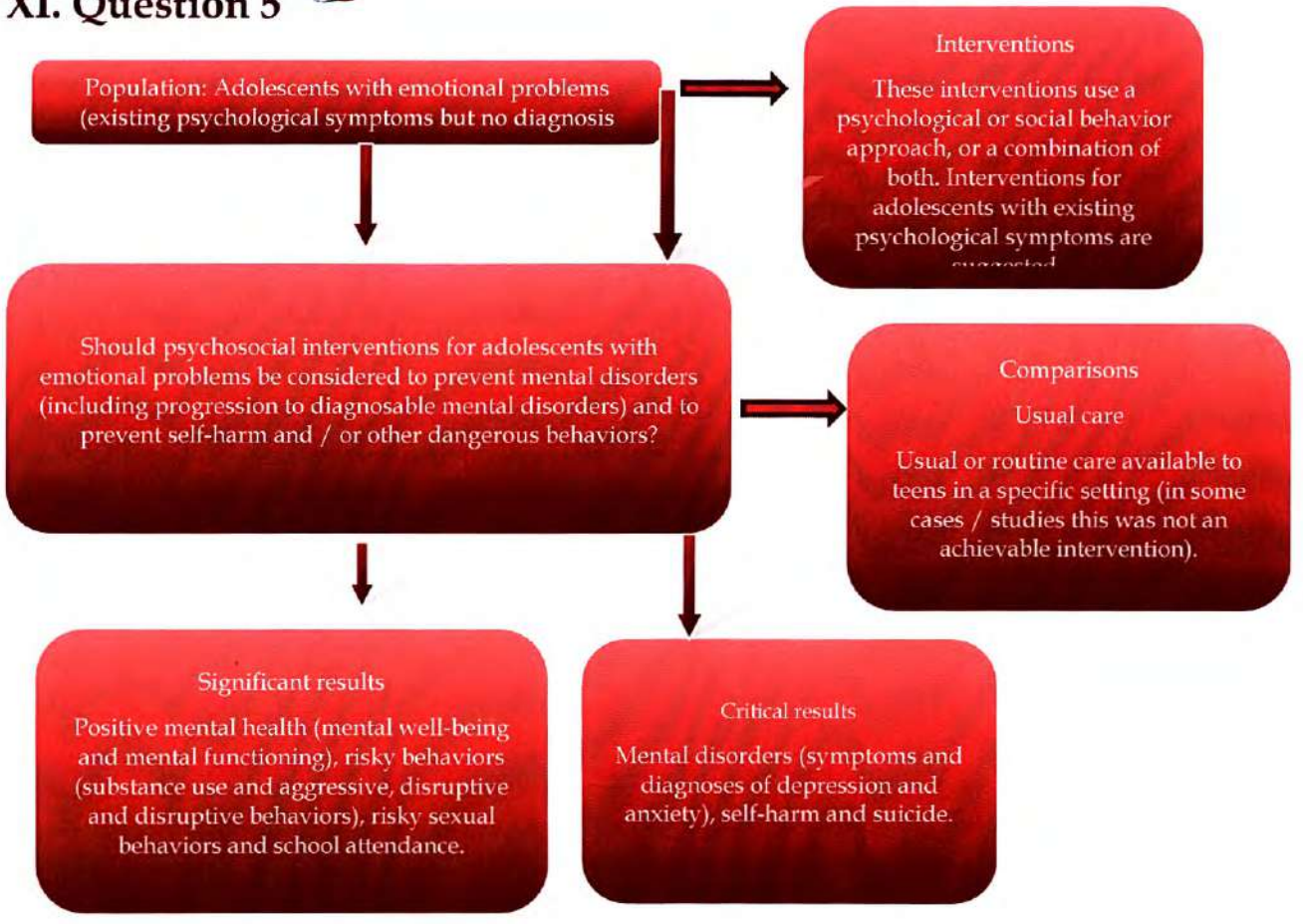
Adolescents in rural environments, or in environments where HIV is highly stigmatized, may have greater difficulty accessing these types of interventions, but may need them more.

This review did not identify any interventions for adolescents living with HIV among major populations [such as young sex workers, injecting drug users, transgender men and women, or men having sex with men].

Extremely vulnerable to HIV and stigma, these groups of the population who may have additional needs and are exposed to significant health and psychosocial risks. There is a need for research on the most vulnerable subgroups of this population.

Young women aged 15-24 are at particularly high risk of HIV infection and may benefit from gender-specific psychosocial interventions, interventions to address the many related vulnerabilities around sexual and reproductive health, and gender norms.

XI. Question 5



Emotional disorders , such as anxiety and depression, are becoming more and more common in adolescents. The development of these disorders can lead to a range of negative effects on adolescents, such as worse performance at school, problems in peer relationships, and increased participation in risky behaviors.

Poor outcomes in the context of mental health in adolescents pose a major problem, increasing the risk of physical and mental health problems in the future.

Opportunities also increase: for a diagnosis of depression in adulthood, poor job performance, reduced income, suicidal ideation, and physical health problems such as diabetes.

Indicated preventive interventions aim to avoid the onset of a diagnostic, mental health condition in identified high-risk adolescents who are already experiencing mild to moderate symptoms.

Such interventions are often more tailored to individual needs than universal, school-based interventions. This can bring greater satisfaction to both the implementer and the participants and increase sustainability.

Recommendation D

Recommendation D 

Indicated psychosocial interventions should be offered to teens with emotional symptoms.

