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A manual on youth mental health promotion,
prevention, and education in the context of youth work

Youth Mental Health

What's inside

About this manual

Youth Health Literacy
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The project

For a healthier Europe, promoting good health is an integral part of Europe 2020, the EU 10-year economic-growth strategy. Health policy is important to Europe 2020 objectives for smart and inclusive growth because keeping the people informed, healthy, and active has a positive impact on the future of the EU. There is growing evidence that health and literacy are closely linked, and therefore, influence other parameters of life such as poverty, inequality, discrimination, power relations, and income levels. Hence, health literacy is a strategy which contributes to the improvement of community's health, participation, and wellbeing where health is the basic human right that guarantees people autonomy and responsibility for their own health, and wellbeing. But despite its immense benefits, health literacy remains a challenge for the European public health. Research findings show that more than a third of the EU population face difficulties in finding, understanding, evaluating, and using information to manage their health, especially sexual and mental health. Whereas according to the World Health Organisation, health education interventions have formative character, since they manage to integrate both cognitive and attitudinal processes that allow behaviour modification, and become a conscious, rational, and voluntary action.

Thus, in this project, we sought to create a partnership aiming to strengthen partners' capacity to develop a youth work that can meet the health literacy needs of our targeted groups through inclusion and diversity; by using the approaches that offer potential for reaching out to and engaging targeted groups. From previous projects, efforts were falling short on these aspects, and thus, failing in meeting the needs of our targeted groups in the longer term perspective. Though each project focused a lot on needs assessments among the targeted groups, there was no room for impact measurement to see whether social change was happening. To meet those needs, the consortium and the targeted groups benefited from applying the Impact Pathway, Participatory Action Research, and Rights-Based Approaches in project's implementation. Project partners met their needs by strengthening their own capacities through research, experiential learning, and by sharing good practices on how programming a Youth Health Literacy Intervention must be rights-based; youth and their rights to health must be at the centre of such an intervention. Whereas the project targeted groups participated in community-based interventions to transform their health literacy problems into the human right language that abides to the EU's youth health policies.

The manual

This manual seeks to identify and present the impact of systemic racism and racial/gender discrimination on the mental health and well-being of young adults who belong to a racial, sexual, and gender minority group. Whereas racial and gender discrimination is a human rights violation, and a psychological process that affects all racial, gender, and sexual minorities, there is no evidence-based information on its effects on racialised young people's social and mental well-being. Therefore, this manual looks at how systemic racial and gender discrimination becomes a psychological factor in the production and manifestation of mental, emotional, behavioural, and substance use disorders affecting racialised young adults submerged in the victimhood of lived experiences of discriminatory and racist events.

That is, depression, anxiety, depersonalisation, loneliness, disconnection, cultural identity abandonment, and drug abuse are often common among young adults who belong to a racial, sexual, and/or gender minority group. Several decades of research show that the promise and potential lifetime benefits of preventing a mental, emotional, behavioural, or substance use disorder are greatest by focusing on the young people and that early interventions can be effective in preventing the onset of such disorders. Indeed, according to the EU's health policies, the national priorities should include: *(1). Assurance that the individuals who are at risk receive the best available evidence-based interventions prior to the onset of a disorder* and *(2). The promotion of positive mental, emotional, and behavioural development for all young people should be a mental health priority.*

Indeed, mental, emotional, and behavioural problems among the racialised young adults; including both diagnosable disorders and the other problem behaviours, such as early drug and/or alcohol abuse, antisocial or aggressive behaviour, and/or violence, have enormous personal, family, and societal costs. In addition, such mental, emotional, behavioural, and/or substance use disorders interfere with racialised young adults' ability to accomplish personal and professional developmental, such as establishing healthier relationships, succeeding in school, or transitioning to the workforce.

The consortium

Author: TERRAM PACIS

Established in 2010, a human rights, non-profit organisation in special consultative status with The United Nations Economic and Social Council. Through education and training we facilitate youth build a universal culture of human rights.

Contributor: Comitato d'Intesa

Created in 1977, gathers associations operating in different sectors such as: youth policy, interculturality, sustainable development, social solidarity, assistance of persons with special needs and support a healthy way of life.

Contributor: Ministry for Gozo

An important public body that caters for Gozo, especially Gozitan Youths, and has connections all over Europe. It is a hub for innovative European Youth Education. Learners who are associated with this setup are youth in Malta and Gozo.

Contributor: National College "Ienăchiță Văcărescu"

One of the top of Dambovita county's learning establishments. Under the attentive guidance of exceptionally professional teachers , the students develop their skills and creativity, as well.

Contributor: Universidade Atlântica

Created in 1996 as a public interest institution that focuses on the creation, transmission, and diffusion of knowledge, sciences, and technology through the articulation of studies, teaching, research, and experimental development.

Manual glossary

- ***Health literacy:***
  Refers to the personal skills and social resources needed by an individual to access, understand, apply, and use information and services to make health decisions, as well as the ability, capacity to communicate, affirm, and implement those decisions.

- ***Youth health literacy***
  Refers to the degree to which youth have the capacity to obtain, process, understand, and apply the most basic health information which is needed to make appropriate health decisions.

- ***A health literate youth:***
  Refers to the young person who has the ability and capacity of placing their own health and well-being and that of their family and community into context, understanding which factors are influencing them, and knowing how to address them.

- ***Youth mental health:***
  Is conceptualised as a state of well-being at which a youth realises his or her own abilities, can cope with normal stresses of life, can work productively and fruitfully, and is able to make some contributions to his or her community.

- ***Youth mental well-being:***
  Is the combination of feeling good, which incorporates not only the positive emotions of happiness and contentment, but also such emotions as interest, engagement, confidence, and affection; and functioning effectively (in a psychological sense).

- ***Mental illnesses:***
  Are mental health problems that affect the way we think about ourselves, relate to others, and interact with the world around us. Examples of mental illness can include depression, anxiety, bipolar disorder, schizophrenia, eating disorder, Post Traumatic Stress Disorder, psychosis, perinatal depression, addictive behaviours, etc.

- ***A protective factor:***
  Can be defined as a characteristic at the biological, psychological, family, or community (including peers and culture) level that is associated with a lower likelihood of problem outcomes or that reduces the negative impact of a risk factor on problem outcomes.

- ***A risk factor:***
  Can be defined as a characteristic at the biological, psychological, family, community, or cultural level that precedes and is associated with a higher likelihood of problem outcomes.

- ***Mental health promotion:***
  Is defined as intervening to optimise positive mental health by addressing the determinants of positive mental health before a specific mental health problem has been identified, with the ultimate goal of improving positive mental health of youth.

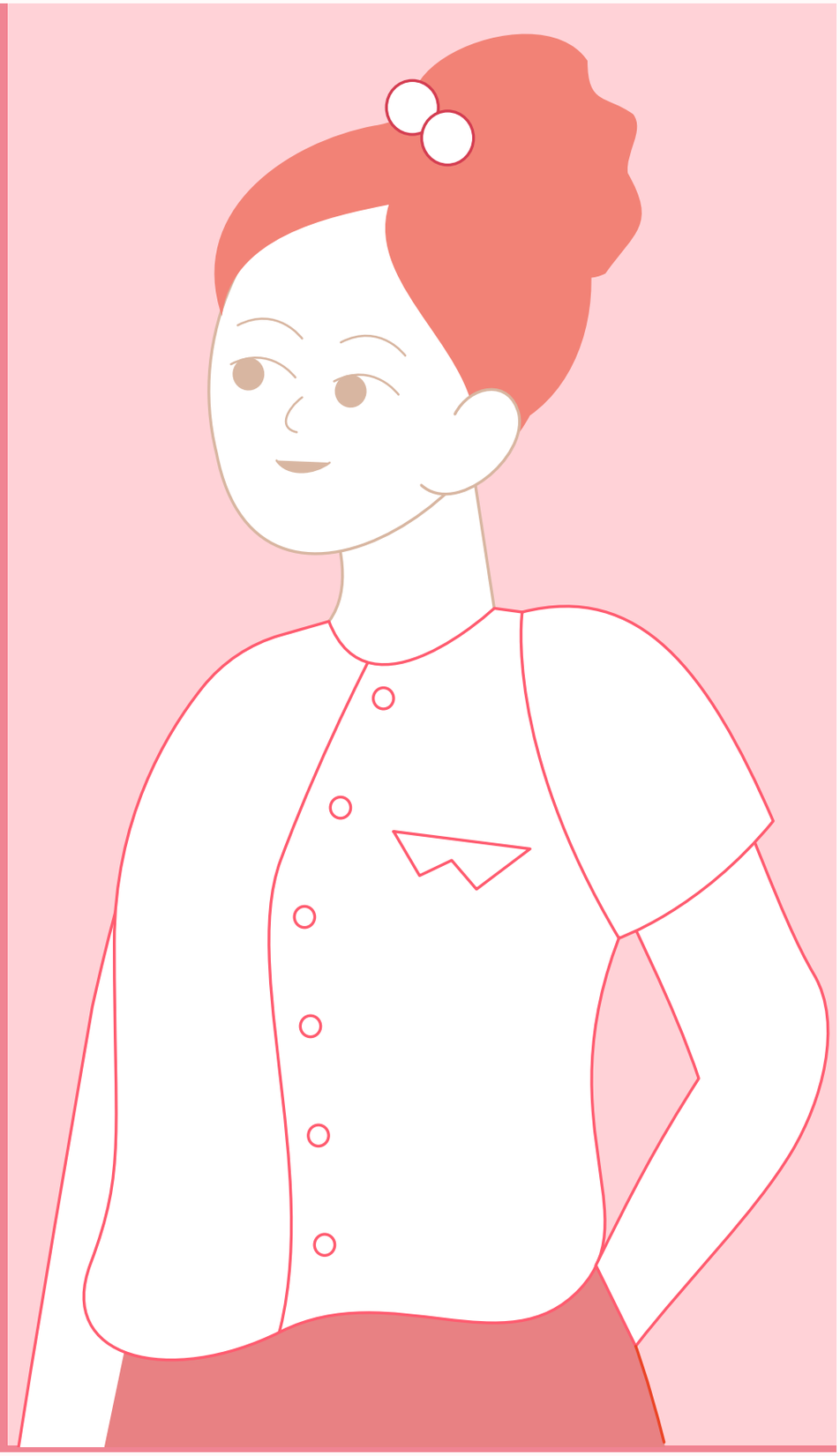
- ***Mental health prevention:***
  Is defined as intervening to minimise mental health problems by addressing determinants of mental health problems before a specific mental health problem has been identified, with the ultimate goal of reducing the number of future mental health problems among youth.

- ***Positive youth development:***
  Means an intentional, pro-social approach that engages the youth within their communities, schools, organisations, peer groups, or families in a manner that is both productive and constructive.

- ***Sexual and gender-based violence:***
  Refers to violation of fundamental human rights by act, omission, or advocacy of hatred that perpetuate gender-stereotyped norms and roles that deny human dignity and self-determination of an individual and hamper human development.

CHAPTER-1

Youth mental health determinants



1.1. Youth mental health and well-being

Youth mental health is conceptualised as a state of well-being at which a youth realises his or her own abilities, can cope with normal stresses of life, can work productively and fruitfully, and is able to make some contributions to his or her community. An emphasis is placed on the developmental aspects, such as having a positive sense of identity, the ability to manage ones' thoughts, emotions, as well as to build social relationships, and the aptitude to learn and acquire an education, ultimately enabling the youth's full and meaningful participation in society. **Youth mental well-being** is the combination of feeling good, which incorporates not only the positive emotions of happiness and contentment, but also such emotions as interest, engagement, confidence, and affection; and functioning effectively *(in a psychological sense)*. It incorporates the development of youth's potential such as having some control over life, having a sense of purpose *(working towards valued goals)* and experiencing positive relationships. Hence, youth mental well-being and youth mental health problems are interdependent: mental well-being reduces the risk of mental, emotional, behavioural, and substance use disorders, whereas mental health problems reduce mental well-being.

Evidence shows that the largest group of youth with poor mental well-being are those with a mental health problem. Thus, promotion of mental well-being is important for prevention of mental illness, and also an important factor in recovery from a mental, emotional, behavioural, or substance use disorder. Among youth, a high level of good mental health and mental well-being is associated with a range of positive impacts such as improved educational and/or work outcomes; more healthier lifestyles; reduced risk-taking behaviours *(such as smoking, excessive alcohol, and substance abuse)*; and reduced productivity of crimes, violence, and/or antisocial behaviour. Hence, good mental health and mental well-being is not only important in terms of the youth's health and well-being, but it also has a huge economic impact.

A mental illness or a mental disorder:

A mental illness is when a person has ongoing symptoms that cause frequent distress and affect his or her ability to function. Mental illness can influence the way a person thinks, feels, behaves and/or relates to others. Mental illness can refer to a wide range of conditions that affect a person's mood, thinking, and behaviour. Examples of mental illness can include depression, anxiety, bipolar disorder, schizophrenia, eating disorder, Post Traumatic Stress Disorder, psychosis, perinatal depression, addictive behaviours, etc.

Therefore, if these ongoing symptoms become more severe, a person may then meet the definition of having a mental disorder, which is the legal definition. The presence of a mental, emotional, behavioural, or substance use disorder is described as a clinically significant condition characterised by the alterations in thinking, emotions, and behaviour associated with personal distress and/or impaired functioning. Such abnormalities must be sustained or recurring, and they must result in some personal distress or impaired functioning in one or more areas. They are all characterised by specific symptoms, and usually follow a more or less predictable natural course, unless interventions are made (WHO, 2001).

Thus, the more risk factors youth are exposed to, the greater the potential impact on their mental health. The factors which can contribute to stress during young adulthood include exposure to adversity, pressure to conform with peers, and exploration of identity. Media influence and gender norms, and quality of peer relationships can exacerbate disparity between a young person's lived reality and their perceptions and/or aspirations for the future. Exposure to racism or racial or gender discrimination, hate speech, violence (especially bullying as well as sexual and/or gender-based violence), harsh parenting and socioeconomic problems are all recognised risks to youth mental health. Hence, determinants of youth mental health and well-being include not only individual attributes such as the ability to manage one's thoughts, emotions, behaviours, and/or interactions with others, but also the social, cultural, economic, political, and environmental factors such as national policies, social protection, living standards, working conditions, and the community social supports. So, depending on the local context, the marginalised youth are placed at greater risks of mental health conditions due to their living conditions, stigma, discrimination and exclusion, and/or lack of access to quality support and services. Indeed, in many European societies, youth mental health problems related to gender-based violence and systemic racism are of growing concern, especially for racialised young adults as well as for lesbian, gay, bisexual, transgender, queer and/or non-

binary persons who experience discrimination and other forms of human rights violations. Hence, promoting racialised young adult socio-emotional learning and psychological well-being and ensuring their access to mental health care are critical for their health during youthhood and adulthood.

1.2. Mental illnesses and mental health

Mental illnesses are mental health problems that affect the way we think about ourselves, relate to others, and interact with the world around us. They affect thoughts, emotions, feelings, and behaviours. Mental illnesses can disrupt a person's life or create severe challenges, but with the right supports, a person can get back on the path to recovery and wellness. It is important to understand that there are many and different types of mental illnesses that affect people in different ways. And with each mental illness, people might have many very different symptoms and challenges. However, the symptoms are just one piece. Access to services, support from loved ones, and the ability to participate in communities play a big part in the way people experience mental illnesses. Moreover, cultural values, social and gender norms, as well as personal beliefs also shape the way people understand and deal with mental illnesses. But no matter how people talk about their experiences, they need to use medical terms if they seek help in the health system. This is just how the system works, mental illnesses are just like any other illness, and everyone deserves care, help, and support.

