HAND BOOK

ON SOCIAL AND EMOTIONAL COMPETENCES OF YOUNG PEOPLE WITH MENTAL HEALTH DISORDERS

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Hndbook You Pro Me.

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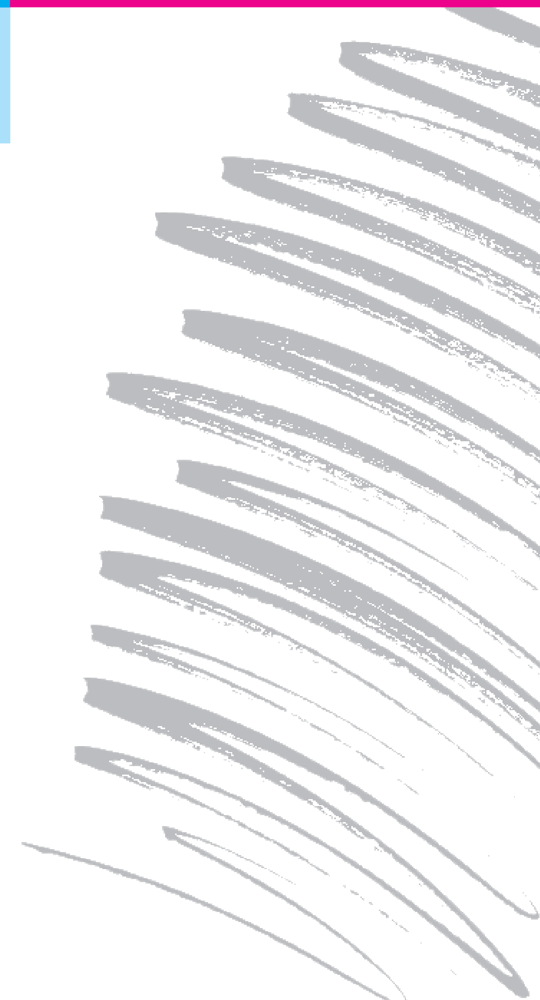


YOU PRO ME
Youth Workers Promoting Mental Health

INTRODUCTION

The desk research and consultation with youth workers and young people that led to the report "Youth Work and Mental Health. European Report on Youth Worker Competencies and Young People Needs" has allowed us to focus on the specificity of youth work in the field of youth mental health. The cognitive, practical and value aspects, now clearly recognized and defined at the international level and which distinguish the role of youth work, have been interfaced with the field of skills necessary for psychosocial intervention on youth mental distress.

From this preliminary work, two fundamental evidences have emerged:

- Youth work, in its various forms and agencies, is emerging in Europe as an important component of the social fabric and contributes consistently to the well-being of young people, offering them spaces for contact and exchange that foster inclusion and participation;
- The psychosocial discomfort of young people is a particularly widespread and critical phenomenon in contemporary societies, well beyond what the services institutionally dedicated to it are able to intercept and cope with; it involves on the one hand isolation, social exclusion and deviant behavior; on the other hand, the risk of exiting into real psychiatric pathologies, often then diagnosed and treated late in adulthood.

Expanding and deepening the horizon of intervention of youth work towards the vast and heterogeneous spectrum of youth psychosocial discomfort is therefore a challenge that requires a particular refinement of skills, to be exercised with particular balance. These, in fact, on the one hand, cannot pretend to overlap the domain of technical-specialist intervention; on the other hand, require knowledge and training that enrich the "traditional" profile of youth work as a "social animator" with predominantly "educational" functions, making it capable of dealing with more specific and complex needs.

The purpose of this Handbook could therefore be summarized as an effort to provide youth workers with cognitive, practical and relational skills that enable them to intervene with proactive outreach, involvement, emotional support, and the building of a working relationship, as well as promoting help-seeking, in collaboration with institutional social and health services.
A certain degree of implementation of youth work in mental health has already been carried out for some time in various countries, through rather heterogeneous but sufficiently documented experiences. Among the partner countries of the YouProMe-Youth Workers Promoting Mental Health project, these experiences are also included, thanks to specific policies, within an institutionally recognized and formalized organizational framework: most explicitly in England, where the role of the youth worker in mental health, alongside other professions, operates in a formal way. In Romania, although enjoying equally formal recognition at the national level, the application of the youth worker role does not follow a specific mandate in the field of youth mental health. In Italy and Greece, although a rich series of experiences similar to this specific role has been documented, there is still no formal recognition at the national level.
An element that seems to play a decisive role in this process is the dynamic of "top-down bottom-up integration": experiences that started from the bottom, on the basis of a direct knowledge of the needs of local communities, gain visibility and credibility by meeting the actions of central political and legislative direction.
A further usefulness of the Handbook, next to the other products of the project, is therefore to propose a toolkit that allows those (individuals or agencies) who intend to apply themselves in this field, to be supported by tools, both cognitive and practical, suitable for this purpose.

The Handbook, as well as the Portfolio and the Toolbox You Pro Me, is organised as a progressive pattern of functions that imply a gradual shift of focus from the personal world of the young person experiencing psychological distress to the world of social relations in which he/she is inserted. This is a shifting process that implies an integration of the Youth Worker's intervention with the different resources and the numerous actors of the territorial context, necessarily "open", in which he/she operates.

The Functions identified by the You Pro Me project team can be considered as areas of content both of the specific professionalism of the Youth Worker and of the specific needs of the young people with whom they work, which are united by a common and transversal objective:

Function 1. Recognising the mental health challenges of young people.
Function 2. Involving young people with mental health problems.
Function 3. Supporting young people in dealing with mental health challenges.
Function 4. Improving social and emotional competencies of young people with mental health problems.
Function 5. Connecting young people with mental health problems to the community.