Strength of recommendation: **Strong** for reducing the symptoms of depression / anxiety and / or preventing mental disorders [depression and anxiety] and promoting positive mental health. Condition for improving school attendance.

Security of evidence: **Very low**

Important remarks: Based on the available evidence, group-based TNS may be considered for adolescents with symptoms / emotions.

Reasoning: The reliability of evidence often diminished because studies were subject to risk to promote mental health positive thinking approach in adolescents with emotional problems. This was despite the very low security of the evidence.

The reason is that the benefits outweigh the potential harms. Moreover, considerations of significant values, capital and cost-effectiveness justify investing in interventions for this at-risk group, prejudices due to difficulties, interventions and reliance on self-reported outcomes, both elements of which are common in these types of study interventions. However, a strong recommendation was made to reduce the symptoms of depression and / or anxiety and / or prevent mental disorders [depression and anxiety

Poor mental health among adolescents is a major risk factor for physical and mental health problems later in life. Early intervention in adolescents who are already displaying emotional problems has proven crucial in preventing mental health problems and optimizing health and life trajectories.

Implementation of the intervention

Most interventions were performed in schools [n = 38, 54.3%], eight tests 11.4%] were performed in a university setting.

One intervention [1.4%] was implemented in a community setting and the other two [2.9%] were conducted through a combination of school and community settings. Community facilities included participants' homes, clinics, or community centers. Moreover, seven interventions were performed exclusively through a digital platform [10.0%], and seven were performed face to face with the help of a digital component.

Six interventions were performed in one health center [8.6%]. Six studies did not report where the intervention took place [8.6%].

Mental health professionals performed the majority of interventions [n = 44, 62.9%]. Ten studies were conducted only digitally or in print and therefore did not involve staff [14.3%]. Eight of the trials used a staff combination [11.43%], while three used teachers [4.3%] and four did not specify the implementer [5.7%].

The intervention was attended by a peer leader, but none of the interventions used health professionals other than mental health specialists.

Over half of the interventions were performed in groups [n = 39, 55.7%], while 24 were performed individually [34.3%]. Seven interventions were implemented using a mixture of group and individual approaches [10.0%]. Overall, 12 studies did not show total contact time of interventions [17.1%]. From those who reported the time, the contacts ranged from 1 to 24 hours, with an average of 9 hours. Only 4 of the studies [5.7%] explicitly involved adolescents in the development of the intervention, while 15 [21.4%] adapted their intervention approach to suit the individual needs of adolescents

Results of Meta-Analysis

Results of Meta - Analysis	Time Points			
	Effect size	P-value	95% of confidence intervals	
Mental Disorders [Depression & Anxiety]	-0.3058	0.0000 *	-0.4220	-0.1897
Self-harms & Suicides	0.0078	0.9672	-0.4677	0.4833
Positive / Mental health	0.1941	0.0003 *	0.0965	0.2918
Oppressive, disruptive, and aggressive disorders	-0.2016	0.1076	-0.4604	0.0572
Use of substances	-0.1054	0.2132	-0.2889	0.0781
Behaviors dangerous to sexual and reproductive health				
School attendance * *				

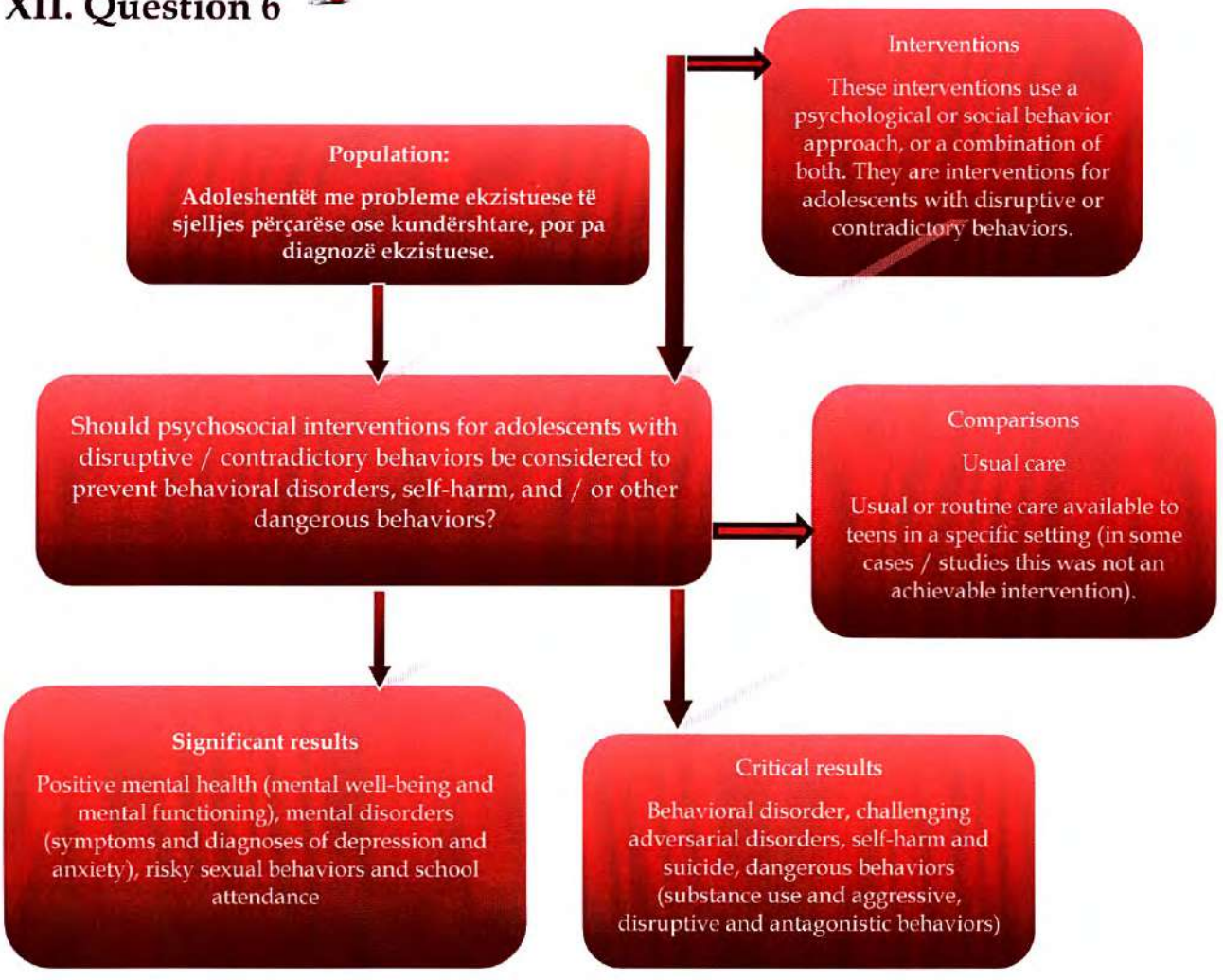
* P <0.05. For [positive] mental health , the magnitude of the positive effect indicates a beneficial effect. For all other results, a magnitude of negative effect indicates a beneficial effect. ** School attendance was not meta-analysis because only one study measured this result