It is normal for children and youth to experience various types of emotional distress as they develop and mature. Example; it is common for children to experience anxiety about school, or youth to experience some short periods of depression that are transient in nature. However, when those symptoms persist, it may be time to seek professional assistance. While most youth are physically and emotionally healthier; racialised young adults in the general population often meet criteria of at-risk group for lifetime mental disorders as a result of facing discrimination and negative attitudes. As with physical health, mental health is not merely the absence of the disease or the mental health disorder. It includes emotional well-being, psychological and social well-being, and involves being able to: *successfully navigate the complexities of life; develop fulfilling relationships and adapt to change; use appropriate coping mechanisms to achieve well-being; realise one's potential and have needs met without discrimination;* and *develop skills that help one navigate the different environments they inhabit.*

Table 1. Types of mental disorders

DISORDERS	DESCRIPTIONS
Anxiety disorders	Anxiety disorders are all related to anxiety. May include excessive and uncontrollable worry, strong fears around everyday things or situations, unwanted thoughts, panic attacks, or fear of past scary situation. Anxiety disorders are the most common mental disorders, and they can create barriers in people's lives. Panic disorder and phobias are examples of anxiety disorders.
Depressive disorders	Depressive disorders affect a person's mood (emotions), and can affect every part of life. When someone experiences a emotional disorder, they may feel sad, hopeless, tired, or numb for long periods of time. At times, some people experience an unusually 'high' mood and feel powerful and energetic, but this can also create problems. Depression and bipolar disorder are examples of emotional disorders. Depression and anxiety share some of the same symptoms, including rapid and unexpected changes in mood. Anxiety and depressive disorders can profoundly affect school attendance or school-work. Social withdrawal can exacerbate isolation and loneliness which could lead to suicide.
Eating disorders	Eating disorders are really not about food. They are complicated disorders that are often a way to cope with difficult problems or regain a sense of control. Eating disorders, such as anorexia nervosa and bulimia nervosa, commonly emerge during adolescence. They involve abnormal eating behaviour and preoccupation with food, accompanied in most cases by concerns about body weight and shape. Anorexia nervosa can lead to premature death, often due to medical complications or suicide, and has higher mortality than any other mental disorder.

Psychotic disorders	Psychosis is a health problem that affects how people understand what is real and what is not real. People may sense things that are not real or strongly believe things that cannot be real. Schizophrenia is one example of a psychotic disorder. Conditions that include symptoms of psychosis most commonly emerge in late adolescence or early adulthood. Symptoms can include hallucinations or delusions. These experiences can impair young people's ability to participate in daily life and education and often lead to stigma or human rights violations.
Personality disorders	Personality disorders are patterns of thoughts, feelings, and behaviours that may last for a long time and create challenges in a person's life. People who experience personality disorders may have difficulties developing healthy and satisfying relationships with others, managing their emotions well, avoiding harmful behaviour, and working toward important life goals. Personality disorders can affect the way people understand and view themselves and others and cope with problems. Borderline personality disorder is one example of a personality disorder.
Risk-taking behaviours	Risk-taking behaviours for youth mental health, such as alcohol or substance use or sexual risk-taking, start during adolescence. Risk-taking behaviours can be an unhelpful strategy to cope with emotional difficulties and can severely impact young people's mental and physical well-being. Perpetration of violence is a risk-taking behaviour that can increase the likelihood of low educational attainment, injury, involvement with crime or death.
Suicide and self-harm	Suicide is the fourth leading cause of death among young people 15-19 years. Risk factors for suicide are multifaceted, and include 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 either enhancing or weakening suicide prevention efforts.

The presence or the absence of various combinations of protective and risk factors contribute to youth mental health. Efforts can be undertaken to promote positive youth mental health and prevent and/or minimise mental health problems. Youth with mental health disorders may face challenges in their homes, school, community, and interpersonal relationships. Despite these challenges, for most youth, their mental health distress is episodic, not permanent, most can successfully navigate the challenges that come from experiencing a mental health disorder with treatment, professional, or peer supports and services, and a strong family and social support network.

1.3. Mental health risk and protective factors

As young people grow and reach their developmental competencies, there are contextual variables that promote or hinder the process. These are frequently referred to as protective or risk factors. The presence or absence and various combinations of protective and risk factors contribute to youth mental health. Thus, identifying protective and risk factors in youth guide the prevention and intervention strategies to pursue with them. Protective and risk factors may also influence the course mental health disorders might take if present.

1. A protective factor can be defined as a characteristic at the biological, psychological, family, or community (including peers and culture) level that is associated with a lower likelihood of problem outcomes or that reduces the negative impact of a risk factor on problem outcomes.

2. A risk factor can be defined as a characteristic at the biological, psychological, family, community, or cultural level that precedes and is associated with a higher likelihood of problem outcomes.

Table 2. Factors for mental, emotional, and behavioural disorders

INDIVIDUAL	
Risk factors	**Protective factors**
• Difficult temperament: inflexibility, low positive mood, withdrawal, poor concentration. • Low self-esteem, perceived incompetence, negative explanatory, and inferential style. • Low-level depressive symptoms and dysthymia. • Anxiety, insecure attachment, or extreme need for approval. • Poor social skills: communication and problem-solving skills • Emotional problems in childhood • Favourable attitudes toward drugs or early substance use. • Antisocial behaviour.	• Positive physical development. • Academic achievement and intellectual development. • High self-esteem • Emotional self-regulation • Good coping skills and problem-solving skills. • Engagement and connections in the following contexts: school, with peers, employment, community, culture, etc.

FAMILY	
Risk factors	**Protective factors**
• Parent-child conflict or violence. • Negative family environment (drug and alcohol abuse or substance abuse in parents). • Family dysfunction, violent conflicts. • Parent with anxiety or parental depression. • Parental or marital conflict. • Poor attachment with parents. • Poor parental supervision. • Sexual abuse or gender-based violence.	• Family provides structure, limits, rules, monitoring, and predictability. • Supportive relationships with family members. • Clear expectations for behaviour and values.

PEER, COMMUNITY, SOCIETY	
Risk factors	**Protective factors**
• Peer rejection • Racial or gender discrimination. • Systemic racism or school bullying. • Poor academic achievement • Community or school-level stressful or traumatic events. • Community or school violence. • Low commitment to school. • Aggression toward peers. • Associating with drug-using peers. • Loss of close relationship or friends.	• Presence of mentors and support for development of skills and interests • Opportunities for engagement within school and community. • Positive social norms and cultural values. • Clear expectations with peers' relationships. • Physical and psychological safety.

If a youth has a constellation of risk factors, it is important to seek assistance for the young person with family support.

Table 3. Signs and behaviours to look for in youthhood.

Untreated mental health problems can disrupt youth functioning at home, school and in the community. Without treatment, youth with mental health issues are at increased risk of school failure. Parents and family members are usually the first to notice if a youth has problems with emotions or behaviour.	• Decline in school performance; • Persistent nightmares; • Persistent disobedience or aggression; • Frequent temper tantrums; • Poor grades in school despite efforts; • Regular refusal to go to school or take part in social activities; • Extreme difficulties in concentrating that get in the way at school; • Depression shown by sustained, prolonged negative mood and attitude, often accompanied by sadness or irritability; • Severe mood swings, strong worries or anxieties that get in the way of daily life, such as at school or socialising. • Repeated abuse of alcohol or drugs.

1.4. Mental health promotion and prevention

Adverse youthhood experiences are associated with the poor youth mental health and well-being. Youthhood experiences of both racial and gender discrimination and other forms of racism may underlie and/or exacerbate other adverse youthhood experiences. We explored mental health-issues associations with experienced racial and/or gender discrimination relative to other adverse youthhood experiences; using the data from open-ended consultations with a group of 20 racial and gender minority young adults. The participants responses were used to assess associations between racial and gender discrimination and the mental health conditions relative to other adverse youthhood experiences. Workshops conversations indicated that prevalence of other adverse youthhood experiences was the highest among youth who belong to a racial or gender minority group; and that both racism and racial and gender discrimination and other adverse youthhood experiences were associated with a higher likelihood of developing one or more risk factors for mental, emotional and behavioural disorders. That is, adjusted associations between racial and gender discrimination and mental health conditions differed by race or gender and were strongest for mental health conditions among young adults who belong to racial and/or gender minority groups. So, results suggest that racial and gender discrimination and other adverse youthhood experiences are greatly associated with the youth mental health outcomes, with differences in relative associations by race and gender. Thus, public mental health efforts to prevent youthhood adversity, including the prevention of racial and gender discrimination and other forms of racism are greatly associated with improvements in racial and gender minority youth mental health outcomes and well-being.

Public mental health efforts mean implementing mental health promotion and prevention interventions aimed at strengthening the racial and gender minority youth capacity to regulate their emotions, enhance alternatives to risk-taking behaviours, build resilience for managing difficult situations and/or adversity, and promote supportive, diverse, and inclusive social environments and/or social networks. Though such programmes require a multi-level approach with varied delivery platforms; for example, digital media, health or social care settings, schools and/or community-based, and varied strategies to reach racialised youth, particularly the most vulnerable racialised youth within the LGBTIQA community. The racialised youth develop in the contexts of family, school, community, and the larger culture which offer multiple opportunities to support positive youth mental health outcomes. Hence, preventing, addressing the risk factors for mental, emotional, and behavioural disorders or problems should focus on change in developmental processes within those contexts. So, it is crucial to address the needs of racialised and LGBTIQA youth who are the most vulnerable to mental health problems. Avoiding institutionalisation and prioritising early detection and treatment by respecting the rights of the of all racialised and LGBTIQA youth to mental health care and services.

Mental health promotion and prevention:

- **Mental health promotion** is defined as intervening to optimise positive mental health by addressing the determinants of positive mental health before a specific mental health problem is identified, with the ultimate goal of improving positive mental health of youth.
- **Mental health prevention** is defined as intervening to minimise mental health problems by addressing determinants of mental health problems before a specific mental health problem has been identified, with the ultimate goal of reducing the number of future mental health problems among youth.

Mental health promotion and prevention are both at the core of the public health approaches to children and youth mental health outcomes which address mental health of all youth, focusing on the balance of optimising positive mental health and preventing and treating mental health problems. That is, youth mental health promotion attempts to encourage and increase protective factors and healthier behaviours that can help prevent the onset of a diagnosable mental disorder and reduce the risk factors that can lead to the development of a mental disorder. It also involves creating the living conditions and environments that support youth mental health and allow the youth to adopt and maintain healthier lifestyles in a space that respects and protects their basic civil, political, socio-economic, and cultural rights. Indeed, without the security and the freedom provided by these rights, it is therefore very difficult to maintain a high level of mental health among racialised and LGBTIQA youth most vulnerable to mental health problems. Specifically, mental health for this group can be promoted and prevented through interventions that support positive youth development.

Positive youth development means an intentional, pro-social approach that engages the youth within their communities, schools, organisations, peer groups, or families in a manner that is both productive and constructive. A positive youth development intervention recognises, utilises, and enhances youth's strengths, and promotes positive mental health outcomes for young people by providing equal youth rights and opportunities, fostering positive relationships, and providing a crucial lens for promoting mental health by focusing on the protective factors in a young person's environment, and on how these factors could influence one's ability to overcome adversity.

Table 4. Family and school interventions

INTERVENTIONS	OUTCOMES
Parenting-based interventions	• Reduced aggressive, disruptive, or antisocial behaviour; • Improved parent–child interaction; • Reduced substance abuse and significantly reduced drug and polydrug use (tobacco, alcohol, and marijuana); • Improved academic success; • Significantly reduced drug and polydrug (tobacco, alcohol, and marijuana); • Non-discrimination and gaslighting LGBTIQA children.
Family-based interventions	• Prevention of the development of antisocial behaviour; • Reduced physical abuse, aggression, and harsh parenting; • Reduced odds of youth reaching diagnostic criteria for any mental disorder; • Reduced levels of aggressive behaviour and less involvement with deviant peers; • Reduced rates of growth in tobacco, alcohol, marijuana use and lowered likelihood of being diagnosed with a substance use disorder.
School-based interventions	• Supporting ecological changes in schools: diverse and including schools for racialised and LGBTIQA pupils. • Reduced disruptive behaviour and increased academic engaged time; • Reduced likelihood that initially aggressive pupils would receive a diagnosis of conduct disorder; • Significantly reduced likelihood that persistently highly aggressive pupils would receive a diagnosis of antisocial personality disorder as a young adult; • Prevention of suicidal ideation and suicide attempts • Significantly reduced risk of illicit drug abuse or dependence disorder at ages 19-21.

1.5. Rights-based approach to mental health

With widespread human rights violations and discrimination experienced by youth with mental disorders, a human rights perspective is essential in responding to such a global burden, the stigmatisation of mental disorders. Which furthermore emphasises the need for services, policies, legislations, plans, strategies, and the programmes to protect, promote and respect the rights of all persons with any mental disorders in line with the International Covenant on Civil and Political Rights, along with the International Covenant on Economic, Social and Cultural Rights, the Convention on the Rights of Persons with Disabilities, the Convention on the Rights of the Child, and the International Convention on the Elimination of All Forms of Racial Discrimination. The impacts of systemic racial and gender discrimination underlie and/or exacerbate the mental health and well-being conditions of racialised and LGBTIQA young adults: the largest group of youth with poor mental health and well-being and the most vulnerable to risk factors for mental, emotional, behavioural, and substance use disorders. So integrating and applying the rights-based approach to youth mental health and well-being should start by looking at how racial and gender discrimination as both a human rights violation, and a psychological process in the creation of

risk factors for mental, emotional, behavioural, and substance use disorders affects all the racialised and LGBTIQA young adults in different ways.

We established that racial and gender discrimination experiences are greatly associated with poor youth mental health outcomes among racialised and LGBTIQA young people. Adjusted associations between racial and gender discrimination and mental health conditions differ by race and gender and are strongest for mental health conditions among youth who belong to racial and/or gender minorities. So, systemic racial or gender discrimination is a psychological factor in the production and manifestation of mental, emotional, behavioural, and substance use disorders that affect the mental health and well-being of racialised and LGBTIQA youth who are submerged in victimhood of lived experiences of discriminatory or racist, and gender-based violence incidents. Therefore, depression, anxiety, depersonalisation, loneliness, disconnection, identity abandonment, drug abuse are common among the youth who belong to racial and/or gender minority groups who have experienced one or more of incidents of racism, discrimination, and/or gender-based violence. Hence, the most far-reaching advantage in applying the rights-based approach in youth mental health promotion and prevention is the way youth organisations should interact with and create interventions for the racialised and LGBTIQA youth, making sure that all the young people, in all their diversity, can equally participate in the set-up of a youth mental health promotion and prevention intervention.

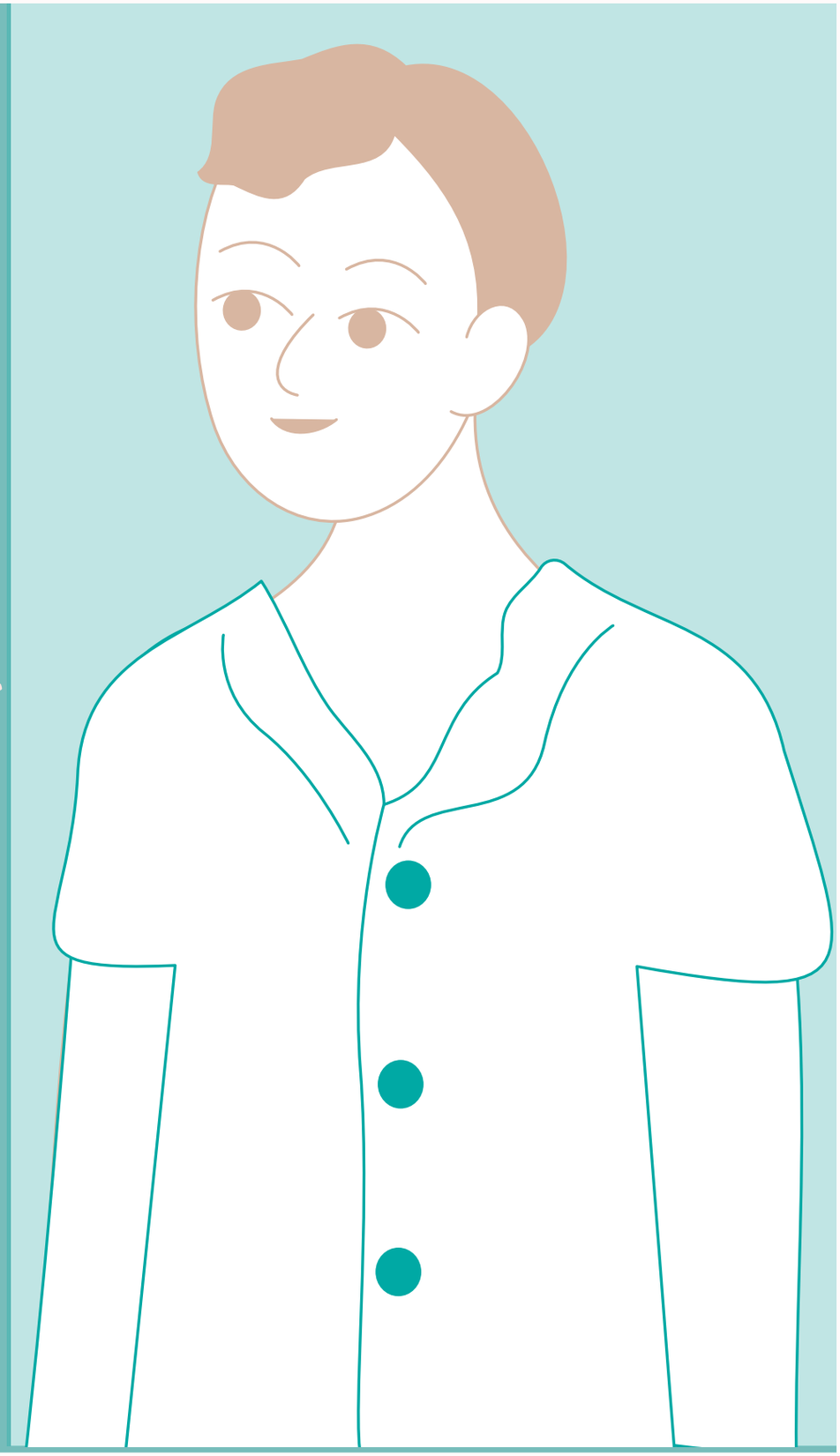
Ensuring racialised and LGBTIQA youth's participation entails transitioning from perceiving the racialised and LGBTIQA youth as passive beneficiaries to recognising them as the rights-holders, and the active agents in social transformation process. So, inclusive, and meaningful participation of the racialised and LGBTIQA youth in mental health promotion and prevention is both a means and an end in itself. It means putting racialised and LGBTIQA young people at the centre of all the youth interventions by empowering them to identify and helping to address the main obstacles and structural barriers preventing them from achieving the desired positive mental health outcomes. Indeed, since the promise and the potential lifetime benefits of preventing mental, emotional, behavioural, and/or substance use disorders are greatest by focusing on young people, early interventions are effective in preventing the onset of such disorders. So, integrating the rights-based approach in youth mental health promotion and prevention ensures that: *(1). Racialised and LGBTIQA youth who are at risk and the most vulnerable receive the best available evidence-based interventions prior to the onset of a disorder;* and *(2). Promotion of positive mental, emotional, and behavioural development for racialised and LGBTIQA youth is a mental health priority.*

Table 5. Rights-based approach working principles.