To this end, the manual is organized into four sections:
1. An introductory section on youth mental health and the issues most often faced by youth workers because they are characteristic of this age group.
2. The presentation of scenarios, narrative vignettes that describe situations that a young person experiencing mental health problems may find themselves experiencing and with which the Youth worker is called upon to deal. Each scenario represents a moment for the Youth worker to reflect on the skills to be used, the goals to be achieved, and the tools to be used.
3. In section three, best practices of Youth workers using their skills to make a difference for youth mental health. These practices were selected based on their significance and through direct contact with Youth workers.
4. A glossary of terms expressed in a cross-cutting language that clearly and usefully defines the concepts and tools characteristic of this type of intervention.

YOUPROME

Youth Worker Promoting Mental Health - YOUPROME is a transnational European project funded by the National Youth Agency under the Erasmus+ program.

This project lays the foundations within the new EU Youth Strategy 2019-2027. The new strategy takes into account a series of dialogues conducted between 2017 and 2018 with young people from all over Europe. The dialogues have developed 11 #Youth Goals that identify transversal problems with an impact on children's lives. The fifth Youth Goal is dedicated to "Mental Health and Well-being" and aims to achieve better mental well-being, putting an end to the stigma of mental health problems, thus promoting the social inclusion of all young people. Young people want to acquire skills to increase their ability to deal with mental health problems and express the need to have greater support from youth workers, teachers or other non-social and health professionals, in particular on training in healthy lifestyles, developing emotional skills and understanding their mental health.

Emotional and social competences as well as Social and Life Skills represent, for young people, a fundamental tool to confront the needs and the changes of daily life. That is, the ability to establish interpersonal relationships and to assume responsibilities related to their social role, to make choices, and to solve conflicts. In young people facing a mental health problem, these skills can be impaired or deficient.

In this context the youth worker guides and supports these young people in their personal, social and educational development by making them take a leading role in their own life and health path to help them to overcome developmental blocks and recover their potential.

The YOUPROME project combines the interest in youth work and the field of mental health with the primary objective of deepening the skills and methods of intervention of the youth worker so as to better identify the specific identity and the necessary "tool bag".

Youth Mental Health Issues

What is mental health?

WHO constitution states that "health is a state of complete physical, mental and social well- being and not merely the absence of disease or infirmity. (WHO, 2021a)". As is now well known, this imply that promoting mental health (an essential component of health) means not just to remove disorders or disabilities, but it requires a wider perspective that considers needs, purposes, and personal realization. Mental health allows people to build good relationships both with themselves and with others, so that's also include the capability to feel oneself as a productive-meaningfulness part of the belonging community. WHO says that this condition must involve the ability to "think, emote, interact with each other, earn a living and enjoy life (WHO, 2021a)".

Talking about promotion's strategies, this overall perspective grounds the adoption of a socio- ecological approach that is pursued by creating and supporting environments that protect and promote mental health. This promotion perspective implies multiple and synergical interventions dealing with different aspects involved in mental health, thus including basic civil rights, work/training opportunities, caregivers' support, psychosocial competencies.

Risk factors for mental health

According to WHO (2021a), the main risk factors most likely to impair mental health are violence and persistent socio-economic pressures, with the clearest evidence associated with sexual violence. Rapid social change, stressful work conditions, gender discrimination, social exclusion, unhealthy lifestyle, physical ill-health and human rights violations result also further factors strongly associated with a poor

mental health. Finally, WHO mentions the role of specific psychological, personality and genetic factors in increasing the people's vulnerability to developing mental health problems.

How to prevent-support youth mental health

In order to implement and support the WHO Guidelines on mental health promotive and preventive interventions for adolescents (WHO, 2020), WHO and UNICEF have published the Helping Adolescents Thrive Toolkit, a product that collect four evidence-informed strategies and two implementation approaches to "promoting positive mental health, preventing mental health conditions, and reducing engagement in self- harm and risk behaviors" in adolescence (WHO, 2021a).

WHO paid a specific attention on the adolescence because has recognized the great potential of preventive intervention's strategies in influencing the flexible developmental pathway of young people. As everybody experienced, adolescence is a period of rapid physical, psychological and social changes, during which the brain maturation is particularly permeable to environmental and social stimuli. In fact, HAT (Helping Adolescent Thrive) toolkit is based on the socio-ecological approach mentioned above, that intends to intervene on risk factors at individual, family, community and social level, paying a specific attention on sociocultural context and care system as well (WHO, 2021).

The four HAT's prevention strategies are:

1. Implementation and enforcement of policies and laws (political level) to support the implementation and enforcement of laws and policies to protect and promote adolescent mental health..
2. Environments to promote and protect adolescent mental health (community level) to create supportive, healthy and safe environments in which adolescents live, study, work and socialize.
3. Caregiver support (family level) to ensure that caregivers are supported to promote and protect adolescent mental health.

4. Adolescent psychosocial interventions (individual level) to ensure that adolescents benefit from evidence- informed psychosocial interventions.