In addition to the main meta-analysis, sensitivity analyzes were performed to detect potential effects in studies that used different ways to screen participants in the intervention.

All studies in this review have used some form of screening, where the differences made are as follows:

- **High,** refers to studies that screened and included only adolescents who were considered high-risk or high-threshold, based on symptomatology.
- **Average /moderate,** refers to studies that examined and included adolescents with moderate symptoms [in other words, not adolescents with higher scores].
- **Mixed,** refer to studies that examined and included adolescents with high and moderate symptomatology.

XII. Question 6



Behavioral problems affect about 7% of 9- and 15-year-olds with an estimated prevalence of 3.3% for challenging opposition disorder and 4% for behavioral disorder. Many more children and adolescents may present with such problems [but do not meet the criteria for a formal diagnosis] than have been formally diagnosed. Due to their social status and health implications, the external behaviors of children and adolescents are seen as a concern for Public Health [GP].

Their behaviors can cause significant problems at school, in peers, and in the normal functioning of the family that can continue into adulthood, increasing the risk of substance use.

The data show that behavioral problems in adolescence cause social and health damage, a result that reflects on poor results in school, profession, health as well as other negative consequences that are reflected in adulthood. Moreover, behavioral disorder is strongly associated with delinquency and criminal activity.

Recommendation E

Recommendation E

Indicated psychosocial interventions skills should be provided for adolescents with disruptive / contradictory behaviors.

These interventions reduce aggressive, disruptive, and hostile behaviors, prevent mental disorders [depression and anxiety], and promote positive mental health. Interventions should be performed carefully to avoid increased substance use adolescents with disruptive and contradictory behaviors.

Strength of recommendations: **Conditional**

Security of evidence: **Very low**

Important remarks: According to the available evidence, effective psychosocial interventions for adolescents at risk or diagnosed with behavioral disorders often include: training for parents, based on social learning approaches; and training in problem-solving social and interpersonal skills for adolescents. They may also include multimodal interventions for teens and their parents, based on a model of social learning.

Results of Meta-Analysis

Results of Meta - Analysis	Time Points			
	Effect size	P-value	95% of confidence intervals	
Behavioral disorder				
Challenging opposition disorder				
Self-harms & Suicides				
Disorders, contradictory, disruptive and aggressive	-0.4812	0.0220 *	-0.8855	-0.0769
Use of substances	0.2116	0.0056 *	0.1881	0.2351
Mental / positive health	0.2888	0.0418 *	0.0126	0.5649
Mental Disorders [Depression & Anxiety]	0.4416	0.0084 *	- 0.7501	-0.1330
Behaviors dangerous to sexual and reproductive health				
Attendance at school				

* P <0.05. Italics are only indicative, given the statistical estimation procedures used. For positive mental health, the magnitude of the positive effect indicates a beneficial effect.

All the negative effect magnitude results showed a beneficial effect. In addition to the main meta-analysis, sensitivity analyzes were also performed to detect potential effects.

The questionnaire used a review form. However, the review team made the following differences.

- High refers to studies that have examined and included only adolescents who are considered to be at high risk or high threshold, based on symptomatology.
- Average / moderate refers to studies that examined and included adolescents who showed moderate symptomatology [in other words, not adolescents with higher scores].
- Mixed refer to studies that examined and included adolescents with high and moderate symptomatology.

XIII. EVALUATION

XIII. Evaluation[4]

Symptoms of Mental and Behavioral Disorders in Adolescents

Adolescents who have physical complaints or after a general health evaluation have:
Typical complaints of emotional, behavioral, or developmental disorders.
Risk factors such as malnutrition, abuse and / or neglect, frequent illnesses, chronic illnesses [e.g. HIV/AIDS]

Guardian - concerns for the teenager:

Difficulty keeping up with peers or performing daily activities that are considered normal for age - Behavior [e.g. very active, aggressive, frequent and / or severe anger, desire to be very alone, refusal to do regular activities or go to school]

Teachers - concerns for teenagers

For example, easily distracted, disruptive in the classroom, often gets into trouble, difficulty in carrying out school activities.