PRINCIPLES	CONTRIBUTIONS
Human rights for all	Ensures that when planning, designing, delivering, evaluating a mental health promotion and prevention intervention, it should always address the unique challenges, social obstacles, and structural barriers racialised and LGBTIQA youth face.
Meaningful and inclusive participation	Ensures that including racialised and LGBTIQA youth in a mental health promotion and prevention intervention, is a first step towards addressing risk factors for mental, emotional, behavioural, and substance use disorders among racialised and LGBTIQA youth.
Non-discrimination and equality	Ensures that a mental health promotion and prevention intervention must assess patterns of racial and gender inequality, racial and gender discrimination, as well as racism and understand how mental health and well-being of racialised and LGBTIQA youth are affected by lack of equal rights and opportunities, or limited access to services or offerings.
Accountability and rule of law for all	Ensures that racialised and LGBTIQA youth can seek justice, redress, compensation when their rights to mental health care, equal distribution of resources, equal opportunities, access to services or offerings are violated.
Transparency and access to information	Supported by disaggregated data, ensures the first step to making racialised and LGBTIQA youth's mental health problems visible, to better inform the planning and designing of a youth mental health promotion and prevention intervention and the making of youth mental health policies.

CHAPTER - 2

Social research on youth mental health



2.1. Context and objective

2.1.1. Research context

In our research, we sought to understand how both positive and negative youthhood experiences shape the youth's mental health outcomes and well-being. Adversities in youthhood, such as experiencing poverty and food insecurity, exposure to violence, caregiver separation, loss, and other forms of chronic and/or traumatic stress, have been shown to have the longer term detrimental effects on mental health, well-being, and longevity. So, adverse youthhood experiences, including indicators of household dysfunction, child abuse, neglect, and intimate partner violence have all been researched to establish a strong, and graded relationship between cumulative youthhood adversity and mental health problems later in life. However, in addition to adverse experiences described above, racial, gender, social, and structural determinants are also widely recognised as significant contributors to the youth mental health and well-being. Racial, gender, social, and structural inequalities, as well as lived discrimination, independent from other adverse experiences can be detrimental to youth mental health and well-being with regards to young people's biological, educational, social, and psychological development.

Our focus is on demonstrating how adverse community environments (e.g., racist, discriminatory systems and/or racism experiences), are embedded in and emerge from community and structural contexts that hinder youth's capacity for resilience against the harmful impacts of systemic racial, gender inequalities and increase the risk of experiencing a mental health problem later in life. Thus, this provides a comprehensive framework for examining the interplay of individual, community, and structural-level experiences and for guiding community efforts to advance equity in the youth mental health promotion and prevention. So, this study applies this framework to explore the impact of racial and gender discrimination as independent youthhood adversities and/or as compounding factors for other youthhood adversities. That is, exposure to racism and/or discrimination on the basis of one's racial or gender identity, are linked to a host of negative mental health outcomes and/or risk behaviours across the lifespan. Thus, building on other research in the field, primarily among racialised and LGBTIQA adolescents or youth; it establishes the clear relationship between racial, gender discrimination and mental health concerns and behavioural problems among the racialised and LGBTIQA youth, such as depressive symptoms, low self-esteem, anxiety, internalising and externalising racial prejudices and/or gender stereotypes (e.g., behaviour or conduct problems), alcohol use and/or substance abuse. Though the manifestation of racism, racial and/or gender discrimination as independent youthhood adversities and risk factors for mental, emotional, behavioural, or substance use disorders, differ by context, reflect disparities linked to systemic and historical forms of racism in different social contexts.

Our analysis of the different reports and surveys conducted within different EU countries found that youth of African descent, compared to youth of White races, experience higher rates of incarceration and neighbourhood violence, and such racial disparities are widely considered to be reflective of structural racism in criminal justice, education systems, and in housing and employment policies. So, the analysis' outcomes allowed us to determine the most common risk factors for the mental, emotional, behavioural, and substance use disorders among the racialised and LGBTIQA youth based on an experienced racial or gender discrimination. *Whether the youth: has been treated and/or judged unfairly due their racial or gender identity; was a victim of or witnessed neighbourhood violence, was residing with a person with a drug or alcohol abuse problem, was residing with anyone with a mental illness or who was suicidal or was living in economic hardship*. Although not without its limitation, experiences of racial or gender discrimination rely on person reports; given the risk of recall, social desirability, and fear present when youth are asked about such experiences retrospectively. Nevertheless, our research has examined racial and gender discrimination as a distinct form of adversity, concluding that experiencing racial, and gender discrimination would be an underlying and significant factor in the association between adversity and mental health outcomes during youthhood.

2.1.2. Research objective

The objective was to assess, explore, identify, and analyse how impacts of systemic racial and/or gender discrimination as the independent youthhood adversities and/or as compounding factors for other youthhood adversities shape youth mental health and well-being in the longer term. Further, we wanted to ask racialised, LGBTIQA youth how they think youth mental health promotion and prevention should be integrated in youth work practices by:

1. Expressing the required knowledge, skills, and attitudes to promote and prevent mental health in youth work.

2. Illustrating the factors limiting racialised, LGBTIQA youth capacity and participation to promote and prevent mental health in youth work.
3. Presenting their frustrations in accessing current educational and training offerings on mental health. And how they wish those offerings would be changed to better serve them.
4. Outlining the appropriate educational and training interventions that would meet their learning needs to effectively promote and prevent mental health in youth work.
5. Determining the types of education resources that could be developed and produced to help them effectively promote and prevent mental health in youth work.

2.2. Methodology and limitations

2.2.1. Research methodology

Through workshops with 20 racialised and LGBTIQA youth who are between 18 and 35 years old, identified as youth activists, youth workers, and anti-racism activists living in Norway, we aimed at exploring how racialised and LGBTIQA youth are advocating for mental health promotion and prevention in youth work. Research was conducted using Open-Ended Consultations, allowing the participants to voice their priorities, concerns, opinions, needs, gap, and ideas on how the exposure to racism and/or discrimination on the basis of one racial or gender identity, are linked to a host of negative mental health outcomes and risk behaviours across the lifespan of racialised and LGBTIQA youth. Open-Ended Consultations' workshop activities enabled the participants to determine appropriate mental health promotion and prevention measures that reflect the needs of racialised, LGBTIQA youth. They identified why current or existing initiatives on youth mental health promotion and prevention fail to integrate and consider the various needs of the racialised and LGBTIQA youth with mental health problems or at risk of mental health problems. Research insights and collected data were analysed and compiled in **Section 2.3.**

An open-ended consultation is a research methodology that uses face-to-face workshop learning activities to voice the priorities, concerns, opinions, perspectives, unmet needs, unfilled gaps, and ideas of a specific targeted group before addressing a particular issue, or problem which that target group wants to approach or to address to achieve the desired social and/or cultural change. Moreover, an open-ended consultation can be used to analyse best practices in education or training to identify why existing approaches in the current programmes are failing to meet the knowledge, skills, or attitudes of a specific targeted group vis-à-vis a particular problem the targeted group is facing. The open-ended consultation is conducted through workshop activities, which differ from one session to the other based on the current thematic or topic and targeted group's characteristics and its role in the concerned community. So, an open-ended consultation introduces the necessity of adapting project's learning materials to the targeted groups' learning needs and/or knowledge gaps, by using gathered data during open-ended consultations as the basis for planning, designing, and delivering project activities and outputs.

So, an open-ended consultation is:

- An interactive participation: it facilitates an inclusive discussion among participants to answer questions and solve problems together. It provides competitive workshop activities that allow participants to test their knowledge, skills, and attitudes in the current subject and be able to assess the unmet needs or unfilled gaps.
- A participant-centred approach: it takes into consideration personal, professional, and lived experiences of the targeted groups to accomplish research goal and objectives, by respecting balance between active and experiential learning.
- An engaging research process: it requires a clear understanding of key factors limiting a target group's participation and inclusiveness in a certain process aiming to address a particular problem that requires community's contribution to prevent and/or respond to the effects the problem is having on the target group.

2.2.2. Research limitations

This study is subject to several limitations for consideration. First, the youth mental health education, promotion, and prevention in Europe fall far short in identifying and presenting the impacts of systemic racism and racial, gender discrimination on mental health and well-being of youth who belong to racial, and gender minority groups. Whereas racism and racial or gender discrimination are psychological processes that affect all racialised, LGBTIQA youth, there is no evidence-based research on the effects of systemic racism

and racial or gender discrimination as independent youthhood adversities both on the social and mental well-being of their victims and survivors. Second, the experiences of 20 racialised, LGBTIQA youth who participated in this study, cannot nearly capture all the experiences of racial, gender discrimination and racism among the racialised, and LGBTIQA youth. That is, such a small number of participants cannot observe, explain, and identify all instances of subtle and overt racism and racial or gender discrimination targeting all the racialised and LGBTIQA youth. So, subtle and overt racism can be pervasive in the school and other social settings, and often include interpersonal experiences of discrimination, structural and institutional system level inequities, cultural or ideological beliefs that impact racialised and LGBTIQA youth mental health. Therefore, the measure of racism and racial or gender discrimination in this study captures only a proportion of a continuum of common adverse experiences, which might create significant chronic mental, emotional, behaviour stress among racialised and LGBTIQA youth, and shape their current and long-term mental health outcomes and academic performance.

Third, examined variables are participants reported and are subject to recall, particularly for adverse youthhood experiences in which a participant might have been a victim of domestic violence and/or community violence. The previous research we conducted on invisible racism, established that there are potentials of under-reporting racism, and racial, gender discrimination due to a variety of individual perception and/or social desirability biases, lack of safe space for racialised youth, and sociocultural factors. Further, differential mental healthcare access by race contributes to racial disparities in detection and diagnosis of the youth mental, emotional, behaviour, and substance use disorders among the racialised young people. Even though the limitations, in descriptive analyses, we were able to assess racism and racial, gender discrimination as effect modifiers to the relationship between cumulative youthhood adversity experiences and youth mental health outcome. However, it should be noted that insufficient data on racism and racial, gender discrimination often under-represented in social epidemiological research poses a significant barrier to understanding the various impacts of racism and racial, gender discrimination on the mental health of racialised and LGBTIQA youth.

2.3. Research insights and results

As previously described, we conducted consultations to explore, identify the thoughts, perspectives of participants on how non-formal youth education can be used to strengthen the capacity and the resilience of the racialised, LGBTIQA youth in promoting or preventing mental health problems such as depression, anxiety, depersonalisation, frustration, anger, loneliness, pain, disconnection, identity abandonment caused by internalising youthhood adverse experiences of racism and racial, gender discrimination.

- Therefore, this section uses the data and inputs from workshops discussions with the participants to present the areas of improvement in terms of promoting and preventing youth mental health within youth work through non-formal education practices.

The consultations data analysis is presented in four categories:

1. Youth mental health learning needs;
2. Youth mental health knowledge;
3. Youth mental health knowledge gaps;
4. Youth mental health promotion and prevention.

2.3.1. Youth mental health learning needs

During consultation workshops, when the participants were asked to discuss and identify their desired knowledge, skills, attitudes, and competences to promote and/or prevent youth mental health and well-being in youth work:

- They identified and presented various areas of improvement, necessary to meet youth mental health learning needs of racialised, LGBTIQA youth:
    1. Providing racialised, LGBTIQA youth with mental health education and training opportunities tailored to their lived experiences.
    2. Enhancing racialised, LGBTIQA youth's knowledge on youthhood adverse experiences of racism, and racial, gender discrimination.
    3. Strengthening racialised, LGBTIQA youth capacity in youth mental health promotion and prevention.

Table 6. Youth mental health learning needs

LEARNING NEEDS	AREAS OF IMPROVEMENT
Providing racialised, LGBTIQA youth with mental health education and training opportunities tailored to their lived experiences.	• Conducting community-based participatory action research to assess and identity mental health problems among racialised, LGBTIQA youth based on their lived experiences. • Creating education and training activities tailored to racialised, LGBTIQA youth's lived experiences of racism, and racial, gender discrimination. • Developing open education resources for racialised, LGBTIQA youth on promoting and preventing mental health in youth work.
Enhancing racialised, LGBTIQA youth's knowledge on youthhood adverse experiences of racism, and racial, gender discrimination.	• Conducting community-based participatory action research to assess and identity associations between youthhood adverse experiences of racism, and racial, gender discrimination and mental health problems. • Creating education and training activities on the associations between youthhood adverse experiences of racism, and racial, gender discrimination and mental health problems. • Developing open education resources and awareness-raising campaigns on the associations between youthhood adverse experiences of racism, and racial, gender discrimination and mental health problems targeted at racialised, LGBTIQA youth.
Strengthening racialised, LGBTIQA youth capacity in youth mental health promotion and prevention.	• Conducting community-based participatory action research to assess and identity risk and protective factors for mental, emotional, behavioural, and substance use disorders among racialised, LGBTIQA youth. • Empowering racialised, LGBTIQA youth in creating mental health promotion and prevention community-based interventions to further promote protective factors for mental, emotional, behavioural, and substance use disorders. • Empowering racialised, LGBTIQA youth in designing mental health promotion and prevention media-based interventions through awareness raising campaigns on protective factors for mental, emotional, behavioural, and substance use disorders.

2.3.2. Youth mental health knowledge

In consultation workshops, when the participants were asked to discuss and then identify their existing knowledge in terms of capacity and experience with regard to youth mental health promotion and prevention in youth work:

- They identified and presented various areas where this knowledge exists and at what extent, which is herein used a reference, establishing that there is an identifiable level of existing youth mental health knowledge among racialised, LGBTIQA youth:
    1. Individual knowledge on youthhood adverse experiences of racism, and racial, gender discrimination based on lived experiences.
    2. Common sense knowledge on risk and protective factors for mental, emotional, behavioural, and substance use disorders.
    3. Advocacy knowledge on youth mental health promotion and prevention through community-based interventions.