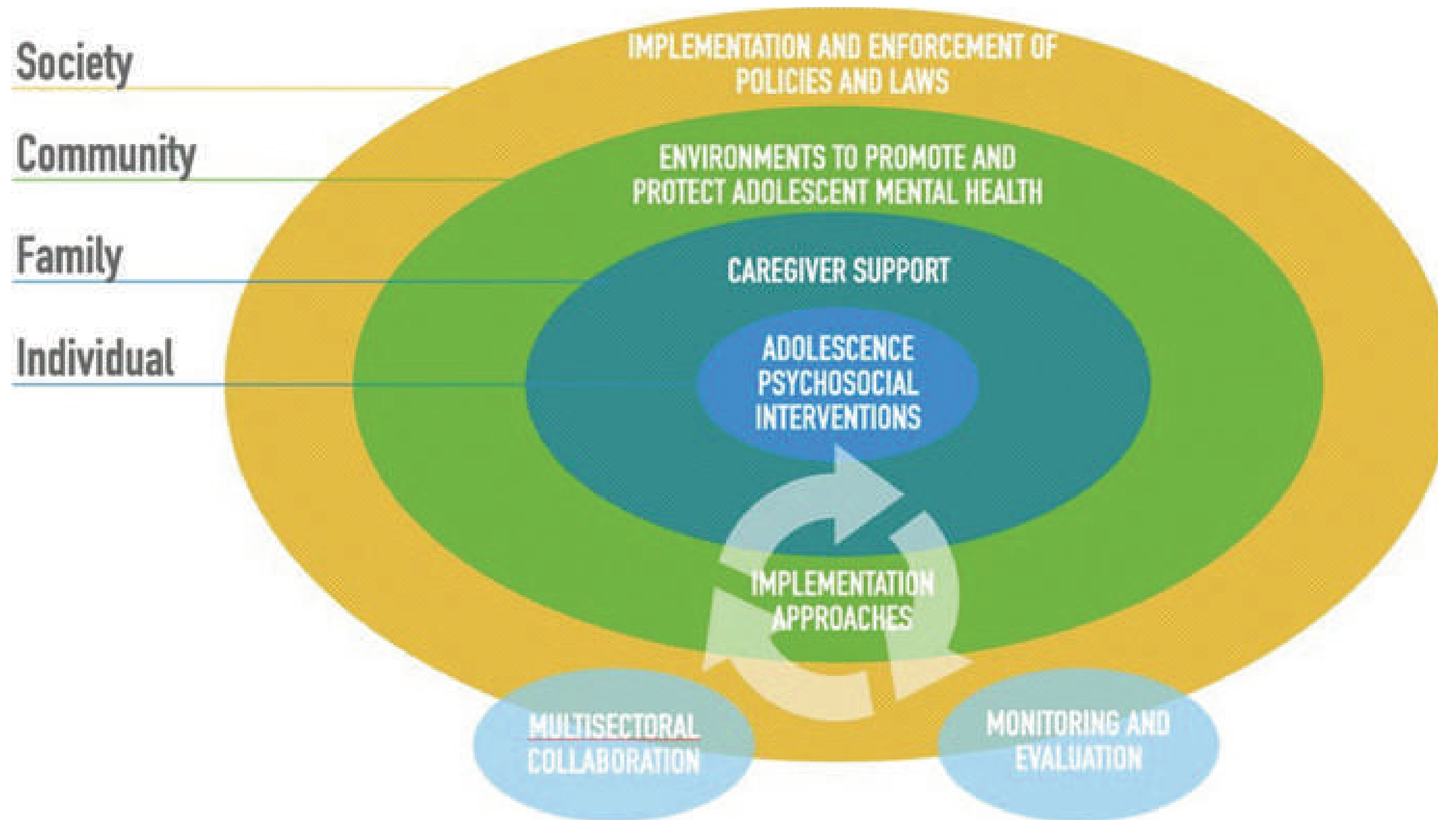
The two implementation approaches – transversal organizational activities needed to realize the whole prevention program – are:
1. Multisectoral collaboration: It highlights the importance of collaboration between multiple sectors and stakeholders – public, private and civil society – at national and local levels to support the development and implementation of preventive and promotive mental health programming for adolescents.
2. Monitoring and evaluation: It focuses on how to develop a monitoring and evaluation system which can provide policy-makers and programme managers with critical information on whether programmes and policies are being implemented as intended and are having their intended impact.

Disease, illness and sickness: a dimensional approach

Giving the complexity that constitutes mental health, we do have to assume the variability of psychic distress, in terms of entity and subjectivity.

In the DSM-5 (APA, 2013) – the latest version of the most famous Diagnostic Manual for Mental Diseases – is strongly underlined the importance to consider mental disease as a heterogeneous condition, with a very different range of expressions, intensity, timing. To establish if someone is experiencing a mental illness, we cannot rely just on the presence of specific symptoms or behaviors indicative of a diagnosis. The subjective perception of mental pain and/or hopelessness; feedbacks coming from social context (family, work/school, community) about the degree of impaired functioning within social relationships; cultural and gender background are all factors that in the quite infinite number of their possible combinations, shape the presence and the extent of mental illness, its meaning, its consequences, its severity, its prognosis (APA, 2013).

HAT's prevention strategies for adolescent mental health



That’s why it’s very important – dealing with people who can experience mental distress – to have a variety of evaluation resources at your disposal.

An article published in 2000 (Boyd) has explored the etymological roots and the progressive usage of terms related to mental health, stating that “the precise meaning of terms like health, healing and wholeness is likely to remain elusive, because the disconcerting openness of the outlook gained from experience alone resists the reduction of first-person judgments (including those of religion) to third-person explanations” (Boyd, 2000, p.1). It deepens the differentiation of the terms disease, illness and sickness, offering definition for three different “modes of unhealth”. According with this proposal, “Disease then, is the pathological process, deviation from a biological norm. Illness is the patient’s experience of ill health, sometimes when no disease can be found. Sickness is the role negotiated with society” (ibidem, 2000, p.10). Thus, the article claims the essentially subjective dimension of “health”, offering a link with the Latin verb “valere”: “Valere, from which value derives, means to be in good health in Latin. Health is a way of tackling existence as one feels that one is not only possessor or bearer but also, if necessary, creator of value, establisher of vital norms”. The author concludes that, in this sense, “what constitutes health in one person may well, as Nietzsche said, <look like the opposite of health in another person>” (Boyd, 2000, p.14). This reflection may help to underly how a health condition has to do with the feeling of being part of a socio-relational system in a personally satisfying way and how relevant it is to adopt as individualized an approach as possible in supporting and promoting mental health.

Main mental and behavioral disorders in youth

I would there were no age between ten and three-and-twenty, or that youth would sleep out the rest; for there is nothing in the between but getting wenches with child, wronging the ancientry, stealing, fighting.

William Shakespeare, The Winter's Tale

Description

WHO has published a Mental Health Intervention Guide (mhGAP-IG), part of the Gap Action Programme, which is born from the detection of a significant gap in terms of services and access, compared to the actual mental health needs of the population (WHO, 2016). The second version (2016) of the mhGAP Intervention Guide (mhGAP-IG) for mental, neurological and substance use (MNS) disorders is addressed at different health workers (i.e., doctors, nurses, other health workers as well as health planners and managers) who intervene in non-specialist health settings and provides clinical tools to assess and manage the main MNS disorders.