Health workers or social services in the community [concerns about adolescents]

- e.g. behaviors that break the rules or the law, physical aggression

1

Evaluation of development of disorders

Are aggressive behaviors repeated in the child / adolescent, are they disobedient or challenging, for example:

EVALUATION FOR BEHAVIORAL DISORDER

– Argument with adults
– Challenge or refusal to comply with their demands or rules - Extreme irritability/anger - Frequent and severe anxiety, [temperament] - Difficulty understanding others - Provocative behavior - Excessive levels of fighting or harassment - Cruelty to animals or people - Serious destruction of property, arson - Theft, repeated lying, absence from school, running away from home.

Middle childhood [6-12 years old]
Avoidance or delay in following instructions, complaints or debates with adults or other children, occasionally losing, - patience.

Adolescents [ages 13-18]

- Failure to follow the rules, giving reasons that the rules and restrictions are unfair or unnecessary, occasionally being rude, negligent, debatable or challenging with adults..

I.

NO YES

Suspected

delayed developmental disorder

Are there any signs / symptoms that suggest: – Deficiencies in nutrition, including iodine deficiency

– Anemia - Malnutrition - Acute or chronic infectious diseases, including ear diseases and infections, HIV / AIDS

NO YES

Manage conditions by integrating childhood disease management

Evaluate the child for eyesight and / or hearing impairment: See if the child fails to: - Look at the eyes - Instruct to follow a moving object with head and eyes - For hearing evaluation, see if the child fails to:

- Turn his head to see if there is anyone behind him [if he hears noise] - Show reaction to loud noise

– Make noises through different sounds, if it is a baby [say the names the baby has heard most often - mom, dad].

NO YES

Consult a specialist for evaluation

Go to part 2

2

II.

Evaluate for problems from indecision and hyperactivity

EVALUATE FOR PROBLEMS FROM INATTENTION OR HYPERACTIVITY

Is it the child / adolescent:

- Hyperactive? - Can not stand still for a long time? - Easily distracted has difficulty in performing tasks? - Moves incessantly.

Are the symptoms persistent, severe, and causing significant difficulty in daily functioning?

Are the symptoms present in multiple settings?

– Have they lasted at least 6 months - Are they inappropriate for the child / adolescent developmental level?

– Are there significant difficulties in day-to-day, personal, family, social, educational, professional or other functions?

Take into account ADHD

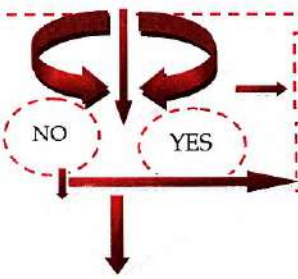
ADHD, most likely

Take into account problems with behavior

Take into account ADHD

Exclude physical conditions that may resemble ADHD.

Does the child / adolescent have any of the following symptoms: - Thyroid disease - Acute or chronic infectious diseases, including HIV / AIDS - Uncontrolled pain e.g. from an ear infection, sickle cell anemia.



Treat physical condition

Go to part 3

III. 3

EVALUATION FOR BEHAVIOR DISORDER

Does the child / adolescent have repetitive aggressive, disobedient, or challenging behaviors, for example:

EVALUATION FOR BEHAVIOR DISORDER 3 – Debate with adults - Challenge or refusal to comply with their demands or rules - Extreme irritability / anger - Frequent and severe anxiety - Temperament - Difficulty understanding others - Provocative behavior - Excessive levels of fighting or Harassment - Cruelty to animals or people - Serious destruction of property, arson - theft, repeated lies, absence from school, running away from home.

NO YES

[18 months-5 years]

[6-12 years]

[13-18years]