Table 7. Youth mental health knowledge

EXISTING KNOWLEDGE	AREAS OF KNOWLEDGE
Individual knowledge on youthhood adverse experiences of racism, and racial, gender discrimination based on lived experiences.	• Knowing that racial and gender inequalities and imbalanced power relations in racial and gender minority groups are the root causes of youthhood adverse experiences of racism, racial, gender discrimination among racialised, LGBTIQA youth. • Knowing the perpetuation and perpetrators of youthhood adverse experiences of racism, and racial, gender discrimination and their impacts on social and mental well-being of racialised, LGBTIQA youth. • Knowing that experiencing racism and racial, gender discrimination is a human rights violation either by act, omission, or advocacy of hatred supported by social, cultural, and gender norms and racist or discriminatory laws and policies.
Common sense knowledge on risk and protective factors for mental, emotional, behavioural, and substance use disorders.	• Knowing some of the risk and protective factors for mental, emotional, behavioural, and substance use disorders based on personal experiences or observations among racialised, LGBTIQA youth. • Knowing where to find information on the risk factors for mental, emotional, behavioural, and substance use disorders and how they can affect or hinder racialised, LGBTIQA youth's personal, social, and professional development. • Knowing the crucial role of protective factors for mental, emotional, behavioural, and substance use disorders in racialised, LGBTIQA youth's positive personal, social, and professional development.
Advocacy knowledge on youth mental health promotion and prevention through community-based interventions.	• Participating in schools and community events or workshops programmes on youth mental health promotion and prevention targeted at young people and the public in general. • Advocating for community interventions and media-based awareness-raising campaigns as the most effective approach to work with and include racialised, LGBTIQA young people in youth mental health promotion and prevention. • Attending international mobility programmes focusing on collaboration and exchange of good practice in the field of youth mental health promotion and prevention.

2.3.3. Youth mental health knowledge gaps

So, the most crucial part was identifying and understanding the knowledge gaps between what kind of knowledge the racialised and LGBTIQA youth current have in terms of capacity and experiences and what kind of learning needs the racialised and LGBTIQA youth current have in terms of knowledge, skills, attitudes, and competences to promote and prevent youth mental health and well-being in youth work.

Table 8. Youth mental health knowledge gaps

LEARNING NEEDS	KNOWLEDGE GAPS	EXISTING KNOWLEDGE
Providing racialised, LGBTIQA youth with mental health education and training opportunities tailored to their lived experiences: • Conducting community-based participatory action research to assess and identity mental health problems among racialised, LGBTIQA youth based on their lived experiences. • Creating education and training activities tailored to racialised, LGBTIQA youth's lived experiences of racism, and racial, gender discrimination. • Developing open educational resources for racialised, LGBTIQA youth on promoting and preventing mental health in youth work.	**Knowledge gaps that need to be closed for racialised, LGBTIQA youth to promote and prevent youth mental health in youth work:** • Before planning any youth interventions, youth organisations should be equipped with the skills for conducting community-based participatory action research to assess and identity mental health problems among racialised, LGBTIQA youth based on their lived experiences. • The data from such a participatory action research should then be used to plan and design youth mental health promotion and prevention education and training activities as well as to develop open educational resources tailored to racialised, LGBTIQA youth's unique lived youthhood adverse experiences of racism, and racial, gender discrimination.	**Individual knowledge on youthhood adverse experiences of racism, and racial, gender discrimination based on lived experiences:** • That power relations, racial and gender inequalities within the racial, gender minority groups are the root causes of youthhood adverse experiences of racism, and racial, gender discrimination among racialised, LGBTIQA youth. • That perpetuation of youthhood adverse experiences of racism, and racial and gender discrimination have impacts on social and mental well-being of racialised, LGBTIQA youth. • That experiencing racism and racial, gender discrimination is a human rights violation either by act, omission, or advocacy of hatred supported by social, cultural, and gender norms and racist or discriminatory laws and policies.
Enhancing racialised, LGBTIQA youth's knowledge on youthhood adverse experiences of racism, and racial, gender discrimination: • Conducting research on the associations between youthhood adverse experiences of racism, and racial, gender discrimination and mental health problems. • Creating education activities on the associations between youthhood adverse experiences of racial, gender discrimination and mental health problems. • Developing tools and awareness-raising campaigns on the associations between youthhood adverse experiences of racism, and racial, gender discrimination and mental health problems.	**Knowledge gaps that need to be closed for racialised, LGBTIQA youth to promote and prevent youth mental health in youth work:** • Youth organisations should be equipped with the skills and competences for creating educational and training activities on the associations between youthhood adverse experiences of racism, and racial, gender discrimination and mental health problems. • Youth organisations should be equipped with the skills and competences to developing educational resources and planning, designing, and running awareness-raising and advocacy campaigns on the associations between youthhood adverse experiences of racism, and racial, gender discrimination and mental health problems targeted at racialised, LGBTIQA youth.	**Common sense knowledge on risk and protective factors for mental, emotional, behavioural, and substance use disorders:** • Knowing some of the risk and protective factors for mental, emotional, behavioural, and substance use disorders based on personal experiences or observations among racialised, LGBTIQA youth. • Knowing where to find information on the risk factors for mental, emotional, behavioural, and substance use disorders and how they can affect or hinder racialised, LGBTIQA youth's personal, social, and professional development. • Knowing the crucial role of protective factors for mental, emotional, behavioural, and substance use disorders in racialised, LGBTIQA youth's positive personal, social, and professional development.

Strengthening racialised, LGBTIQA youth capacity in youth mental health promotion and prevention:	Knowledge gaps that need to be closed for racialised, LGBTIQA youth to promote and prevent youth mental health in youth work:	Advocacy knowledge on youth mental health promotion and prevention through community-based interventions:
• Conducting community-based participatory action research to assess and identity risk and protective factors for mental, emotional, behavioural, and substance use disorders among racialised, LGBTIQA youth. • Empowering racialised, LGBTIQA youth in creating mental health promotion and prevention community-based interventions to further promote protective factors for mental, emotional, behavioural, and substance use disorders. • Empowering racialised, LGBTIQA youth in designing mental health promotion and prevention media-based initiatives through awareness raising campaigns on protective factors for mental, emotional, behavioural, and substance use disorders.	• Youth organisations should be equipped with the skills and competences for facilitating the empowerment of racialised, LGBTIQA youth in creating mental health promotion and prevention community-based interventions to further promote protective factors for mental, emotional, behavioural, and substance use disorders. • Youth organisations should be equipped with the skills and competences for facilitating the empowerment of racialised, LGBTIQA youth in planning, designing, and delivering mental health promotion and prevention media-based interventions through awareness raising and advocacy campaigns on protective factors for mental, emotional, behavioural, and substance use disorders.	• Participating in schools and community events or workshops programmes on youth mental health promotion and prevention targeted at young people and the public in general. • Advocating for community interventions and media-based awareness-raising campaigns as the most effective approach to work with and include racialised, LGBTIQA young people in youth mental health promotion and prevention. • Attending international mobility programmes focusing on collaboration and exchange of good practice in the field of youth mental health promotion and prevention.

2.3.4. Youth mental health promotion and prevention

In Table-8, the middle column presents the knowledge gaps that must be closed for the racialised and LGBTIQA youth to better promote and prevent youth mental health in youth work as it was identified during our face-to-face consultations. Thus, the data reveals that youth organisations focusing on meant health, anti-racism, and anti-discrimination should be equipped with the skills and competences in youth mental health promotion and prevention. Indeed, this is the only most favourable approach capable of closing the gaps within the now-existing youth programmes in the overall youth education and youth work towards the mental health promotion and prevention, especially to promote the inclusion and the active participation of racialised and LGBTIQA Youth. As youth-based organisations and youth education institutions continue to put more efforts in strengthening young people's knowledge, skills, attitudes, and capacity on youth mental health promotion and prevention from the young white person's perspective, it paves ways for further discrimination or exclusion of racialised and LGBTIQA youth experiences within youth mental health promotion and prevention interventions in the overall youth work.

Hence, this calls on youth organisations to play a central role in planning, designing, implementing, and evaluating youth mental health promotion and interventions. Which significantly integrate different lived youthhood adverse experiences of racism and racial, gender discrimination while at the same time focusing on preliminary analysis on the associations between youthhood adverse experiences of racism, and racial, gender discrimination and mental health problems among racialised and LGBTIQA young people. That is, to effectively promote, prevent, and/or respond to the racialised, LGBTIQA youth's mental health needs in non-formal educational settings in youth work, as a starting point, youth organisations should:

Table 9. Youth mental health promotion and prevention

MEETING YOUTH LEARNING NEEDS	CLOSING GAPS IN YOUTH WORK
Providing racialised, LGBTIQA youth with mental health education and training opportunities tailored to their lived experiences.	• Before planning any youth interventions, youth organisations should be equipped with the skills for conducting community-based participatory action research to assess and identity mental health problems among racialised, LGBTIQA youth based on their lived experiences. • The data from such a participatory action research should then be used to plan and design youth mental health promotion and prevention education and training activities as well as to develop open educational resources tailored to racialised, LGBTIQA youth's unique lived youthhood adverse experiences of racism, and racial, gender discrimination.
Enhancing racialised, LGBTIQA youth's knowledge on youthhood adverse experiences of racism, and racial, gender discrimination.	• Youth organisations should be equipped with the skills and competences for creating educational and training activities on the associations between youthhood adverse experiences of racism, and racial, gender discrimination and mental health problems. • Youth organisations should be equipped with the skills and competences to developing educational resources and planning, designing, and running awareness-raising and advocacy campaigns on the associations between youthhood adverse experiences of racism, and racial, gender discrimination and mental health problems targeted at racialised, LGBTIQA youth.
Strengthening racialised, LGBTIQA youth capacity in youth mental health promotion and prevention.	• Youth organisations should be equipped with the skills and competences for facilitating the empowerment of racialised, LGBTIQA youth in creating mental health promotion and prevention community-based interventions to further promote protective factors for mental, emotional, behavioural, and substance use disorders. • Youth organisations should be equipped with the skills and competences for facilitating the empowerment of racialised, LGBTIQA youth in planning, designing, and delivering mental health promotion and prevention media-based interventions through awareness raising and advocacy campaigns on protective factors for mental, emotional, behavioural, and substance use disorders.

2.4. Participants' perspective analysis

During workshops debriefing, reflections and feedback among participants called for youth work research examining how indicators of systemic racism, racial, gender discrimination and adverse environments impact racialised and LGBTIQA youth mental health and well-being in distinct ways, separately from the impact of other youthhood adverse experiences. Participants want a youth work that is capable of exploring whether their youthhood adverse experiences of racism or racial, gender discrimination, might be overcome, in part, by resilience to racism, racial, and gender discrimination enhanced by the presence of adaptive coping, learned preparation for racism, racial or cultural socialisation, and/or their communities' support. Due to chronic and pervasive nature of racism, and racial discrimination, the participants strongly highlighted that it is imperative that the family, the schools, and the youth organisations take on the role and responsibilities of anticipating and preparing the racialised and LGBTIQA young people for experiencing everyday racism, racial, gender discrimination. While participants explored

the relationship between forced resilience and adaptive coping and further discussed their negative impacts on youth mental health, they identified active coping and positive racial or gender and cultural socialisation as the potential modifiers that may play a protective role for a mental, emotional, behavioural, or substance use disorder among racialised or LGBTIQA youth. For example, socialisation of culture, proactive coping with discrimination or exposure to positive racial socialisation narrative are associated with lower levels of depression, anxiety, and problem behaviour among racialised.

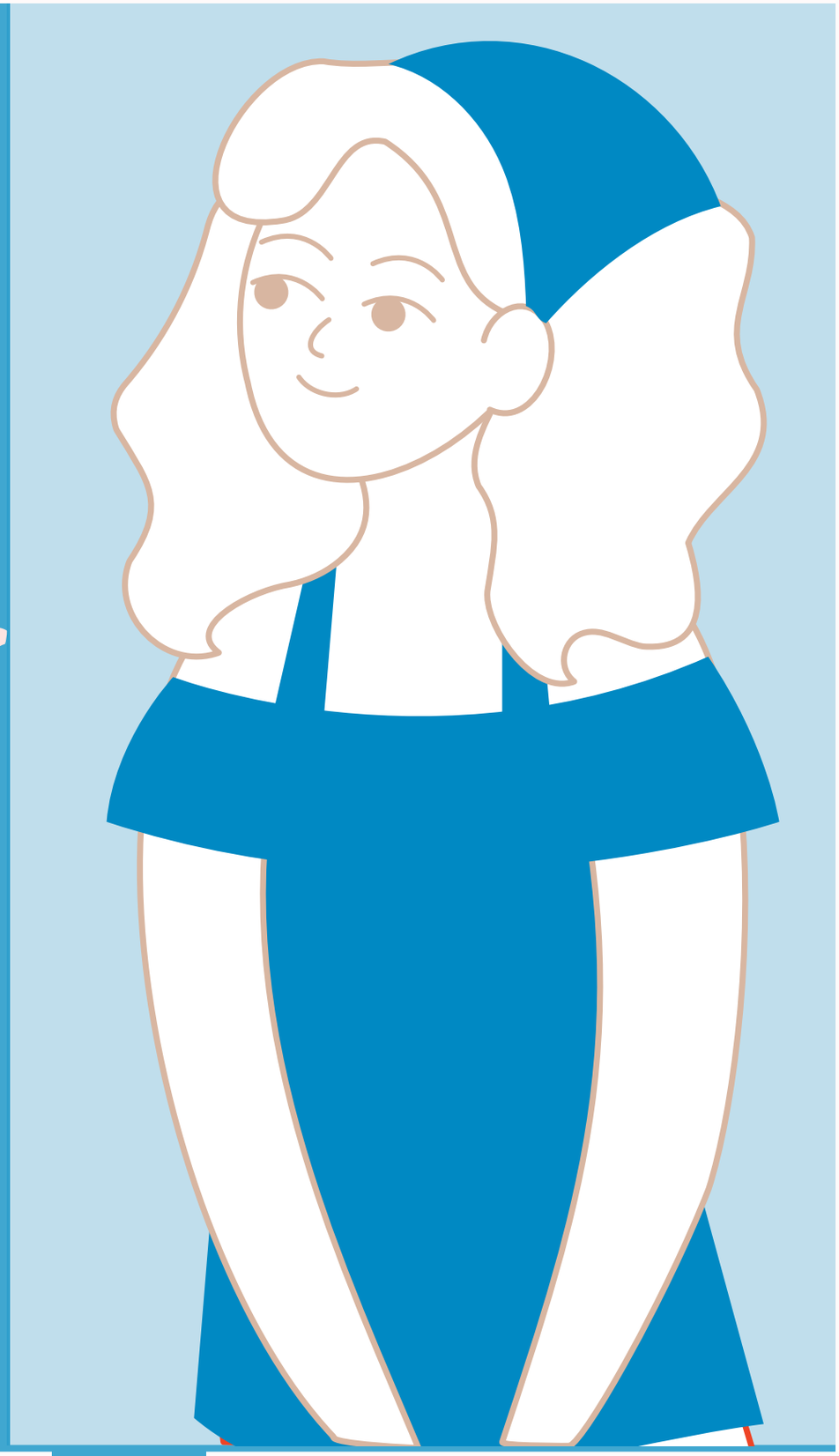
To conclude discussions, we noted that adverse relationships between racial identity connection and psychological health outcomes are complicated. Well researched, planned or designed youth mental health promotion and prevention interventions in youth work may thus explore and bring about the role of active coping, positive racial, gender, and cultural socialisation, positive racial and gender identity, and the preparation for racism, and racial or gender discrimination across racial and gender minority groups. So, strengthening youth-based organisations and youth workers capacity in conducting community-based participatory action research to assess and be understand the associations between youthhood adverse experiences of racism and racial or gender discrimination and mental health problems among racialised, LGBTIQA youth is important. This is perhaps the starting point since adverse experiences of racial and gender discrimination differ by migrant and refugee status, levels of acculturation, and developmental timing of exposure to racism and racial or gender discrimination.

2.5. Discussion and conclusion

We sought to examine the associations of lived racism and racial, gender discrimination to the racialised and LGBTIQA youth mental health outcomes among a representative sample of 20 racialised, LGBTIQA youth. Taking into account the previously documented negative impacts of racism and racial, gender discrimination on social and environmental contexts and mental health across the life course, we can thus hypothesise that lived youthhood adverse experiences of racism as well as racial and gender discrimination are underlying and significant factors in the associations between adversity and mental health during youthhood among racialised, LGBTIQA youth. Overall, greater exposure to youthhood adverse experiences of racism and racial or gender discrimination are associated with a high rate of mental, emotional, behavioural, and substance use disorders among the racialised and LGBTIQA youth. Specifically, lifetime lived youthhood adverse experiences of racism and of racial and gender discrimination are independently associated with higher prevalence of mental health problems, with significant differences across racial and gender minority groups. Therefore, taken together, these data provide preliminary support for concerns that youth mental health education, promotion, and prevention in Europe fall short in identifying and presenting the relationship between early adversities and mental health outcomes and the potential salience of racial and gender discrimination during both child and youthhood on mental health and well-being of young people who belong to racial and/or gender minority groups.