Regarding MNS in youth, mhGAP-IG separates:

- Developmental disorders include intellectual disability as well as autism spectrum disorders, have frequently a childhood onset, imply impairment or delay of central nervous system maturation and have more often a stable course, compared to other mental disorder.
- Behavioral disorders include Attention Deficit Hyperactivity Disorder (ADHD) and conduct disorder. The behaviors considered to identify these disorders – over-activity, inattention, impulsivity, opposition - may be present also in the general population, with different degrees of severity, frequency and impact. What make the difference is the extent of harm the behavior provokes in the youth's relationship with him/herself and with others. Usually, a behavioral disorder is diagnosed when

more areas of youth's functioning (psychological, social, educational, occupational) result seriously compromised.
• Emotional disorders represent the main mental health-related cause of global youth distress. They are driven by increased levels of anxiety, depression, fear, and somatic symptoms (WHO, 2016).

Here we will point our attention on main behavioral and emotional disorders in adolescence:
• Attention Deficit Hyperactivity Disorder (ADHD);
• Conduct disorder;
• Emotional disorders;
• Moderate to severe depression.

Common presentation of disorders

Behavioral and emotional developmental disorders are strongly influenced by the family and the social educational environments to which the younger belongs (WHO, 2016). It is within these relational contexts that the disorder organizes its meaning, expresses itself and can be recognized. That's why it's very important to collect information not only from the individual relationship with the young people, but also from different contexts related to them.

MhGAP-IG gives some examples of how youth mental health disorder may manifest itself through different social contexts' voices:

• **a general health assessment** can allow to recognize risk factors such as malnutrition, abuse and/or neglect, frequent illness, chronic diseases;
• **a parent or a carer** can report difficulties of the youth in joining with peers or in controlling aggressivity that may explode in anger outbursts, or the attitude to be too active, or too solitaire, maybe refusing to do regular activities or go to school;
• **a teacher** can observe a pronounced tendency of the youth in being easily distracted, disruptive, involved in troubles, incapable to complete school works;

• **a community health or social worker** can point out the attitude of the youth to broke the rules/laws, or to be physical aggressive with other people (WHO, 2016). Behavioral problems in adolescence are mainly expressed through the difficulty to be in the relationship with others – both peers and adults – in an adequate and satisfactory way.

DSM defines Attention Deficit Hyperactivity Disorder (ADHD) as a persistent pattern of inattention and/or hyperactivity and impulsivity interfering with the functioning and development and that is inappropriate with the level of development (APA, 2013). In the hyperactive-impulsive subtype the young person may appear overly hyperactive, for example being unable to sit when it is required, running, moving or talking non-stop looking restless. He/she also shows the tendency to do things without forethought, to answer a question before it is completed or to interrupt others while they are talking.

In the inattention subtype the youth results absent-mindedness, repeatedly stopping tasks before completion and switching to other activities, can't stay focused on a task for even a short time, is easily distracted, often loses objects and appears careless in normal daily actions.

In the combined subtype both inattention and hyperactivity/impulsivity symptoms are present (APA, 2013).

Conduct disorder is characterized by problems in controlling and managing emotions - especially anger - that lead to a habitual and persistent violation of limits and rules established by the society or authority figures (APA, 2013). It can involve aggression to people or animals, for example being repeatedly getting into fights and/or bullying acts, having frequent and severe temper tantrums, arguing arrogantly with adults; severe destructiveness to property, fire-setting; stealing, repeated lying, truancy from school, running away from home; defying or refusing to comply with parents' requests or rules (WHO, 2016).

When this set of behaviors is associated with a dimension of affectivity characterized by lack of remorse or guilt, lack of empathy, indifference to the results (for example for the poor performance at school), or general anaffectivity, the DSM-5 speaks of "subtype with limited prosocial emotions". This configuration is most associated with greater severity and persistence of the disorder (APA, 2013).

Emotional problems regard the compromission of a good relationship with proper inner emotional world. They may come in the form of excessive experiences of anxiety, worry, distress and/or rapid changes in mood. This kind of feelings can lead the young person to strongly avoid specific situations like separation from caregivers, social situations, certain animals or insects, closed or open spaces. Within group activities the youth may appear particularly susceptible, easily irritated, frustrated or sad on most occasions. He/she can also show a remarkable attitude to be oppositive or to have behaviors aimed at attracting attention.

The onset of the disorder can be preannounced by visible changes in functioning (e.g., rapid decline in school performance, desire to spend more time alone or at home), changes in sleeping and/or eating habits, less interest in interacting with others or engaging in sports/social activities, more frequent physical illnesses like headaches, stomach-aches or sickness, unwarranted fear of imminent catastrophes such as wars, disasters, terrorist attack (WHO, 2016).

When the symptomatic pattern described above meets specific degree of severity it is necessary to evaluate the presence of a depressive disorder. In the DSM-5 depression is identified in an acute or persistent presence of depressive mood (deep sadness, sense of emptiness, hopelessness), remarkable loss of interest or pleasure felt in most activities, significant weight loss or gain, insomnia or hypersomnia, psychomotor agitation or slowing, lack of energy, excessive feelings of self-evaluation or guilt, reduced ability to concentrate, constant indecision, negative thoughts related to death. The serious impairment of socio- relational dimension of the younger resulted from his/her voice indeed or those of people nearest to him/her (parents, friends, teachers). The serious impairment of the social-relational dimension of the young person can be gathered from the testimony of the young person

himself or from the people closest to him (parents, friends, teachers). DSM-5 emphasizes the evidence that in childhood and adolescence, depression can also manifest itself through emotions apparently opposite to those just described. Thus, at this age it is frequent that the depressed mood presents itself in the form of irritability, outbursts of anger, and not sadness or despair (APA, 2013).