Behavioral Disorder unlikely

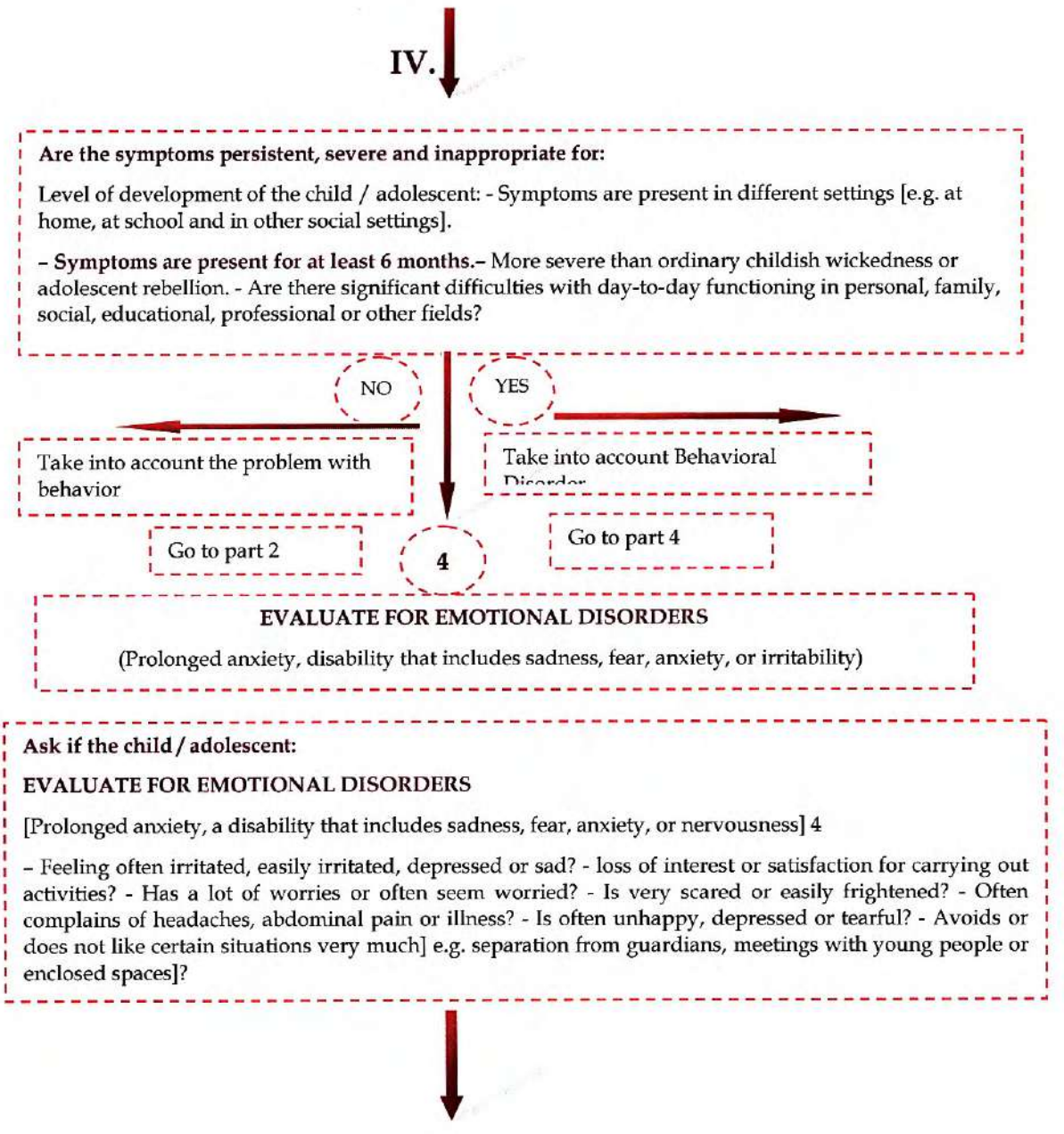
Go to step 4

CLINICAL ADVICE: CHILD / ADOLESCENT BEHAVIOR DISORDERS

Toddlers and young children [age 18 months - 5 years]– Refusing to do what is required of them, breaking the rules, quarreling, complaining, exaggerating, saying things that are not true, denying that they have done anything wrong, being physically aggressive, and blaming others for their bad behavior. Short-term rages [emotional outbursts of crying, screaming, kicking, etc.], usually lasting less than 5 minutes and not more than 25 minutes, usually occur less than 3 times a week. Typical developmental rages should not result in self-harm or frequent physical aggression towards others, and the child may usually calm down afterwards.

Middle childhood [ages 6-12] – Avoidance or delay in following instructions, complaints or debates with other adults or children, losing patience from time to time.

Adolescents [ages 13-18]– Failure to enforce the rules by saying that the rules and restrictions are unfair or unnecessary, occasionally being rude, disregarding, arguing or challenging with adults.


IV.
Are the symptoms persistent, severe and inappropriate for:
Level of development of the child / adolescent: - Symptoms are present in different settings [e.g. at home, at school and in other social settings].
– Symptoms are present for at least 6 months.– More severe than ordinary childish wickedness or adolescent rebellion. - Are there significant difficulties with day-to-day functioning in personal, family, social, educational, professional or other fields?
NO
YES
Take into account the problem with behavior
Take into account Behavioral
Go to part 2
4
Go to part 4
EVALUATE FOR EMOTIONAL DISORDERS
(Prolonged anxiety, disability that includes sadness, fear, anxiety, or irritability)
Ask if the child / adolescent:
EVALUATE FOR EMOTIONAL DISORDERS
[Prolonged anxiety, a disability that includes sadness, fear, anxiety, or nervousness] 4
– Feeling often irritated, easily irritated, depressed or sad? - loss of interest or satisfaction for carrying out activities? - Has a lot of worries or often seem worried? - Is very scared or easily frightened? - Often complains of headaches, abdominal pain or illness? - Is often unhappy, depressed or tearful? - Avoids or does not like certain situations very much] e.g. separation from guardians, meetings with young people or enclosed spaces]?

V.

NO

YES

Go to step 5

CLINICAL ADVICE: APPROPRIATE AGE FOR FEAR AND ANXIETY IN CHILDREN AND ADOLESCENTS

[Age 9 months - 2 years]

- Fear of strangers, anixiety when separated from guardians

Young Children [ages 2-5] - Fear of storms, fire, water, darkness, nightmare and fear of animals

Middle childhood [6-12 years]- Fear of monsters, ghosts, germs, natural disasters, physical illnesses and serious injuries - Anxiety about school or performing in front of others

Adolescents [age 13-18]