For example, all racialised and LGBTIQA youth who experience racism and racial and/or gender discrimination have over twice the prevalence of one or more mental, emotional, and behavioural health conditions, compared to the white European young people who do not experience racism nor racial and gender discrimination. These findings are consistent with the existing literature that demonstrates the associations between perceived discrimination and poor health outcomes among racialised and LGBTIQA youth with particularly detrimental effects on youth mental health. Though the existing evidence is limited, more future research could explore whether the salience of lived racism and/or discrimination among the racialised and LGBTIQA youth, after accounting for other youthhood adversity, can be related to more compounding effects of other significant stressors, such as immigration and refugee status, cultural discrimination, or acculturative stress. Similarly, future research could further investigate racism, and racial, gender discrimination as distinct risk factors for youth mental health conditions among the racialised and LGBTIQA young people. Other research among adolescents and adults has suggested that harmful impacts of racism and racial discrimination are compounded by additional stressors experienced by multiracial individuals and individuals who belong to a racial and/or gender minority group, such as racial and gender identity exploration or abandonment. While our research results indicate that there is a clear association between youthhood adverse experience of racism, and racial, or gender discrimination and the higher prevalence of mental health conditions among the racialised and LGBTIQA youth, be independently or in addition to other adversity, youth organisations should be accustomed to conducting community-based participatory action research to identity the needs and gaps among a specific targeted group, rather than generalising.

CHAPTER-3
Risk factors for youth mental health



3.1. Racial discrimination

Both racism and sexism lie at the intersection of the problem of sex, gender, and race. At that very intersection there are different types of sexual, gender, and racial stereotypes and prejudices that young people of colour or youth of African descent face. And people who have two oppressed identities ***(for example a queer person of colour who belongs to both a racial and gender minority group)*** they do not only experience the sum of these oppressions but also different kinds of oppressions. And when it is a person with even more identities, ***a transgender woman of colour for example***, therefore, multiple systems in her life are intersecting to create unique brand of racial, gender, sexual discriminations. So, before looking at racial discrimination, we need to understand race, gender, and sex since they form overlapping forms of discrimination on grounds of race, sex, gender. But what is racial discrimination?

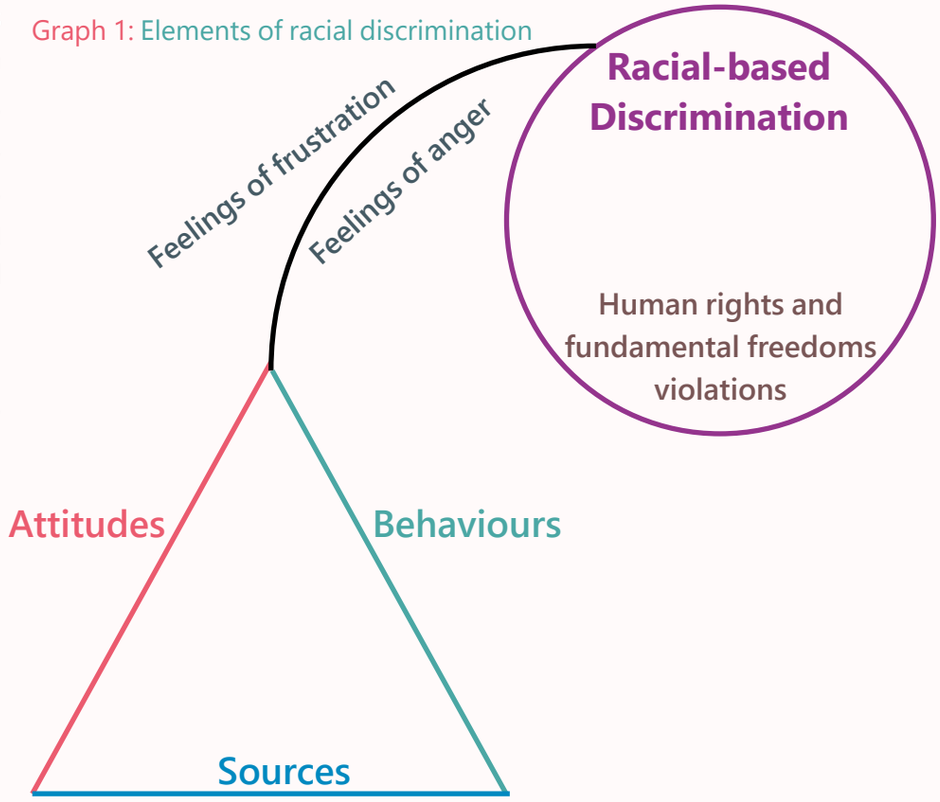
Racial discrimination, in the general sense, incorporates (3) three elements, which hold true in every situation or setting:

1. **Attitudes:** our racial stereotypes and racial prejudices of how we see or perceive ourselves; how we see or perceive others; and of how we see or perceive the context. Here, the orientation of feelings of anger and frustrations are turned inwards.
    - **Racial stereotypes** are assumptions that if racialised individuals or groups share some characteristics, they also share certain attributes. It is a simplified generalisation about people based on race that fails to take individual differences into account.
    - **Racial prejudices** refer to prejudgements based on unreasonable beliefs of a hostile nature formed beforehand and without any knowledge nor actual experience about one's race.
2. **Behaviours:** our actions in relation to our attitudes. Behaviours can be hostile and aggressive, or in contrast, they can be more peaceful and understanding. If hostile and aggressive, the orientation of feelings of anger and frustration are turned outward, in verbal or physical form.
3. **Sources:** are the elements such as poverty and inequality, social and cultural norms, cultural and social values, patriarchy or power relations, and oppressive laws, policies, and institutions.

Hence, it is when our assumptions and belief about ourselves, others, and the context are fuelled and supported by the **Sources** that **our Attitudes** and **our Behaviours** become the contributing factors in the production, the reproduction, and the perpetuation of **racial discrimination**.

That is: **Attitudes** + **Behaviours** + **Sources** = **Racial discrimination**.

Graph 1: Elements of racial discrimination



Graph interpretation

1. On the one hand, **the Sources** formulate and build the base or the foundation of racial discrimination. So, in each racial discrimination context, there are real and identifiable sources.
2. On the other hand, **the Attitudes** and **Behaviours** formulate the pillars of racial discrimination. So, in each racial discrimination context, there are real and identifiable elements of frustration and anger.
3. So, if Sources could be developed but lack sufficient pillars, in other words, lack sufficient contradictory negative attitudes and hostile behaviours, the situation would not evolve into **racial discrimination**.

4. Racial discrimination often occurs without amounting to racism. It is not racism that determines whether racial discrimination exists or not.
    - For example, if an employer refuses to hire a suitably qualified black person as a shop assistant based on the application and instead hired a less qualified white person because they felt they could lose customers if they had a black person working in the shop. This is direct racial discrimination. So, since the employer did not meet nor talk to the black person, this could not amount to an act of racism.
    - For example, a hairdresser refuses to employ stylists that cover their own hair, this would put any Muslim women or Sikh men who cover their hair at a disadvantage when applying for that position as a stylist. This is indirect racial discrimination; it is a regulation put in place by the hairdresser, but it does not amount to an act of racism.
5. So, it is when our attitudes and our behaviours result in negative reactions toward others, are supported by emerging sources that an identifiable situation of racial discrimination is born.

Racial discrimination zone:

Racial discrimination is a violation of fundamental freedoms such as:

- Freedom of conscience and religion.
- Freedom of thought, belief, opinion, and expression, including freedom of press, media, communication, and information.
- Freedom of peaceful assembly and Freedom of association.

Racial discrimination is a human rights violation that can be committed:

1. **By an act:** for example, arbitrarily restricting and depriving people from exercising, claiming, and enjoying their human rights due to their race, gender, or sex. Racial exploitation. Denying people their rights as enjoyed by others on the basis of race.
2. **By omission:** for example, not providing protection against systematic abuses committed by a person or a group against another person in a racial minority group. Omission is the failure of the state to fulfil its obligations of national and/or international law related to the protection, recognition, and realisation of human rights for all.
    - For example, high rates of racial discrimination against refugees in employment, education, labour market and/or services offering are human rights violations. It becomes a human rights violation by omission if the authorities are not taking the necessary steps to bring an end to this situation when they know, knew or should have known about its existence.
3. **By advocacy of hatred:** for example, consciously expression of abusive, discriminatory, as well as hatred speech, messages and/or narratives that constitute mal-information and/or incitement to harassment, coercion, threats, hostility, or violence.

So, what amounts to racism:

Racial discrimination and racism do not occur together, and therefore, it is crucial to identify them as separate elements. Racism occurs when racial discrimination exists and the measures or the means to curb or transform it have failed.

- From the above example of racial discrimination, it can be observed that if the Sources could be developed and gain sufficient negative, contradictory attitudes and behaviours, then, the situation evolves into racial discrimination, but not necessary into racism.
- It is when one's attitudes and behaviours result in abusive reactions in a verbal, physical, or psychological form toward a racialised individual, and these are supported by emerging sources that an identifiable situation of racism is born.

Attitudes + Behaviours + Sources + Discriminated against = Racism

3.2. Internalised racism

Internalised racism is acceptance, by a stigmatised, marginalised member of a non-elite racial group of negative societal beliefs, stereotypes, prejudices, and discriminatory behaviour about them, which might further lead to the rejection of cultural or religious practices of their own racial group. Though individual may or may not be aware of his/her own acceptance of those negative beliefs about him/her, other components that are considered part of racial, gender expression, sexual identity doubt, are also considered part of the construction of internalised racism. Hence, Internalised racism is a psychological process that affects all non-elite racial, gender and sexual

minority groups. It involves the acceptance of the typical conventional representation of race, gender that places racial and gender minority groups beneath a privileged racial group or the persons conforming to socially constructed hegemonic expressions of gender and sexual identities. This tolerance of negative stereotypes about one's racial, gender, sexual group might lead to self-degradation, self-alienation incorporating shame about one's racial, gender, or sexual identity; specifically, the acceptance of prejudices about one's abilities, beauty, sexuality, gender expression, body, and/or intellect worth. Therefore, one of the manifestations of internalised racism is the abandonment of the characteristics associated with one's racial, gender, and/or sexual identity in favour of the privileged racial group's culture and/or values, or the hegemonic expression of gender and sexual identities in the efforts to acculturate to a racist and/or homophobic society. Therefore, this can lead to devaluing of the heritage of one's racial and gender group in favour of acculturating to societal conservative cultural and/or religious beliefs that have been shown to have negative impacts on the mental health and well-being of racial, gender, and sexual minorities.

Hence, the victim of internalised racism is a person that personalises hatred narratives, discriminatory stereotypes, and racial prejudices that are coming at them from society without having a framework for understanding and dealing with such a hate speech, discrimination and/or racism. So, we have two faces of victims:

- **Direct victims:** are those suffering from direct effects of internalised racism. They are those who unconsciously internalise hatred narratives, discriminatory stereotypes, and racial prejudices. They are those who are discriminated against, marginalised, and racialised but consciously or unconsciously adopt a set of attitudes, behaviours, structures, and ideologies of an elite racial group by abandoning their own culture or values to conform to the culture or values of that elite racial group.
- **Indirect victims:** are the sub-oppressors submerged in internalised racism by displaying deep bitterness, lack of compassion and empathy, who explicitly gaslight and condemn attitude, behaviour, or lifestyle of direct victims as being shameful to shared culture or values. These are also the oppressors who belong to an elite racial group who explicitly claim their superiority over a non-elite racial group. These behaviours and attitudes are often handed down; children tend to absorb and retain them unconsciously. They carry traces of these experiences into their youth and adulthood, which is a problematic heritage that creates oppressors and perpetrators of racial discrimination and racism.

3.3. Sex and gender discrimination

By distinguishing sex and gender, we can establish that differences between a woman and man are socially produced, and therefore, changeable, at the same time. Distinguishing sex and gender, enables the two to come apart: so they are separable in the way that a person can be of a male sex and yet be gendered a woman or vice versa or neither as a woman nor a man, to indicate that there are persons who do not fall within binary gender norms. That is, although the biological differences are fixed, gender differences are not as they are the results of cultural practices or social expectations, and thereby, gender differences are oppressive results of social interventions that dictate how women and men should behave: the women are oppressed as women and by having to be women, furthermore, a person of a male sex, gendered a woman, and/or vice versa, or neither or falls under the LGBTIQA community is oppressed as a LGBTIQA person and/or for belonging in the LGBTIQA community. Hence, as result of this oppression, girls, and women in majority and the LGBTIQA persons are exposed to unequal treatments compared to men, and do not have equal rights and opportunity as the men do, which brings about gender discrimination. Since gender is a social construct, it is mutable and alterable by political and/or social reforms that ultimately would bring an end to women and LGBTIQA subordination.

That is, society needs political and social reforms aiming at creating more genderless, though not a sexless society, in which a person's sexual anatomy is irrelevant to who that person is, what that person does, and with whom that person is in love or makes love to. But which political or social reforms should aim at creating a genderless society, which social practices construct gender, or what social construction is, and what being of a certain gender amount to are the major controversies in the field of gender discrimination prevention. Since there is no consensus on these issues. But the issue is not that the male dominance is a result of social learning; rather, socialisation is an expression of power. That is, socialised gender differences in masculine and feminine traits, behaviours, and roles are not responsible for power inequalities. The females and males are socialised differently because there

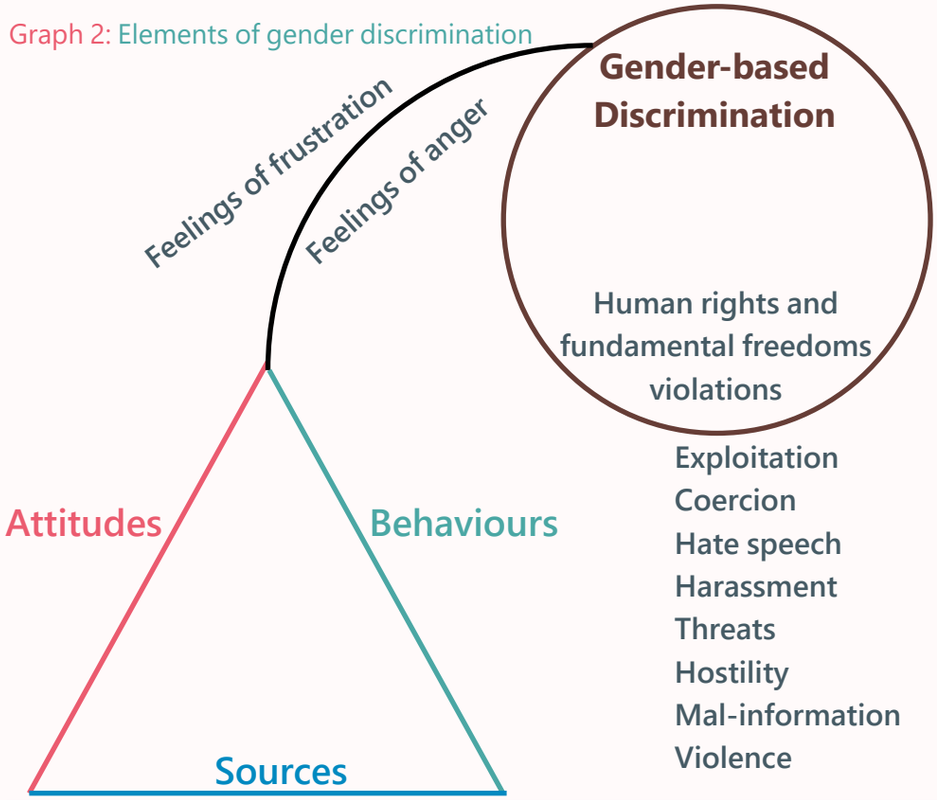
are underlying power inequalities. Hence, dominance/oppression *(power relations)* is prior to differences *(traits, behaviour, and roles)*.

For example:

- Society portrays women with female's sex traits claiming that they are both physically and mentally weaker than the men with male's sex traits.
- As a result, a female gendered woman with the same academic qualifications as a male gendered a man, will face and experience discrimination during the hiring processes when she is passed over for the man even though she might have equal skills and academic credential, as well as the underlying ability, experience, and other attributes that imply equivalent expected productivity for the same work or job.