Emotional regulation: A transversal category to look at mental and behavioral disorder in young people

As we already declared, this handbook is not addressed to mental health professionals, so its goal is not to teach specific techniques or complex psychological theories regarding mental health. Instead, its goal is to permit non-professional figures who work with young people - first and foremost Youth Workers - to gather transversal tools/categories capable of broadening the way they look at, think about and describe the young people they work with. Following this purpose, we dedicated the last section to give some psychopathological references aimed to facilitate the recognition of most common diseases, basing on their **symptomatologic external presentation.**

In this section, we would like to spend a few words regarding a clinical category found useful not only in recognizing potential symptoms of distress and dysregulation processes, but also in identifying the underlying operational logic, thus also the logic that supports the preventive interventions deemed most effective.

Emotional regulation is a clinical category that is attracting increasing interest from the scientific community in the field of psychology. Initially tied to research in the areas of developmental psychology and Borderline Personality Disorder (BPD), the use of this concept has since expanded to the entire area of mental health (Berking & Wupperman, 2012). The current DSM-5 (APA, 2013) “shows that more than 50% of axis 1 clinical disorders, more than 90% of axis 2 personality disorders, and in sum more than 75% of psychological disorders are related to emotion regulation” (Akbari & Hossaini, 2018, p. 28).A recent Italian article (De Berardis et al., 2020) states the importance of including the screening for emotional disturbances and dysregulation in all preventive and interventional mental health programs with adolescents. Authors report an elevated risk to develop anxious and depressive symptoms in persons with unrecognized and untreated emotional dysregulation. Factors related to the development of this kind of condition include childhood traumas and maltreatment, sexual or physical abuse, neglect, learning disabilities, being a victim

of bullying, parental distress, conflicts, severe parental psychiatric disorders, etc (ibidem, 2020). Indeed, adverse life experiences in general population, included the quality of the attachment, childhood traumatic experiences, included neglect and physical and psychological abuses, as well as a number of psychosocial factors including social rejection, bullying and exclusion, lack of social relationships and support, have been found to predict reduced cognitive performance, such as accompanying cognitive patterns and bias, impaired social development, reduction of resilience to distress experiences and increased social stigma (Brogna, et al. in press). Results of complex trauma's researchers demonstrated also how the social connection is a human essential engaged in many cognitive functioning included the affect regulation, self-consciousness, interpersonal functioning, perceptions of self-appraisal and the subjective experience with the others, self- regulation and somatic experience (Zahavi, 2005; Classen, et al., 2017).

But what is meant by emotional regulation?

"Emotional regulation can be described as how a person sustains, strengthens, or impedes his emotions according to his purposes or goals" (ibidem, 2020, p.1).

When this internal system is strongly impaired, emotions can be barely tolerated and – especially regarding intense and unpleasant one – can carry the subject to try regulating them provoking external stimulations on his/her own body, for example with substance use and abuse, additive behaviors and impulsive and risk conducts. These actions, in fact, have the transitory and illusory capacity to modify mood and provide apparent shortcuts to deal with relationship and social life. Unfortunately, what really happens is a reinforce of maladaptive behaviors and a consequent reinforce of emotional dysregulation as well (ibidem, 2020).
A British recent review maintains that "emotional regulation during adolescence depends on the maturation of affective control" (Schweitzer, 2020, p.1). The affective control is defined as the capacity to discern, in the contexts of relationships, affective elements that are useful to reach desired goal from other affective elements that are unproductive for the scope. Thus, to pay attention on the former, while putting aside the latter (ibidem, 2020).

The authors focus on three cognitive phenomena that can represent different developmental trajectories of affective control: rumination, suppression and reappraisal. The rumination indicates the incapability to inhibit repetitive negative thoughts, the suppression represents a wider inhibition of affective states and emotions. On the contrary, reappraisal shows the ability to regulate the impact of intense affective experiences through a redefinition of the meaning of emotions related to the event. A poorer mental health condition is more associated with higher tendency to rumination and suppression and with a lower reappraisal capacity, so these phenomena can be part of those indicators that are likely to be monitored within the observation process of adolescent behaviors (ibidem, 2020).

Alexithymia – etymologically "lack of words for emotions", an individual trait related with the difficulty to recognize, express and distinguish emotions and body sensations – has often been found to be associated with emotional dysregulation (De Berardis et al., 2020). This aspect further supports the importance, in working with young people, to create environments, situations and relationships that facilitate the possibility to talk about one's emotions, to individuate and shape them through confrontation both with peers and adults.

SCENARIOS
SOCRATIC METHOD

Detailing a situation of a young person experiencing mental health problems, through a Socratic approach using three questions focusing on the competencies youth workers would apply in the scenario.

The Socratic method of questioning is named after the Greek philosopher Socrates (469 BC–399 BC). Socrates believed that the highest benefit of his art was to help people do their own thinking in a way that lead to the birth of their own new ideas. In Socratic dialogues, the primary focus is on the original thinking of the respondent as they try to answer Socrates' questions. Asking questions, help the respondents think critically about their previous answers.

The subjects of Socrates' conversations often revolved around defining ideas such as, justice, virtue, beauty, courage, temperance, and friendship. The search for a definition focused on the true nature of the subject under question and not just on how the word is used correctly in a sentence. Socrates style of conversation involved his own denial of knowledge (Socratic irony). In these conversations, Socrates became the student and made those he questioned the teacher. He only wanted to focus on the respondents own thinking. Through the respondent's process of answering Socrates' questions, they experienced their own original thinking in the context of examining their own ideas and themselves. The brilliance of the Socratic method is in the character developing power it has through the exercise of a person's love of asking and answering questions in the pursuit of knowledge.

The Socratic method is a process of questioning used to successfully lead a person to knowledge through small steps. This knowledge can be specific data, training in approaches to problem solving, or leading one to embrace a specific belief. The type of knowledge is not as important as the fact that, with the Socratic method,

the knowledge gained is specifically anticipated by the Socratic questioner. It is not deconstructive, but constructive, it is lead a person, by baby steps, to specific knowledge through a series of questions.