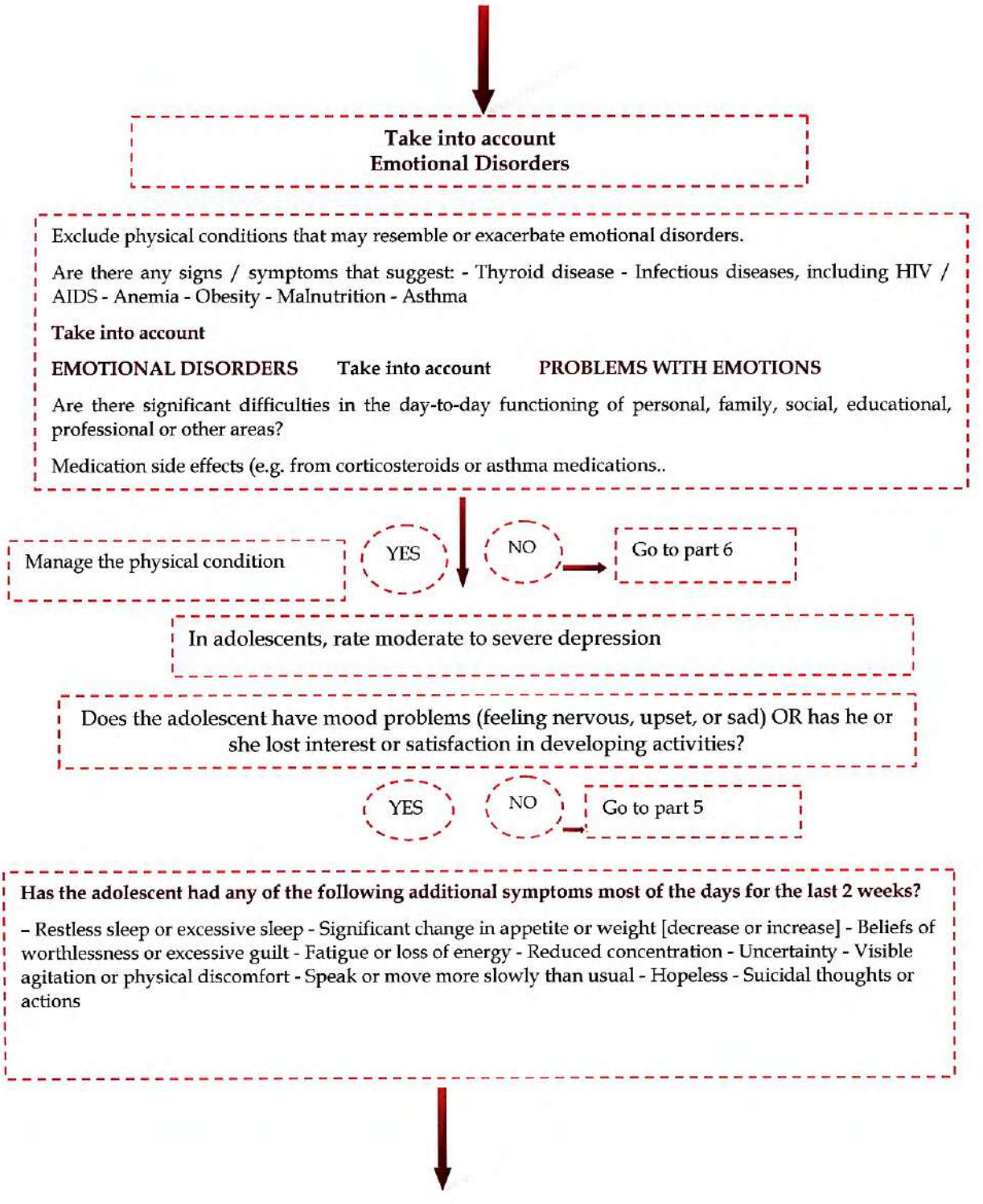
- Fear of rejection by peers, performance in front of others, physical illness, medical procedures, catastrophes (e.g. war, terrorist attacks, disasters)

Are there significant difficulties in everyday life in the personal, family, social, educational, professional or other fields?

YES

NO

Take into account problems with **EMOTIONS**


Take into account
Emotional Disorders
Exclude physical conditions that may resemble or exacerbate emotional disorders.
Are there any signs / symptoms that suggest: - Thyroid disease - Infectious diseases, including HIV / AIDS - Anemia - Obesity - Malnutrition - Asthma
Take into account
EMOTIONAL DISORDERS
Take into account
PROBLEMS WITH EMOTIONS
Are there significant difficulties in the day-to-day functioning of personal, family, social, educational, professional or other areas?
Medication side effects (e.g. from corticosteroids or asthma medications..
Manage the physical condition
YES
NO
Go to part 6
In adolescents, rate moderate to severe depression
Does the adolescent have mood problems (feeling nervous, upset, or sad) OR has he or she lost interest or satisfaction in developing activities?
YES
NO
Go to part 5
Has the adolescent had any of the following additional symptoms most of the days for the last 2 weeks?
– Restless sleep or excessive sleep - Significant change in appetite or weight [decrease or increase] - Beliefs of worthlessness or excessive guilt - Fatigue or loss of energy - Reduced concentration - Uncertainty - Visible agitation or physical discomfort - Speak or move more slowly than usual - Hopeless - Suicidal thoughts or actions

Are there significant difficulties in performing daily functions, family, social life, education, professional or other areas?

YES

NO

Take into account:Problem with Emotions

Go to part 5

Take into account Depression

CLINICAL ADVICE
There may be delusions or hallucinations. If the adolescent is currently being treated for depression the treatment should be adjusted. **CONSULT A SPECIALIST**

Exclude an episode story (s), manic & normal reaction to the last big loss. **DEPRESSION**

5

Evaluate for other **MNS** priority conditions

Are there any other simultaneous MNS conditions? Evaluate according to the main graph mhGAP-IG. See »MC.Do not forget to evaluate for disorders due to substance use. See »SUB.For children with developmental delays/disorders, do not forget to evaluate for epilepsy. See »EPI

Evaluate and Manage

YES

N

6

CLINICAL ADVICE

Ask the child / adolescent directly about these exposures, choose the time when it is appropriate and safe for this conversation to take place [e.g. not in the presence of a guardian who may have abused the child / adolescent]. Adolescents should always be offered the opportunity to meet them on their own, without the presence of a guardian.