Hence, gender discrimination is conceptualised as the differential treatment of a person and/or group on the basis of gender. By this definition, gender discrimination is about *power relations*, rather than gender *traits, behaviour, and roles*.

Graph 2: Elements of gender discrimination



Graph interpretation

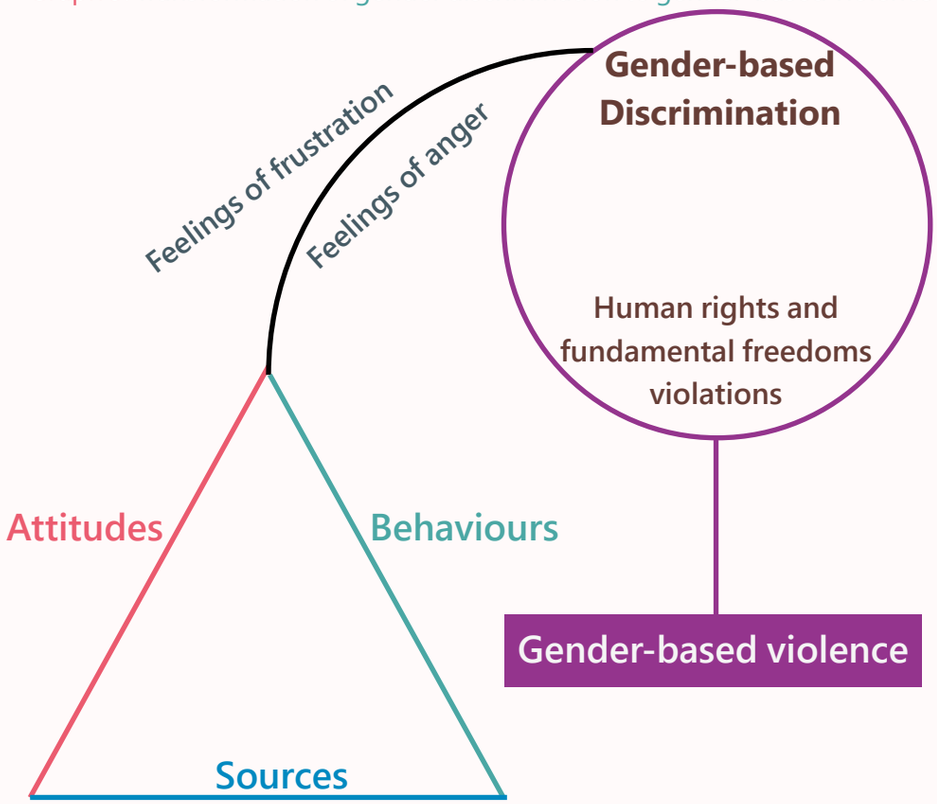
In the same way as racial discrimination, Sex and/or Gender discrimination, in the general sense, incorporates three elements which hold true in every situation or setting:

1. **Attitudes:** our gender stereotypes and prejudices of how we see or perceive ourselves; how we see or perceive others; and of how we see or perceive the context. Here, the orientation of our feelings of anger and frustrations are turned inwards.
    - **Gender stereotypes** are assumptions that if a sexed, gendered group share some characteristics also share certain attributes. A simplified generalisation about people based on gender or sex that fails to take individual differences into account.
    - **Gender prejudices** refers to personal prejudgements based on unreasonable beliefs of a hostile nature formed beforehand and without any knowledge nor actual experience about one's sex or gender.
2. **Behaviours:** our actions in relation to our attitudes. Behaviours can be hostile and aggressive, or in contrast be peaceful and understanding. Here, the orientation of our feelings of anger and frustration are turned outward, in verbal or physical form.
3. **Sources:** are elements such as poverty and inequality, social and cultural norms, cultural and social values, patriarchy and power relations, and oppressive laws, policies, and institutions.

Hence, it is when our assumptions and belief about ourselves, others, and the context are fuelled and supported by the Sources that our Attitudes and our Behaviours become the contributing factors in the production, reproduction, and perpetuation of sex or gender discrimination.

- Society fails to address, prevent, and transform sex and gender discrimination is what gives rise to sexual and gender-based violence.
- That is, sexual and gender-based violence occurs when sex and gender discrimination exist and the measures or the means to curb or transform sex and gender discrimination has failed.

Graph 3: Transformation of gender discrimination to gender-based violence



3.4. Sexual and gender-based violence

Sexual and gender-based violence refers to the violations of fundamental human rights by act, omission, or advocacy of hatred that perpetuate the gender-stereotyped norms and roles that deny the human dignity and the self-determination of an individual and hamper human development. Such human right violations refer to physical, sexual or psychological harms that reinforce female subordination and perpetuate male power and control. While gender-based violence has devastating impacts on women, girls who are the majority of its victims and survivors, LGBTIQA persons, children, boys, men are also targeted by sexual and gender-based violence. So herein, the term gender-based violence is used to distinguish common violence from violence that targets individuals and group of individuals on the basis of their gender and/or sex. Hence, gender-based violence includes acts that inflict physical, mental, and sexual violence and suffering, threat of such acts, coercion, and other deprivations of liberty, whether occurring in private and/or public. Sexual violence, including exploitation and abuse, refers to any acts, attempts or threats of a sexual nature that results, is likely to result, in physical, psychological, or emotional harm.

Gender violence is deeply rooted in unequal power relations that perpetuate and condone traits, behaviour, norms, and roles that tolerate, endorse, and normalise gender inequalities at the family, the community, and State level. The distinction made between public and private spheres should not serve as an excuse for not addressing domestic violence as a form of gender-based violence. Indeed, the exclusion of women and girls from public arena only increases their vulnerability to violence within the family. Moreover, acknowledging that LGBTIQA persons encounter a combined gender and sex discrimination implies that boundaries of gender-based violence should not be defined respectively by the girls and/or women experiences. That is, a lesbian, gay, bisexual, transgender, intersex, or a queer person should not be protected only to the extent that their experiences coincide with those of a binary person, either as a girl and/or woman. Even though the majority of the victims and/or the survivors of gender-based violence are girls and women, making the gender-based violence experienced by a woman the standard gender-based violence form to address. This appears to be both another perpetuation of gender discrimination and gender-based violence against non-binary, and the entire LGBTIQA community; as gender-based violence prevention laws and polices do not protect them by assuming that they cannot and should have pure claims of gender-based violence.

Hence, the fact that there are particularly severe consequences for a lesbian woman, transgender person, or non-binary, then making the gender-based violence experienced by women the standard gender-based violence place the entire LGBTIQA community at risk of denied protection that the girl or the woman would normally get under the same circumstances. The point is that, a human female can experience gender-based violence in any number of ways and that the contradiction arises from society's assumptions that only the claims that fall within the margins of gender binary are pure, and valid, therefore, legitimate. Such exclusive assumptions that deny LGBTIQA persons equal rights and opportunities as those given to girls and women should be challenged in the same way that laws and policies that deny the girl and woman equal rights and opportunities to those of men are being challenged today. For instance, a lesbian woman can experience gender-based violence in the ways that are both similar to and different from those experienced by the cis women, and often a non-binary person experiences double-discrimination: the combined effects of practices that discriminate on the basis of sex and gender.

Table 10. Gender-based violence in youthhood

PHASE	TYPE OF VIOLENCE
Youthhood	• Violence during courtship; • Physical, psychological, and sexual abuse by intimate partners or relatives; • Economically coerced sex; • Sexual abuse in the workplace • Rape and sexual harassment. Arranged marriage and trafficking; • Gaslighting non-binary young adults.

3.5. Stigmatisation of youth mental health

Often youth with mental illness do not receive help for their disorders. They often avoid or delay seeking treatment due to concerns about being treated differently or fears of losing the jobs and livelihood. That is because stigma, prejudice, and discrimination against youth with mental illness is a very big problem. Stigma, prejudice, discrimination against youth with mental illness can be subtle or it can be obvious, though no matter the magnitude, it can lead to more harm. Hence, discrimination associated with mental disorders creates the largest barrier to recovery and is one of the main reasons why young people do not seek help and treatment. Further, the unwillingness to seek help because of the negative attitudes attached to mental health and substance abuse disorders has been found, identified to be one of the risk factors associated with suicidal thoughts. People with mental illness are marginalised and discriminated against in various ways. On the other hand this creates a far more complex problem and compounded discrimination for racialised, LGBTIQA young adults whose mental, emotional, behavioural, and substance use disorders are largely associated with youthhood adverse experiences of racism and racial or gender discrimination.

Stigma comes from lack of information and/or fear. Inaccurate or misleading media representations of mental illness, which further contribute to both factors. And while the public may accept the medical and/or genetic nature of a mental health disorder and the need for a treatment, many people still have a negative view of youth with mental illness; especially, racialised and LGBTIQA youth. Hence, stigmatisation of youth mental health not only directly affects racialised, LGBTIQA youth with mental illness but also their loved ones who support them, often including family members. It can be:

1. **Public stigma,** which involves negative or discriminatory attitudes that the general public has about mental illness.
2. **Self-stigma,** which refers to negative attitudes, including internalised shame, that racialised, LGBTIQA youth with mental illness have about their own conditions.
3. **Institutional stigma,** is more systemic, involving states and private organisations policies that intentionally or unintentionally limit opportunities or rights for racialised, LGBTIQA youth with mental illness. For example: there are fewer mental healthcare, services and information targeted at racialised, LGBTIQA youth, or communities.

Stigma around mental illness, especially within and among racial or gender minority communities is often a major barrier for racialised, LGBTIQA youth in accessing different mental healthcare and services. For example, in some cultures, seeking professional help for a mental illness may be counter to cultural values of strong family, due to the emotional restraint and avoiding shame. Among some groups, including the African and Asian communities, distrust of the mental healthcare system is also a barrier to seeking help. In these contexts, stigma and discrimination often contribute to worsening symptoms and reducing the likelihood of getting treatment. Indeed, self-stigma leads to negative effects to recovery for racialised, LGBTIQA youth diagnosed with severe mental illnesses. Other harmful effects can include:

- Social isolation, bullying, physical violence or harassment;
- Reluctance to seek help or treatment and not to stay with treatment;
- Lack of understanding by family, friends, co-workers, or classmates;
- Fewer opportunities for work, school or social activities or housing.

Looking at a positive side, our research found that youths who are informed with facts about racism or racial, gender discrimination are able to dispel myths about racialised and LGBTIQA youth with a mental health condition and are less likely to discriminate against them. Various approaches can be used to decrease negative attitudes or discrimination, such as avoiding the use of negative labels, showing kindness and respect, or using of mass media to influence attitudes of youth and educating the public by incorporating racialised and LGBTIQA youth with mental health problem or those who recovered as messengers.

CHAPTER - 4

Mental health education in youth work

4.1. Non-formal mental health education

In this chapter, we are focusing on youth mental health education by looking at how to design and implement the most effective youth mental health promotion and prevention interventions. In youth work carried in the context of non-formal education, prevention is seen as distinct from treatment, but complementary in a common goal of reducing the burden of mental, emotional, and behavioural disorders on the healthy development of young people. By contrast, promotion, which some consider as separate from prevention, is viewed as so closely related that it should be considered a component of prevention. Prevention and health promotion both focus on changing common influences on the development of youth to aid them in functioning well in meeting life's tasks and challenges and remaining free of cognitive, emotional, and behavioural problems that would impair their functioning.

Mental health promotion is characterised by a focus on well-being rather than prevention of illness and disorder, although it may also decrease the likelihood of disorder. Indeed, health is more than just the absence of disease and so the goals and methods of prevention and promotion overlap, but the evidence of effectiveness of mental health promotion was sparse, particularly in comparison to that for prevention. There is agreement that mental health promotion can be distinguished from prevention of mental disorders by its focus on health outcomes, such as competence and well-being, and that many of these outcomes are intrinsically valued in their own right. Mental health is a critical component of young people's learning and general health. Fostering social and emotional health in youth as part of healthy youthhood development must therefore be a national priority. There is also increasing evidence that promotion of positive aspects of mental health is an important approach to reducing mental, emotional, and behavioural disorders and related problems as well. Thus, mental health promotion should be recognised as an important component of the mental health intervention spectrum, which can serve as a foundation for both prevention and treatment of disorders. For purposes of this manual and its educational goals, we have adopted a definition of mental health promotion that is consistent with concept used in international contexts.

Table 11. Promotion and Prevention Interventions

MENTAL HEALTH PROMOTION INTERVENTIONS	
DESCRIPTION	EXAMPLE
• Targeted to the general public or a whole population. Mental health promotion interventions aim to enhance individuals' ability to achieve developmentally appropriate tasks (competence) and a positive sense of self-esteem, mastery, well-being, and social inclusion, and strengthen their ability to cope with adversity.	Programmes based in schools, community centres, or other community-based settings that promote emotional and social competence through activities emphasising self-control and problem solving.
UNIVERSAL PREVENTIVE INTERVENTIONS	
DESCRIPTION	EXAMPLE
• Targeted to the general public or population that has not been identified based on individual risk. A universal preventive intervention is desirable for everyone in that group. Universal interventions have advantages when their costs per individual are low, the intervention is effective and acceptable to the population, and there is a low risk from the intervention.	School-based programmes offered to young people to teach them social and emotional skills or to avoid substance abuse. Or programmes offered to the parents to provide them with skills to communicate to their children about resisting substance use.
SELECTIVE PREVENTIVE INTERVENTIONS	
DESCRIPTION	EXAMPLE
• Targeted to individuals or a population whose risk of developing mental disorders is significantly higher. The risk may be imminent, or it may be a lifetime risk. Risk groups may be identified based on biological, psychological, or social risk factors that are known to be associated with the onset of a mental disorder. Selective interventions are appropriate if their cost is moderate and if risk of negative effects is minimal or non-existent.	Programmes offered to children exposed to risk factors, such as parental divorce, parental mental illness, death of a close relative, or abuse, to reduce risk for adverse mental, emotional, and behavioural outcomes.

INDICATED PREVENTIVE INTERVENTIONS	
DESCRIPTION	EXAMPLE
• Targeted to high-risk individuals. They are high-risk individuals who are identified as having minimal but detectable symptoms foreshadowing mental, emotional, or behavioural disorder, or biological markers indicating predisposition for such a disorder, but who do not meet diagnostic levels at the current time. Indicated interventions might be reasonable even if intervention costs are high and even if the intervention entails some risk.	Interventions for children or young people with early problems of aggression or elevated symptoms of depression or anxiety.

4.2. Youth work and mental health education

Mental, emotional, and behavioural disorders among youth, as well as the development of positive health, should be considered in the framework of the individual and contextual characteristics that shape their lives, as well as the risk and protective factors that are expressed in those contexts. So, we begun by outlining the feasible developmental framework for discussion of the risk and protective factors that are central to interventions to promote the healthy development and prevent mental, emotional, and behavioural disorders. Then, the conceptualisation and assessment of positive aspects of youth development, referred to as developmental competencies, were examined through research on the promotion of mental health among the racialised and LGBTIQA youth. And then, the manual, in this chapter, goes on to discuss research on the risk factors and protective factors for mental, emotional, and behavioural disorders, with an attention given to the factors associated with perceived racism and racial or gender discrimination and to the multiple factors associated to social and environmental structures. The emphasis was on identifying the implications of findings from this research for the design and evaluation of appropriate preventive interventions.

In the context of youth work,mental health prevention and promotion for the young people involve both educational and training interventions to alter developmental processes. So, youth education and training should be grounded in a conceptual framework that clearly emphasises and reflects a youth developmental perspective in youth work. Four key features of the developmental framework in youth work for mental health education are therefore important as a basis for both mental health prevention and promotion: *(1). age-related patterns of competence and disorder, (2). multiple contexts, (3). developmental tasks,* and *(4). interactions among biological, psychological, and social factors.* Youth mental health promotion includes efforts to enhance the youth ability to achieve appropriate developmental competences and a positive sense of self-esteem, wellbeing, and social inclusion; and to strengthen the youth ability to cope with adversity. Hence, understanding the reciprocal pathways by which the failures of appropriate developmental competences contribute to psychopathology and by which psychopathology undermines the youth development is needed to design mental health promotion activities aimed at strengthening developmental competencies among young people.