SIX TYPES OF SOCRATIC QUESTIONS

1. Clarification questions (e.g. 'what makes you say that?')
2. Assumption-probing questions (e.g. 'can you prove or disprove that assumption?')
3. Questions to probe reasoning and evidence (e.g. 'can you give an example of this?')
4. Questions about perspectives or viewpoints (e.g. 'what is a different way to look at this?')
5. Probing questions about implications and consequences (e.g. 'what are the consequences of this assumption or belief?')
6. Questioning the question (e.g. 'what do you think the purpose of this question was?')

Jessica, age 14 years.

Context

Jessicais 14 years old. She lives with her two parents, both of whom are professionals and are always busy working. Jessica is the oldest of three children. There is nobody in the family with any known health problems. She studies at school and is a hard working student. She is passionate about animals and likes to go out with her friends. She has a boyfriend. Jessica has a mobile phoneand is a regular user of social networks.

Trigger

'I am just feelingreally flat and I don't feel like I can go back to school but mum and dad say I have to.
'I sent my boyfriend some pics a few weeks ago. I thought he was my boyfriend anyway, but then he showed them to his friend and his friend sent them to everyone. The school found out and now the police have spoken to him and his friend.
'I haven't been back to school since, but now on social media they all call me a slut. I can't deal with them looking at me and I know what they'll be thinking. Even the girls have a similar opinion about me.
'The stupid thing is, everyone does it, everyone sends pics, but I was just unlucky to have a boyfriend who betrayed me. I will never trust anyone again. I feel like everything is over and there's no going back now.'

Consequence

Jessica has been absent from school for a month and refuses to return. She has dropped out of all her school sport activities. Her mother is present with the sport youth worker and has said she is concerned about some of the "dark" things Jessica has been saying. Jessicais eager to change her online presence and regain initial confidence. Jessica and her family are not aware of what support is available and

how to best support her mental health or any knowledge of how a youth worker can mediate in this situation. Jessica has realized the risk of misuse of the Internet and has recognized that she requires support to manage her mental health as this has influenced her decision making.

Questions for discussion

- ☐ What risks are present here?
- ☐ Should you involve other services such as mental health, the police etc.?
- ☐ What do you suggest to Jessica and to her mother to do next?

Matt, 1age 13 years.

Context

Matt is 13 years old. He's relatively small for his age, but he's well within the average range. He has no known medical problems. He is in school. His favorite subject is computer science. He is a very intelligent. He doesn't like to play sports very much. He is a very introverted and has a hard time relating to other people. His parents have recently separated and have shared custody. His mother has moved in with her new boyfriend. He has an 18-year-old sister, Lucy, with whom he has a very good relationship and they spend a lot of time together, especially since their parents' divorce they have becomevery close and Lucy often acts as his mother.

Trigger

'I need a note for PE because the games teacher said I can't keep missing it. The other boys laugh at my body and because I'm not good at sport. I'm not musclyand tough like them and I'm still small. I feel like my body is stupid. I still look like a little kid.
'Yes, I have been hurting myself. Sometimes I punch the brickwall in my room. It makes me feel like I can get throughand be tough.
'I prefer to stay in and play on the computer, because I can do that and no-one judges me on the games. No- one needs to know who I am. Everyoneis trying to get me to go out but I don't want to do anything. I just want them to leave me alone.'

Consequence

Mat has stopped attending PE class. He has changed his manner and style of dress with very baggy clothes. He has looked on the internet several times on how to grow faster and drawn hair on his body. He self-harms to feel stronger. He does not sleep and spends hours and hours on the computer. He goes outside as little as

possible, and when he does go out, he covers himself with a hood. His family tries to help him but he doesn't even listen to his sister. His sister has gone to talk to a PE youth worker.

Questions for discussion

- ☐ How useful is it for Lucy to talk to a youth worker and how could they help the situation?
- ☐ How could the relationship between Mat and his parents be improved, what do you think needs to happen?
- ☐ What is the significance of the PE letter?

Francesco, age 14.

Context

Francesco is a 14-year-old boy with a stutter. A few months ago he joined a scout group, encouraged by his parents who would like him to make new friends. His parents are very worried about him because he spends most of his free time alone. Francesco, in fact, is a shy and introverted boy, who has always had difficulty in relating with his peers. Even in the new scout group, it seems that he is having difficulties. In fact, the leaders of the group reported that during some outings, Francesco preferred to isolate himself, rather than carry out activities with the rest of the group. Some of the boys say that they have heard some of their mates making fun of him for the way he talks.

Trigger

As the weeks go by, the climate between Francesco and the group has become more and more tense. Violent fights often occur, of which, in a totally unexpected way, Francesco is often the initiator. The straw that broke the camel's back seems to have occurred a few days after a bonfire, in which Francesco, despite his hesitations, was convinced by the leader of the group to read a passage in front of everyone. Having to read aloud made Francesco rather nervous so much so that he started to stutter, what he most feared would happen. Some of his classmates began to snicker and laugh among themselves. Francesco felt very humiliated and from that moment he decided that he would no longer be the object of everyone's teasing. A few days later, after the umpteenth mockery, Francesco picked up stones and sticks from the ground and began to throw them at his classmates. One of these, caught on the side, was wounded in the face.

Consequence

The squad leaders reported this episode to the foremen. Some of them described Francesco as a violent boy who only wanted to cause trouble and were convinced that nothing could be done to improve the situation. When the word of the incident spread among the parents of the boys, some of them complained, up to the point, in some cases, of asking that the boy be removed from the scout group as soon as possible.

Questions for discussion

- ☐ Do you think there is another lens with which to view Francis' behavior, judged only as someone "violent, wanting to make trouble"?
- ☐ If you were in this situation, what would you do to encourage interaction between Francis and other classmates?
- ☐ How would you intervene to manage and improve the situation with the parents?

Stefania, 20 years old.