Evaluate the Home

Are emotional or behavioral problems a reaction to or exacerbation of a distressing or frightening situation?
Evaluate for:

Clinical characteristics or any element in clinical history suggesting ill-treatment or exposure to violence (see **[CLINICAL ADVICE]**

Any recent or ongoing severe stress (e.g. illness or death of a family member, difficult living and financial circumstances, being bullied or harmed)

Refer to child protection services if necessary, Explore and manage stressors

Child / adolescent safety as a first priority

Assure the child / adolescent that all children / adolescents in need of protection are protected from abuse

Provide information on where to seek help for any persistent abuse - Arrange additional support including referral to a specialist – Take into account additional psychosocial interventions, Make sure instructions are followed.

YES

NO

CLINICAL ADVICE:

WARNING - CHARACTERISTICS OF CHILD ABUSE, CLINICAL FEATERS

Physical abuse – Injuries [e.g. bruising, burning, choking marks or marks from a belt, whip, key or other object] - Any serious or unusual damage without explanation or with an inappropriate explanation.

Sexual abuse

- Injuries or symptoms of genital or anal organs that are medically unexplained - Sexually transmitted infections or pregnancy - Sexual behavior, etc.

Negligence

– Excessively dirty, inappropriate clothing - Signs of malnutrition, decayed teeth.

Emotional abuse and all other forms of abuse - Any sudden or significant change in the child / adolescent's behavior or emotional state is explained by another cause, e.g. - Unusual fear or severe anxiety [e.g. inconsolable crying] - Self-harm or social withdrawal - Aggression or running away from home - Seeking love indiscriminately from adults - Developing new behaviors of pollution and humidity (dirt and wetting) etc.

ASPECTS OF INTERACTION ARE WITH CHILDREN / ADOLESCENTS

Persistent behaviors that do not respond, especially to a baby (e.g. does not provide comfort or care when the child / adolescent is frightened, hurt, or ill) Hostile or repulsive behaviors - Use of inappropriate threats [e.g. child / adolescent abandonment] or harsh methods of discipline..

Do guardians have any MNS priority conditions that may affect their ability to care for the child / adolescent?

Take into account, in particular, depression and disorders due to substance use.

CLINICAL ADVICE

»Depressive disorder in guardians can worsen emotional state, behavior or developmental disorders in their children / adolescents

Does the child have the right opportunities to play and interact/communicate at home?
Consider asking: Who does the child spend most of his time with? How do you/they play with the child? How often? How do you/they communicate with the child? How often?

Evaluate and manage for guardianship

MNS Terms.

NO

YES

Give age-appropriate stimulation and parenting tips. Refer to

Child Care

Development http://www.who.int/maternal_fëmijë_adolescent/dokumente/kujdes_fëmijë_zhvillim/en/

Take into account the need for additional child support including referral to child protection services where available.

7

Evaluate the Environment - The School

Is the child / adolescent in school?

CLINICAL ADVICE
»Ask the child / adolescent directly about these exposures, when they are appropriate and safe to develop

YES

NO

Provide information about education services and educate the guardian about the importance of keeping the child/adolescent in school as much as possible.

Is the child / adolescent:
bullied, irritated?
Not able to attend and learn?
Do not want / refuse to attend school?

YES

NO

Once you have obtained the consent, contact the teachers and other school staff. Go to management [2,7]
If there has been an absence from school, try to help the child / adolescent return to school as soon as possible and explore the reasons for the absence.

4 mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings: mental health Gap Action Programme [mhGAP] – version 2.0. Geneva: World Health Organization; 2016

XIV. Counseling for adolescents with mental health problems

14.1 Counseling and support [5]

Many children begin counseling treatments primarily with cognitive and behavioral therapy [TNS] therapy, which equips them for healthy thinking, problem solving, and stress management. TNS is adapted to different groups and different situations, and is helpful in preventing depression.

Self-care strategies to lead a normal life are important to everyone. This includes eating well, exercising, spending time with others, and finding time to engage in fun activities. Support groups, programs, or community services that support healthy living can also be helpful.

14.2 Group support

Group support is a great opportunity for young people to share experiences and learn from others. There are also groups specifically, for guardians and family members.

14.3 Medication therapy treatment

It is offered to children and adolescents who have severe disorders to reduce specific symptomatology. If the family is involved and is regular in the treatment process, medication seems to be less necessary.
It is a group of medications used to treat depression and other mental illnesses.

The decision to use medication can be tricky, especially if your child is young.

Medications may be helpful for some children, but there may be additional risks. It is important to have an honest discussion with your doctor in order to know what to expect. Most professionals consider medication for children under the age of 18 as a second alternative to a treatment approach such as counseling.

14.4 Individual psychotherapy

It focuses on improving adaptive skills and reducing specific symptomatology. The following approaches are provided: cognitive and behavioral, playful, psychodynamic, supportive, and eclectic mix of techniques of these approaches.

5 https://qshm-pz.com/

14.5 Family psychotherapy

It is part of the multimodal treatment of all child and adolescent psychiatric disorders, aiming at the development of children and the family. All family members can be present at the session.
Family psychotherapy, among others, is applied to parent-child conflicts, parental disagreements about parenting, child discipline, etc. The following approaches are offered: strategic, structural, integrative, experiential, etc.