Whereas the youth's mental health prevention interventions are intended to avert mental, emotional, and behavioural problems throughout the life span. Hence, these interventions must be shaped based on developmental and contextual considerations, many of which change as young people progress from children into young adulthood. Hence, to develop effective interventions in youth work, it is essential to understand both how the developmental and contextual factors at younger ages influence youth mental health outcomes at older ages and how to influence those factors. Thus, the concept of risk and protective factors is central to framing and interpreting the research and the context analysis needed to develop and evaluate mental health prevention interventions in youth work.

1. A risk factor is defined as a measurable characteristic of a subject that precedes and is associated with an outcome. Risk factors can occur at multiple levels, including biological, psychological, family, community, and cultural levels. We can differentiate risk factors for which there is within-subject change over time *(variable risk factors)* from those that do not change *(e.g., gender, ethnicity, race, genotype: fixed markers)*. Causal risk factors are those that are modifiable by an intervention and for which modification is associated with change in outcomes. A risk factor that cannot be changed by an intervention or for which change in the factor has not been demonstrated to lead to

a change in an outcome is considered a variable marker.

2. **Protective factors** are defined as characteristics at the individual, family, or community level that are associated with a lower likelihood of problem outcomes. The distinctions between risk factors discussed above can also be applied to protective factors. The term *protective factors* has also been used to refer to interactive factors that reduce the negative impact of a risk factor on a problem outcome, resilience. It is often difficult to distinguish the effect of protective factors from that of risk factors, because the same variable may be labelled as either depending on the direction in which it is scored *(e.g., good parenting versus poor parenting, high self-esteem versus low self-esteem)*. For example, low academic achievement is a risk factor for externalising problems, whereas adequate academic performance is a protective factor.

Hence, considering risk and protective factors in the design and evaluation of the youth work mental health promotion and prevention interventions is therefore very important. Over the past several decades a voluminous literature has emerged on risk and protective factors associated with specific mental health disorders and on the multiple disorders and problems that are associated with exposure to the specific risk and protective factors. This literature provides youth work a base for the design and implementation of effective interventions. When potentially modifiable risk and protective factors have been identified through research, then preventive approaches can be developed to change those risk factors in order to prevent or reduce the development of mental, emotional, and behavioural problems. In all, adapting such a research to youth work is essential as it helps to understand the targeted groups and the risk factors various individual might be facing, such as young people exposed to divorce; poverty; bereavement; racism; racial or gender discrimination; substance-abusing parent; abuse or neglect. And although the interventions aimed at these young people typically do not target the risk factors themselves *(e.g., a divorce has already occurred; they have been exposed to racism and racial or gender discrimination; they have abused drugs)*, they can be designed to reduce the likelihood of mental health problem outcomes given these elevated risk factors. In this context the goal of youth work would be to provide these young people with safe and supportive environments.

4.3. Community-based mental health interventions

A major issue within youth work is the balance between delivering evidence-based mental health promotion and prevention interventions and adapting these interventions over time to meet the specific needs of the community. Hence, to address this issue, community-based mental health interventions in a context of youth work, must integrate preventive intervention trial. The aim of preventive intervention trial is to test whether the intervention is effective in changing the initially targeted risk and protective factors and whether the change in these factors accounts for changes in the problem outcome. Since prevention is aimed at averting mental health problems that may occur across developmental stages, a critical feature of the prevention trial is the longitudinal follow-up of participants to assess the intervention's impact on trajectories of development. Further, community-based mental health interventions in contexts of youth work, must integrate randomised preventive trial. Aim of randomised preventive trial is to provides evidence on whether an intervention has successfully changed a risk factor and/or contributed to protective factor and whether that the change is associated with a later change in the problem outcome.

Herein, our focus is on these three alternative implementation approaches: *(1). Direct adoption of a specific evidence-based prevention programme, (2). Adaptation of an evidence-based intervention to community needs,* and *(3). Community-driven implementation*. Table 12 summarises the advantages and the disadvantages of each. These three approaches are not mutually exclusive or exhaustive of all potential approaches. Each requires an active partnership among the targeted groups, the community leaders, the youth-based organisations, and institutions, and researchers and must address the issues of trust, power, racism, gender disparity, priority, and actions. Therefore, the appropriate approach in a given community will depend on its characteristics and priorities and the availability of an existing evidence-based programme that matches its needs. Ideally, the need assessment and evaluation are components of all these three approaches to shed light on why a specific approach works in a particular community or how to generalise knowledge and skills about successful implementation to other programmes, communities, or institutional settings.

4.3.1. Adoption of existing evidence-based interventions

So, adoption of a community-based mental health prevention intervention involves delivering that intervention with high fidelity and by increasing the likelihood that its impact will be similar to that found in the original intervention. Typically, the intervention should have met specific standard of evidence *(often articulated and approved by the funding agencies)*. The outputs of the original intervention, such as the standardised educational resources, and teaching or training manuals, or created or produced media help deliver the intervention in a manner similar to that used by the original intervention. There is limited adaptation of the intervention due to cultural or historical characteristics or particular interests of the community. So, the new implementing organisation needs sufficient mental health education capacity and resources and know-how to ensure monitoring, sustainability.

4.3.2. Adaptation of existing interventions to community

The implementing organisation identifies an evidence-based intervention that matches its needs, values, and resources and modifies and/or adopts elements of the intervention to maximise sustainability of youth mental health education. So, this approach requires to work in close collaboration with the youth at risk to find ways to integrate components of prevention programmes in ways that are acceptable and meaningful to the community and evaluate the results. A youth mental health promotion and prevention intervention should be culturally, racial, and gender sensitive, along with the concerns about whether the given prevention intervention is generic enough to be effective with diverse cultures and racial histories. So, making adaptations to different cultural or racial groups while maintaining core elements of the intervention implemented with fidelity can produce strong results across different cultural and racial groups.

4.3.3. Community-driven implementation

Community-driven implementation is heavily built on the decision making of the community leaders, in partnership with youth-based organisations, with a focus on improving the community's sustainability on youth mental health education. The implementation of a youth mental health promotion and prevention intervention is guided by community-driven agenda. Then, evidence based programmes or principles are often introduced by youth-based organisations who are partners in the process. Built on community-based participatory action research approach, agenda for community action is developed through a cooperative process. Thus, the involvement of youth organisations in identifying priorities helps to establish an organisational structure for building and sustaining one or more interventions.

In racial minority communities, there is a history of mistrust which influences the degree to which youth organisations can involve in decision making, and at same, be trusted to present the interests of the racial minority young people. The traditions of research, including reliance on planned research design, multiple assessments or legal consent documents, are often viewed negatively by the racial minority communities. So, the role of youth-based organisations is listening to the goals and the needs of the racial minorities, with the clear partnership in the decision-making processes evolving over time. The wealth of practical experience and wisdom that the youth-based organisations have, do offer opportunities to establish an empirical basis for the interventions with strong community support, which: *(1). Enhance the relevance of research, (2). Help develop research procedures acceptable to the potential participants from diverse cultures or races, (3). Address challenges to conducting community-based research and maximise the usefulness of research findings, and (4). Foster the development of community resources to sustain prevention funding beyond grant funding.*

Table 12. Comparison of three Implementation Approaches

ADOPTION OF EXISTING EVIDENCE-BASED INTERVENTION	
DISADVANTAGES	ADVANTAGES
• Programme may not fit community needs, strengths, or capacities. • Real-world implementation may differ dramatically from the way originally tested. • Lack of ownership in the programme. • Few evidence-based programmes have the capacity to provide technical assistance and training. • An evidence-based programme may not target outcomes relevant to community.	• High programme fidelity. • Relatively high likelihood of achieving intended impact. • Known resources and requirements for effective implementation. • Likely continued funding under federal and state supported evidence-based prevention.

ADAPTATION OF EXISTING INTERVENTION TO COMMUNITY NEEDS	
DISADVANTAGES	ADVANTAGES
• Key programme components may be modified, thereby reducing outcomes. • Essential programme components not always evident.	• Ownership and high support from community and potentially high adoption. • Programme more relevant to ethnic, racial, gender, or linguistic characteristics of community. • Reasonably more likely to achieve impact.
COMMUNITY-DRIVEN IMPLEMENTATION	
DISADVANTAGES	ADVANTAGES
• Lengthy period to develop community awareness, common vision, and programme. • Potential for ineffectiveness. • Challenges in obtaining funding for sustaining a unique programme.	• Can develop high community acceptance and ownership. • Potential for broader implementation across different organisations and institutions within the community. • Opportunity to empirically evaluate the outcomes of programmes accepted by the community and use quality improvement methods to enhance outcomes over time.

4.4. Youth-friendly mental health interventions

Youth-friendly mental health intervention, a community-based intervention that integrates the needs and interests of the youth in all their diversity. It is a process done through screening for prevention. Prevention screening is a two-part process that first identifies the risk factors whose presence in individuals makes the development of a psychological and/or a behavioural problems more likely, then segments the relevant subset of the population to receive a unique preventive intervention. Screening is carried out:

1. **At the community level and focuses on youth-based risks:** for universal prevention efforts.
    - **E.g.,** training of youth workers to talk about the effect of racism and racial discrimination on the mental health of the racialised and LGBTIQA youth.
2. **At the group or individual levels:** for selective prevention efforts.
    - **E.g.,** screening for the risk factor, like depression, when the racialised and LGBTIQA youth are exposed to racism or racial discrimination.
3. **At the individual level based on unique behaviours that may be prodromal features of mental, emotional, and/or behavioural disorders:** for indicated prevention efforts,
    - **E.g.,** screening for risk factors when a racialised and LGBTIQA youth grades in school fall unexpectedly.

Screening for the community, group, or individual-level risks is based on the identification of risk exposures. Indeed, there is a long list of so many, and possible community-level exposures, which represent risks; including poverty, violence and other neighbourhood stressors, such as a lack of safe schools environments, and lack of access to health care for the racialised and LGBTIQA youth. High-risk exposures for subsets of racialised and LGBTIQA youth can include depression due to physical or sexual maltreatment based on race, gender, and sex. To address such risk factors, could for example be effective through a community-based prevention system that is designed to reduce adolescent delinquency or substance abuse that are connected to experiences of racism or racial discrimination among racialised youth. If used by the youth-based organisations, such a substance abuse prevention approach provides a process for the community to identify its prevention priorities and develop the profile of the community's risk and protective factors. So, its logic model involves community-level training and technical assistance on three steps:

1. Community adoption of an evidence-based prevention framework;
2. Creation of a plan for changing outcomes through evidence-based programmes that target risk and protective factors identified by the community; and
3. Implementation and evaluation of these programmes using both process, summative as well as transfer and impact evaluations.

Its theory of change hypothesises that it takes two to five years to observe changes in prioritised risk factors and five or more years to observe effects

on delinquency or substance use. Hence, in the longer-term perspective, it has positive effects on the targeted risk factors and delinquent behaviour as well as on alcohol use and binge drinking. To address such risk factors, can also be effective through the school-community-university partnership system designed as a means to enhance resilience and reduce adolescent delinquency or substance abuse connected to experienced racism or racial discrimination among the racialised youth. For example, a system aimed at broad implementation of evidence-based interventions, which are designed to support positive youth development and reduce early substance use delivered in rural areas with supports at the local and state levels. Hence, underlying such a system is the building of an infrastructure that supports local ownership and capacity building but also leadership and institutional support. Two group are involved: *(1). the elementary and secondary school systems,* and *(2). the community providers of services for youth and families together with youth-based organisations*. As the intervention is delivered by local practitioners, it focuses on building strong support of the school–local community teams, which chooses interventions and are responsible for their implementation. The long-term goal is to provide infrastructure support and a more direct assistance to sustain effective, empirically based intervention in the communities that can reduce substance abuse, violence, and other conduct problems in the schools.

4.5. Youth addressing mental health stigma

Herein, stigma refers to when someone is viewed with disapproval because of a particular characteristic, such as having a mental health problem. Thus, stigma relating to mental health means that the people with mental health condition may be viewed negatively and have negative assumptions made about them, and/or just be discriminated against because of their mental health. Though this can also result in people with mental health concerns feeling shame, guilt, and being afraid to tell others about their experiences. This can make it hard for them to access support and help. The way people view mental health, and how they respond can be influenced by their cultural beliefs, knowledge of mental health and the amount of contacts they have had and the type of contacts they have had with people with mental health problems. So, stigma associated with mental health conditions is a major barrier to service seeking among the youth, particularly among racialised and LGBTIQA youth. Hence, building awareness around the invisibility of the mental health challenges and the continuum of wellness to illness may help to break down stigma's impact as a barrier to service seeking. Indeed, stigma around mental illness puts youth at a more risk for not seeking help for themselves and/or not helping their peers dealing with mental distress. Often due to the variety of harmful stereotypical attitudes and behaviours enacted against the youth who are labelled as mentally ill, most families would prefer to hide or deny that their child has a mental health condition. Common stigmatising beliefs include the notion that mental illness signals personal deficits, weakness, difference, or the lack of self-control, and that all youth with mental illness cannot recover and are dangerous and violent. Therefore, stigma intersects with culture and is found throughout all levels of society. It can be understood at intersecting levels: structural; social; and self-stigma:

1. **Structural stigma** refers to policies or practices of institutions that systematically restrict the rights and the opportunities for young people living with mental health disorders.
2. **Social stigma** refers to the process whereby social groups endorse stereotypes about the youth with a mental health disorder and act against them.
3. **Self-stigma** occurs when youth living with mental health disorders internalise societal attitudes and discriminatory practices.

On the other hand, youth are a critically important population in terms of mental health promotion, prevention, education, literacy, and treatment from a developmental perspective. About half of mental health disorders first arise by about mid-adolescence, with suicidal ideation and attempts being particularly high among young people. Negative impacts of mental health challenges on developmental trajectories make adolescence and youthhood the optimal times to intervene, both for full threshold mental disorders and sub-threshold mental health challenges. Thus, this calls for greater investment in the youth mental health promotion and prevention efforts. Early intervention approaches connect youth with services before a full-threshold disorder develops. Despite the potential for intervening early, youth are highly impacted by stigma, and stigma in turn constitutes a major barrier to service seeking. Indeed, perceived stigma is one of the main reasons why the youth choose not to seek mental health services. Service

seeking is fostered by factors such as parental support and social support, positive past service experiences, and the youth own motivation to develop coping skills and to address negative impacts of mental health challenges. A variety of youth mental health promotion and service design strategies foster service seeking among the youth with mental health challenges, such as increasing youth health literacy and developing youth-friendly service settings that address a wide range of challenges, and reduce stigma.

A range of stigma reduction approaches, for instance, intergroup direct contact with individuals impacted by stigma is the key to reducing prejudice. Although social contact is a key ingredient of anti-stigma interventions, for the service providers, the professional contact may not have the same stigma reduction effects. Therefore, other approaches, such as the internet-based interventions, arts-based interventions, media-based interventions, or peer support have the most potential to reducing mental health stigma. Among the youth, the classroom-based or youth work-based contact approaches have proven to be successful. Since such interventions can reduce stigma, they may increase the willingness of youth to seek services when needed. Looking at a youth-led mental health awareness promotion campaigns, in which high school students can lead educational workshops for at-risk middle school students in the after-school programme, the analyses reveal statistically significant changes in the Knowledge and at three intersecting levels: structural; social; and self-stigma. The analyses suggest that salutary results can be realised because of the very brief interventions with youths around the topic of mental health awareness. But the effect sizes of such anti-stigma interventions are consistently small and mental health stigma remains a considerable societal problem.

Hence, looking at youth work-based mental health awareness promotion intervention, the youth mental health skills interventions are developed for the purpose of reducing the factors associated with suicidal behaviour. It is an intervention that can have a more positive impact on the racialised and LGBTIQA youth's feelings of hopelessness, suicidal ideation, and ability to intervene in a peer suicidal crisis situation. When used as a comprehensive mental, emotional, or behaviour disorders prevention approach, the youth mental health skills interventions can make significant changes in mental health attitude and can thus contribute to the reduction of mental health stigma at all the three intersecting levels: structural; social; and self-stigma.

This is because, in order to effectively set up such a community-based intervention, extensive input must be solicited from the targeted racialised and LGBTIQA youth to fit their own cultural norms, social values, and the natures of the perceived racism and/or racial/gender discrimination. Then, various key aspects of giving instruction, problem solving, and helping others in that cultural, social structure, and racial context must be examined. Hence, focus groups participants must be the racialised and LGBTIQA youth themselves to give guidance on the intervention's content, implementation issues, and intervention refinement.