Context

Stefania is a 20-year-old girl who, since she lost her father at an early age, lives alone with her mother, her only point of reference. Stefania is a girl with great potential, who in the past has collected several successes at school, but now, after struggling to get her high school diploma, she can not find her way. In fact, during the last year of school, she started to have some problems. Her mother recounts that during her last year of high school, Stefania gradually lost interest in everything around her, in everything that had filled her life up to that point. She no longer wanted to study, nor to go out with friends: she did nothing but isolate herself more and more, until she became a very lonely girl. Despite this, thanks to the understanding and supportive attitude of the teaching staff, she still managed to graduate.

Trigger

Today Stefania, one year after graduation, spends her days locked up at home. Sometimes she goes shopping or wanders around the neighborhood by herself, with a circumspect, anxious and worried attitude. Sometimes neighbors see her talking loudly without an interlocutor. On other occasions she stops passers-by, insistently asking for help because she believes she is being followed. The mother, whose worry is only increasing day by day, some time ago decided to consult her general practitioner.

Consequence

The neighbors, once they realized that her requests for help had no basis in truth, began to distrust her words and to look at her with suspicion. This situation has only increased Stefania's loneliness. Today, without friends or a meaningful relationship, without an activity that engages her during the day, she finds herself with-

out a life project. Despite the fact that she has recently started to attend a Mental Health Center (MHC) , as recommended by her general practitioner, and that the drug therapy has alleviated her symptoms, her mother remains concerned about her daughter's situation. For this reason, the MHC itself has suggested to Stefania and her mother to turn to the youth center of the neighborhood, in order to combine the clinical and therapeutic activities in which she already participates in the Mental Health Center, with socialization and recreational activities that can allow her to return to cultivate passions and interests.

Questions for discussion

- ☐ How would you intervene to help Stefania feel less isolated and to make the youth center setting welcoming to her?
- ☐ What initiatives would you organize to make people who live in Stefania's neighborhood less wary of people with the same difficulties as her?
- ☐ What opportunities could you offer Stefania to promote her resources and facilitate the resumption of an independent life project?

Sara, age 15 years.

Context

Sara is 15 years old and a 10th grade high school student. She changed school recently and is having a hard time in adapting to the new environment, has low interest in school activities and interacting with peers. She also appears to be fearful in her interaction with teachers. Because of all that, she is at risk of dropout.

Trigger

If I think of the word 'SCHOOL' it doesn't bring any good memories to me. I remember the first day of school, being afraid of that change, being separated from my mother at the school entry by a teacher who seemed to care little of a 7-year-old crying and scared of entering the school. She was, how can I call it, a very harsh teacher. She rarely smiled and said nice words to us. And even though I was curious in learning all those new things at school, I was afraid of expressing myself and getting sanctioned of (perhaps) being mistaken. Not all my colleagues had this issue and most of them seemed to be coping well with her teaching style, but I guess I have always been more sensitive and emotional. And fear was something that always came along the way in my relationship with school. If I am to visualise those early experiences with school, I see her in front of the classroom, very firm, and me trying to somehow hide in my bench in the back of the classroom. What I hear is 'you did not do this right, you never understand anything, you don't pay enough attention to what I am teaching'. What I feel is fear, that I am never going to do things right, that I am always upsetting my teacher, that I am never going to be good enough.
Whenever I started a new school year and met new teachers on new disciplines, I had this expectation of him/her to be a kind person, that would care about me and I would feel safe in that class. If that did not happen, then I would shut down myself and show little interest in that subject. I always set high expectations for myself, I promise that I would study hard, but I back off whenever I am confronted with a teacher of this kind.

Consequence

Because of her negative experiences with school, Sara feels disempowered and is failing in (re) engaging with the learning process. Her teachers do not some to understand what the issue is and neither do her parents. She does not even want to talk about this with anyone. She is experiencing trust issues when it comes to expressing and sharing her feelings.

Questions for discussion

- ☐ What can you do to help Sara gain confidence in sharing her feelings and identifying what is blocking her from enjoying school?
- ☐ What do you think school/schoolteachers do next?
- ☐ How would approach a conversation with Sara's parents on her issues?

Maria, age 17 years.

Context

Maria is 17 years old and until she was 15 years old, she has always been an exemplary student with good performance and good grades, being described as a sociable teenager. At 15 she moved to another school. After that, her parents noticed differences in her behavior. Maria started skipping classes, started to have bad grades, and began to isolate herself.

Trigger

I just hate myself. No one likes me in the classroom. My colleagues are right to call me all those names and say I am worthless. I just wish I could stay at home all day, locked up in my room and not to have to look anyone in the eyes.
Every morning I go to school they make fun of my loose clothes and tell me how fat I am, and that no one will ever like me. Boys, I mean. I don't want to go to school anymore. Those two colleagues who pretend to be my friends they do nothing when the others mess up with me. My parents don't care about me, my teachers don't care about me, I wish I could just end up this nightmare in some way.

Consequence

She got along with some of her classmates, but it was clear to the teachers that Maria felt like she didn't "fit in". The class principal spoke to some of the students in private and they eventually revealed that Maria was bullied by a group of students in the class. They called her names, made fun of the way she dressed, body shaming her. Due to the bad grades, Maria eventually failed the 11th grade. However, despite having changed the class she went to previously, her former classmates continued to harass her. Her parents began to consider moving her to another school after becoming aware of the bullying situation. Maria is considering dropping out of school, although she always dreamed of going to college.

Questions for discussion

- ☐ What is the main factor that led Maria to consider dropping out and classify each of the factors?
- ☐ The fact that Maria moved to another class improved her situation?
- ☐ What measures should have been applied by the teachers and the school to prevent Maria from considering dropping out?

George, 23 years old.

Context

George is a university student who is 23 years old. On the surface of his social media, George appears to be a very gregarious person, capable of making a lot of friends and having fun with his peers on a daily basis. However, if you take your observations a step further and meet him in person, you'll see that he has some anxiety tendencies, especially when he's around a lot of people. He was requested by his university supervisor to present his master's thesis last week, and he assigned the duty to a third party because imagining himself in front of an audience made him feel weak. However, his issues have larger dimensions. George has reported to the mental health professional that he is having issues with his sexual life as the stress and anxiety he feels causes erectile dysfunction.