14.6 How can we help the family?

Many people feel guilty or frustrated when a loved one is diagnosed with a mental illness and this can affect family relationships. Family counseling provides an opportunity to share experiences and help develop a strategy to take care of the well-being of the whole family.

It is better to be honest with siblings and other family members about a child's illness. That way, your child has some sources of support to be understood by the community as well.

14.7 Counseling for adolescent cases with minor offenses

Provides support for adolescents in the face of difficult life experiences to build resilience, develop new coping skills, better understand relationships, and manage change.

14.8 Online psychotherapy

Offered on the Internet-based program, the "I Fight Depression" platform, based on the principles of Cognitive and Behavioral Therapy, the adolescent version, which has been proven to be effective in treating depression.

14.9 Imposing parental ambitions on children

Dreams guide our lives, offer a sense of stability in time and space, are unpredictable but often achievable, but parents 'expectations of their dreams become a burden on the shoulders of children and parents' dreams are an obligation to them.

Many parents tend to impose their views on their children when it comes to career development. They aim to make their children doctors, scientists, engineers, architects, etc ... they unknowingly kill the innocence of the child and put them in an eternal race by showing complete disregard for their desires, aspirations and happiness.

- **Can a person** who has been forced to give up his dreams for the sake of a secure career **ever find happiness**?
- **Is it right for parents to force their children** to fulfill their dreams even when they know that the career path chosen by them does not interest the child?

There are several reasons why parents have this tendency to force their children to make their dreams come true.

- Competition
- Profits in the future
- Career myths
- Education system

Parents are advised to simply free their children from their ambitions, their expectations, to let their children live their dreams.

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XVI. Abbreviations

ADHD	Attention Deficit Hyperactivity Disorder
ARV	Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
NIPHK	National Institute of Public Health of Kosovo
STI	Sexually Transmitted Infections
PHC	Primary Health Care
MoH	Ministry of Health
MSM	Men who have sex with men
MNS	Mental neurological disorders of substance use
mGAP	Gap Mental Health Action Program
LGBT	Lesbian, Gay, Bisexual and Transgender
LMIC	Low and medium income countries
WHO	World Health Organization
IDU	Injecting Drug Users
FSW	Female Sex Workers
PTSD	Post Traumatic Stress Disorders
ChAMHC	Child and Adolescent Mental Health Center
MHC	Mental Health Centers
SDGs	Sustainable Development Goals
CIH	Community Integration Houses
MH	Mental Health
PH	Public Health
UNICEF	United Nations Children's Fund
CBT	Cognitive Behavior Therapy
TG	Transgender

ANNEX

XVII. Questionnaire

1. What are your reasons for talking to a counselor?

☐ Problems at school	☐ Friends	☐ Family
☐ Bullying/bullied	☐ Feeling upset / sad	☐ Feeling anxious / stressed
☐ Temperament	☐ Alcohol, drugs or gambling	☐ Trouble sleeping
☐ Food / your image	☐ Other [please explain].....?	

2. How long have you had this problem? [circle one]?

☐ Less than 3 months ☐ 3 to 6 months ☐ 6 to 12 months ☐ 1 to 2 years

3. Because your privacy is important to us, do you have a cell phone or an alternative number that you would like us to call you?

☐ Yes ☐ No ☐ Number to call ☐ You want us to contact you on your phone #?

4. Can we leave you a message on your mobile number? ☐ Yes ☐ No.

Examples of problems that people sometimes have
Please circle which is true for you: NEVER, SOMETIMES or OFTEN

Questions 1.	Never	Sometimes	Often
You are easily distracted, you have trouble keeping up with your usual activities	0	1	2
You fail to finish the things you started	0	1	2
You have difficulty following instructions	0	1	2
Impulsive, act without thinking first	0	1	2
Jump from one activity to another	0	1	2
Disturbed / Troubled	0	1	2
Total 1			
Questions 2	Never	Sometimes	Often

Questions 4.	Never	Sometimes	Often
Worried that something bad will happen to the people you are close to	0	1	2
Worry about being separated from those with whom you are close	0	1	2
Fear of going to sleep without having parents close by	0	1	2
Extremely upset when you leave someone close to you	0	1	2
Extremely upset when you are away from someone close to you	0	1	2
You feel sick before you separate from those with whom you are close	0	1	2
Total 4			
Questions 5	Never	Sometimes	Often

Weird	0	1	2
Challenging, talk to adults	0	1	2
You blame others for your mistakes	0	1	2
Get bored quickly by others	0	1	2
Argue a lot with adults	0	1	2
Angry and irritable	0	1	2

Total 2

Questions 3	Never	Sometimes	Often
You steal things at home.	0	1	2
You destroy things that belong to others	0	1	2
You damage your school or property	0	1	2
You destroy someone else's house, building or car	0	1	2
You physically attack people	0	1	2
You use weapons during the fight	0	1	2

Total 3

Worried about making things better	0	1	2
Worry about behaviors in the past	0	1	2
Worry about doing the wrong things	0	1	2
Worry about things in the future	0	1	2
Fear of mistakes	0	1	2
Too anxious to enjoy people	0	1	2

Total 5

Questions 6	Never	Sometimes	Often
You have no interest in your ordinary activities	0	1	2
You do not feel satisfaction from your usual activities	0	1	2
Difficulty finding pleasure	0	1	2
Not as happy as the other children	0	1	2
You feel hopeless	0	1	2
Unhappy, sad or desperate	0	1	2

Total 6