For example, after the focus groups, it could be established that suicidal behaviour among racialised, LGBTIQA youth might be attributed to direct modelling influences *(e.g., peer and/or extended family member's suicidal behaviour)* in conjunction with their local environmental influences *(e.g., geographic isolation)* and the individual characteristics *(e.g., hopelessness, depression, anxiety, and the alcohol or drug use)* that mediate the decisions related to the self-destructive behaviours. Hence, integrating Youth Mental Health Skills Training Workshops within youth work in the context of non-formal education can be used throughout the intervention to complement traditional ways of shaping behaviour. Each skill-building activity should be selected from the research supporting best practices for social emotional regulation and cognitive skills development: methods of group cognitive as well as of behavioural development and treatment. Hence, modifications must be made to strategies identified.

For example, in the lessons on recognising and overcoming depression, the Pleasant Events Schedule can be modified to reflect the racialised or LGBTIQA youth socialisation in the training context and used as the basis for the workshops' activities. In a training addressing stress management, for instance, the eight ways of coping advanced by Folkman and Lazarus can also be shared during the workshop activities to better determine cultural coping preferences and coping styles. The coping strategies most highly endorsed by the participants during the workshops must be emphasised throughout the intervention. This encourages the inclusion of traditional and contemporary world views in the intervention without compromising its core psychological components.

CHAPTER-5

Design and delivering of youth mental health training

D1 S1 YOUTH HEALTH LITERACY MENTAL HEALTH AND WELLNESS

A01. Empowerment in youth mental health and wellbeing

Learning activity	Reflecting on experience workshop
Training method	Experiential learning: Workshop-based learning
Goal of the activity	This workshop is used to capture the motivation, imagination, and energy of the workshop audience. Reflecting activities encourage workshop participants to look back on their own personal and/or professional behaviour in a way that prepares them for new learning and change. Reflection is often used at the beginning of a workshop or at a transition from one topic to another. To design a reflecting activity, it is important to identify the past experience that you want to invoke and to do so in an engaging way that can be linked to the workshop topic.
Targeted audience	Young people; youth workers or youth educators; trainers or facilitators; youth-based organisations; and other educators involved in youth education and training.
Learning objectives	• Develop participants' knowledge, skills, and attitudes on how to engage with young people on youth mental health and wellness during training interactions. • Strengthen participants' training skills and capacity in using interactive learning activities to integrate youth mental health and wellness literacy in youth work.
Instructions	1. Divide the participants in small groups. Ask each member of the group to think of and share with the group at least five (5) words that each set describe "Youth Mental Health" and "Youth Mental Wellbeing" based on their experiences and knowledge. 2. Upon completion of this spontaneous interaction, ask each group to analyse and interpret different words from all participants to generate one Word Cloud for each term composed only of ten (10) words that reflect everyone in the group. 3. Ask them to analyse and interpret the terms "Youth Mental Health" and "Youth Mental Wellbeing" and create a list of at least five (5) types of Youth Health and a list of at least five (5) types of Youth Rights. Then provide a flip-chart to each group: a. Which type of three (3) interventions in the context of non-formal education that youth work can use in order to effectively meet youth's learning needs and knowledge gaps in Youth Mental Health and Youth Mental Well-being? b. What do you think are the most appropriate training activities that youth can participate to strengthen their knowledge, skills of Youth Mental Health and Youth Mental Wellbeing? c. Create one complete training activity that can strengthen youth knowledge, skills, and attitudes of Youth Mental Health and Youth Mental Well-being.

Debriefing	1. Check the results in the bigger group with all participants. Discuss the experience with the participants. Ask questions such as: a. How did you manage to do the activity? b. Are you satisfied with the results of your group? c. What was difficult and how could it be done better? 2. Then use the follow-up questions for interactive discussions: a. How can you define or characterise the terms "mental health literacy" and "mental well-being literacy"? What do they have to do with each other? b. What challenges and opportunities are you facing in dealing with or addressing different forms of mental health and well-being problems in your practice or work? c. How do you see a lack of mental health and well-being literacy impacting you personally or the communities or the groups that you work with?
Learning outcomes	• Participants are able to apply gained knowledge and skills to engage with young people on youth mental health and wellness in their youth work. • Participants are able to use interactive training learning activities to integrate youth mental health and wellness literacy in their youth work.
Training logistics	• Flipchart paper, large sticky notes, markers, and a tape. • A wall with enough space to attach several sheets of flipchart.
Required time	90 Minutes: As a facilitator you should expect to spend: • 15 Minutes for presenting giving instructions. • 50 Minutes for participants to complete their tasks in small groups. • 25 Minutes for reflection and discussion during debriefing.
Challenges	• This activity brings together different concepts related to what youth need to make effective health decisions for themselves as a means to develop healthier lifestyles necessary to achieve a greater state of health and well-being. We have created a set of 12 workshop learning activities that reflects essential themes in the field of youth health literacy. • The themes including Youth mental health and well-being, Drug abuse and youth well-being, Gender and sexual health literacy, and Digital youth health literacy are discussed, and each is linked to a workshop learning activity. So, beyond having experience in youth health literacy, the facilitator should have experience in human rights education and cultural literacy to facilitator this workshop.
Adjustments	• You can adapt the questions to the profile of the group and context in which a workshop takes place. • This activity works best with small groups, 20-25 participants.

D1 S2 YOUTH HEALTH LITERACY MENTAL HEALTH AND WELLNESS

A02. Challenges to youth mental health and wellbeing

Learning activity	Experimenting and practicing workshop
Training method	Experiential learning: Workshop-based learning
Goal of the activity	This workshop encourages participants to use knowledge in a practical way. These activities provide an opportunity for participants to practice and involve themselves in new behaviours and skills. The workshop provides participants a safe environment in which to try out new things before putting them into practice in the "real world." To design experimenting activities, it is important to identify the specific skills you want participants to acquire and to provide ways for these skills to be practiced in a useful way. Role plays are commonly used as experimenting activities in workshops.
Targeted audience	Young people; youth workers or youth educators; trainers or facilitators; youth-based organisations; and other educators involved in youth education and training.
Learning objectives	• Develop participants' knowledge, skills, and attitudes on how to engage with young people on youth mental health and wellness during training interactions. • Strengthen participants' training skills and capacity in using interactive learning activities to integrate youth mental health and wellness literacy in youth work.
Instructions	1. Ask each participant to present a situation describing a time in their lives when they felt excluded or unable to claim, exercise, enjoy their rights to mental health? 2. Divide participants in small groups. In their small groups, ask each participant to present their situation. Ask them to listen to each-other and then to compare any similarities and differences among those situations. 3. Ask them to analyse and interpret various situations from all participants in the group to identify common aspects enough to create a one situation story that reflects everyone in the group. Then provide a flipchart to each group: a. Did the interpretations of various situations provide you the opportunity to learn how to overcome differences and become allies to address a common problem from different perspectives? If yes, how? If no, why not? b. How can youth education and training offerings in the field of youth health literacy address the needs, gaps, or challenges expressed in your one situation to fully claim, exercise, and enjoy the rights to mental health? c. Which learning activities the person(s) in your one situation could undertake or be involved in, in order to strengthen knowledge, skills, and attitudes on how to claim, exercise, and enjoy the rights to mental health?

Debriefing	1. Check the results in the bigger group with all participants. Discuss the experience with the participants. Ask questions such as: a. How did you manage to do the activity? b. Are you satisfied with the results of your group? c. What was difficult and how could it be done better? 2. Then use the follow-up questions for interactive discussions: a. How can you define or characterise the terms "mental health literacy" and "mental well-being literacy"? What do they have to do with each other? b. What challenges and opportunities are you facing in dealing with or addressing different forms of mental health and well-being problems in your practice or work? c. How do you see a lack of mental health and well-being literacy impacting you personally or the communities or the groups that you work with?
Learning outcomes	• Participants are able to apply gained knowledge and skills to engage with young people on youth mental health and wellness in their youth work. • Participants are able to use interactive training learning activities to integrate youth mental health and wellness literacy in their youth work.
Training logistics	• Flipchart paper, large sticky notes, markers, and a tape. • A wall with enough space to attach several sheets of flipchart.
Required time	90 Minutes: As a facilitator you should expect to spend: • 15 Minutes for presenting giving instructions. • 50 Minutes for participants to complete their tasks in small groups. • 25 Minutes for reflection and discussion during debriefing.
Challenges	• This activity brings together different concepts related to what youth need to make effective health decisions for themselves as a means to develop healthier lifestyles necessary to achieve a greater state of health and well-being. We have created a set of 12 workshop learning activities that reflects essential themes in the field of youth health literacy. • The themes including Youth mental health and well-being, Drug abuse and youth well-being, Gender and sexual health literacy, and Digital youth health literacy are discussed, and each is linked to a workshop learning activity. So, beyond having experience in youth health literacy, the facilitator should have experience in human rights education and cultural literacy to facilitator this workshop.
Adjustments	• You can adapt the questions to the profile of the group and context in which a workshop takes place. • This activity works best with small groups, 20-25 participants.

D1 S3 YOUTH HEALTH LITERACY MENTAL HEALTH AND WELLNESS

A03. Raising awareness on youth mental health and wellbeing

Learning activity	Planning for application workshop
Training method	Experiential learning: Workshop-based learning
Goal of the activity	This workshop provides a stimulus for implementing and utilizing new learning outside the workshop context. Planning activities prepare participants for and increase the likelihood of transfer of learning to new context or in their work environment. These activities are often used at the conclusion of a workshop or when the focus of the workshop is about to shift from one topic to another. To design planning activities, it is important to identify ways to have participants look toward the future and identify specific ways to put new learning into practice.
Targeted audience	Young people; youth workers or youth educators; trainers or facilitators; youth-based organisations; and other educators involved in youth education and training.
Learning objectives	• Develop participants' knowledge, skills, and attitudes on how to engage with young people on youth mental health and wellness during training interactions. • Strengthen participants' training skills and capacity in using interactive learning activities to integrate youth mental health and wellness literacy in youth work.
Instructions	1. Divide participants into their small groups of 4 or 5 persons per group. Then give each small group a flip chart and Handout-A03.1. and Handout-A03.2. 2. Ask each group to discussion the example of the counter-narrative campaign on Handout-A03.1. The discussions should focus on participants' interpretations, descriptions, and meanings the make out of that campaign. 3. After concluding the discussions in small groups, ask each group to use a flipchart to complete Handout-A03.2. Ask each group: a. To think about the youth mental health and well-being context they would like to raise awareness about through counter-narrative/alternative campaign? b. To describe the characteristics of the audience they want to target. What is the behavioural or social change they aim to contribute to? c. To describe how they will achieve that impact. How many people do they aim to reach? How much campaign content do they aim to produce? How many times per week do they plan to post a new content? d. To create campaign's content: message(s); medium for each message; and call to action for each message. Which social media channels will they use to run the campaign? Which methods will they use to measure the impact?

Debriefing	1. Check the results in the bigger group with all participants. Discuss the experience with the participants. Ask questions such as: a. How did you manage to do the activity? b. Are you satisfied with the results of your group? c. What was difficult and how could it be done better? 2. Then use the follow-up questions for interactive discussions: a. How can you define or characterise the terms "mental health literacy" and "mental well-being literacy"? What do they have to do with each other? b. What challenges and opportunities are you facing in dealing with or addressing different forms of mental health and well-being problems in your practice or work? c. How do you see a lack of mental health and well-being literacy impacting you personally or the communities or the groups that you work with?
Learning outcomes	• Participants are able to apply gained knowledge and skills to engage with young people on youth mental health and wellness in their youth work. • Participants are able to use interactive training learning activities to integrate youth mental health and wellness literacy in their youth work.
Training logistics	• Flipchart paper, large sticky notes, markers, and a tape. • A wall with enough space to attach several sheets of flipchart.
Required time	90 Minutes: As a facilitator you should expect to spend: • 15 Minutes for presenting giving instructions. • 50 Minutes for participants to complete their tasks in small groups. • 25 Minutes for reflection and discussion during debriefing.
Challenges	• This activity brings together different concepts related to what youth need to make effective health decisions for themselves as a means to develop healthier lifestyles necessary to achieve a greater state of health and well-being. We have created a set of 12 workshop learning activities that reflects essential themes in the field of youth health literacy. • The themes including Youth mental health and well-being, Drug abuse and youth well-being, Gender and sexual health literacy, and Digital youth health literacy are discussed, and each is linked to a workshop learning activity. So, beyond having experience in youth health literacy, the facilitator should have experience in human rights education and cultural literacy to facilitator this workshop.
Adjustments	• You can adapt the questions to the profile of the group and context in which a workshop takes place. • This activity works best with small groups, 20-25 participants.

Manual references

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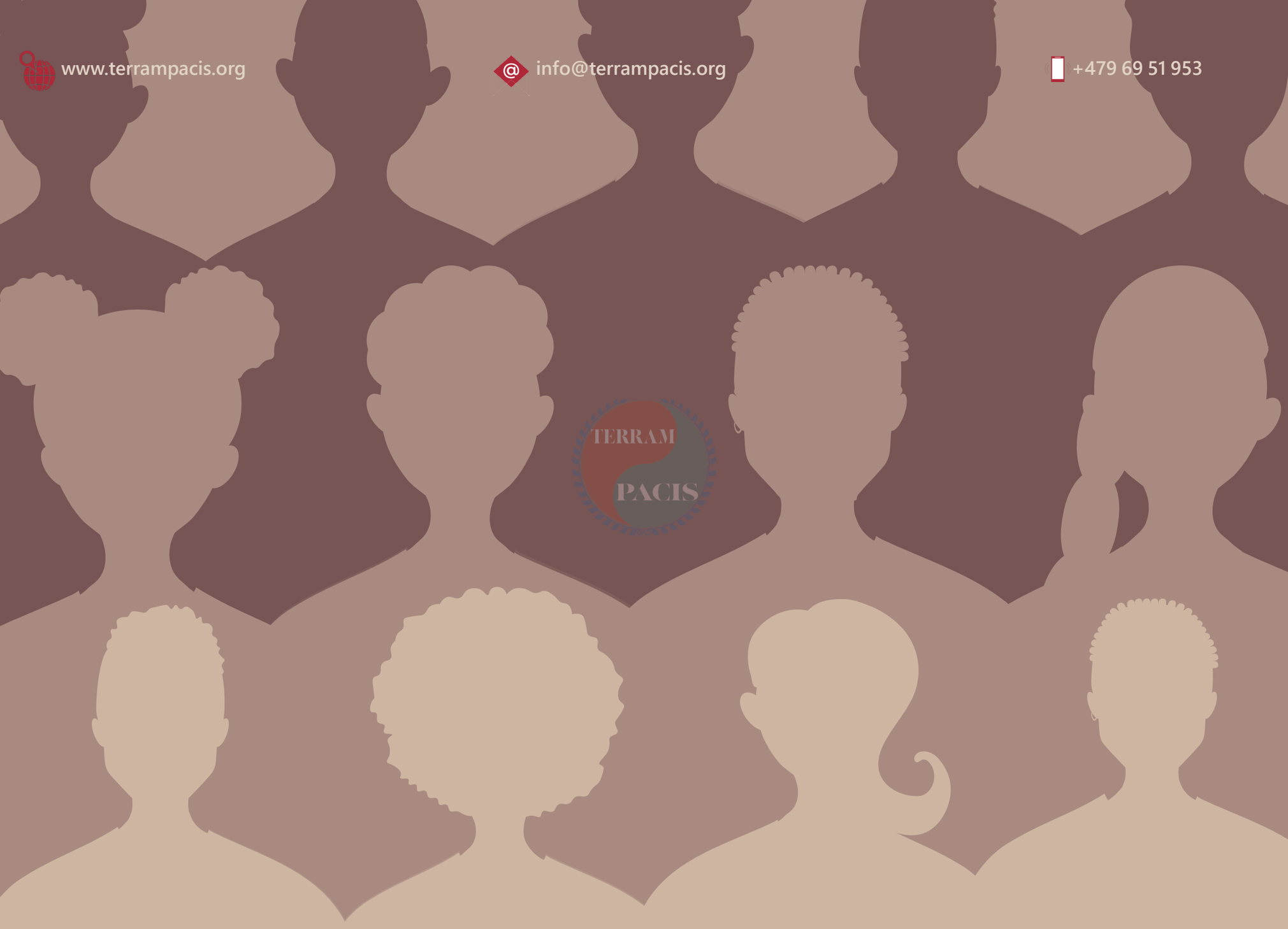
www.terrampacis.org
info@terrampacis.org
+479 69 51 953



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