Trigger

George has formed an image about himself that does not reflect the reality. He considers himself constantly inferior to others and less capable. He compares himself to the other men he sees and thinks he is less muscular than he should be. Last year he developed alopecia and lost a large part of his hair resulting in an even more negative self-image.

Consequence

George is going through a very trying time. He is attempting, but failing, to enjoy his sex life. He believes that he is insufficient for his partner and that he will not be able to satisfy her, and with this attitude he has never had an erection resulting in fail intercourse affairs. In reality, he believes that the partners he has tried to sexually engage with have stigmatized him, as his weakness has been spread out to the school. He is obsessed with the concept that he does not have a typical attractive body and that people who get close to him would laugh at him. His mental health

professional, under the intervention framework, suggested George to visit a youth center where he will have the chance to meet peers and engage into social and cultural activities. At this Youth Center George met a Youth Worker, Nicolas.

Questions for discussion

- ☐ Why is George maintaining a set up social life on his media?
- ☐ Why does George think he does not have a typical attractive body? What would be the core influence?
- ☐ Why do you think the mental health professional asked George to engage into a Youth Center?

Tina, 16 years old.

Context

Tina is a sixteen years-old teenager and high school student. Despite of her age, Tina and has extensive knowledge on certain socio-political aspects and she can express her political stances without any hesitation. Tina envisions herself in the future pursuing political science although she worries that her athletic career might hinder her studies. She avoids hanging out with her peers because she believes they are inferior to her, and she feels that romantic encounters are a waste of time. People at school find her "weird" and offensive as she is a source of conflicts, adversarial attitudes as she presents hatred behaviors towards people who have a different belief or opinion than her. Last week, she asked the school principal to take over the duties of school representative because the current representative, in her opinion, weighs more than she should, as a result of which she promotes incorrect body standards to her students.

Trigger

- 7 years ago, her father was killed in a car accident after an immigrant broke the red light.
- She is the only daughter and her mother considers her a role model.

Consequence

The teachers at the school are very worried about her behavior and what she manifests. He had announced in class that it would be better for people of foreign origin to attend separate schools and leave the country when in their own county's conditions are more favorable. She ignores the suggestions of her teachers as she believes that they are not capable of finding radical solutions to transform the state, otherwise they would not be ordinary high school teachers. At a cultural event aimed at promoting democracy and its principles, Nicolas who is the Youth

Worker and the Trainer, faces Tina and her oppressing opinion as she interrupted the event to present semi-scientific data on why democracy aims to manipulate the society rather than benefiting.

Questions for discussion

☐ If you were Nicolas the Youth Worker, what would you do?
☐ Do you think that there is a correlation between Tina's behavior and her father's car accident?
☐ Do you think that Tina lacks empathy? Why?

Ash (born as F. C. - female name), age 20.

Context

Ash lives as an unic child in an economically and culturally challenged household. The mother, with two strokes on her history, makes recurrent hospitalizations. The father is not very present and active, excessively involved in work. Until the age of 18 years A. is followed by the TSMREE1 - public psychiatric service for minors - for anxiety problems and difficulties in social relations, which lead to a progressive impoverishment of the affective network.
A. attends the linguistic high school with relational and scholastic difficulties that lead him to interrupt his studies. When A. came of age, the family turned to the psychiatric service for adolescents and young adults of territorial competence where, however, A. does not seem to be doing well. The referral to the Day Care Center (DCC) of Via Plinio (Rome) - of which we report the intervention - is therefore made in agreement with the territorial service of competence, with the aim of offering A. another opportunity to build reliable bonds that allow him/her to get out of the condition of isolation in which he/she finds himself and to support him/her in dealing with issues related to gender identity, which are becoming more and more prominent.

Trigger

- Cerebral ischemia of the mother leads to the emergence, around 12-13 years of age, of heteroaggressive behaviors aimed at objects that turn progressively towards the self-injurious pole.
- The exacerbation of family tensions leads to a further attitude of closure and withdrawal, characterized by an important depressive-anxious state that forces him/her to stay closed at home.
- The loss of a friend who attended the Day Care Center significantly intensifies the levels of suffering and isolation.

Consequence

The family situation does not allow the parents to offer A. a direct support, nor to follow him in the rehabilitation path started. A. arrives, therefore, at the Day Care Center in a condition of total closure and distrust of others and of his own future, in need of support but at the same time rejecting. A. faces adolescence full of doubts and uncertainties, which also involve the sphere of gender identity, at first asking to address him/her using a name established by him/her, then neutral pronouns, until he turns to a male gender identity. In addition, the loss of a friend who attended the Day Care Center with him/her brings further pain, increasing the tendency to closure that has always characterized him/her. In an initial phase, he/she refuses the psychotherapeutic support offered by the psychiatric service to which he/she would be assigned for territorial competence, reporting that he/she does not feel sufficiently at ease in that type of context. The Day Care Center therefore becomes the only link to a psychosocial rehabilitation pathway, as well as the only protective space that A. seems to rely on.

Questions for discussion

- ☐ What role can the work of the DCC's Youth Workers take on in A.'s life and how can it help him/her in the resumption of social life?
- ☐ What other services could be involved for more accurate and comprehensive management of his/her case?
- ☐ What risks does the Youth Worker take in approaching individual grief, also related to gender issues, when confronted with a person who rejects most offers of help?

M., age 19.

Context

M. is 19 years old. She lives at home with her parents and the older brother. She shows a psychiatric familiarity on her maternal and paternal lines. She graduated from high school with a degree in linguistics and is going to begin college, choosing language mediation as her major. She uses her free time on social media, as an influencer with many followers - from which she has also obtained substantial financial revenues - on platforms such as Instagram and Tik Tok. She presents good social network and practices athletics.

Trigger

• Family conflicts: the parental climate is often conflicting, as is the relationship with M. With her mother, M. oscillates between a symbiotic relationship and a push for independence, often complaining of intolerance for what she perceives as an intrusive maternal tendency. The mother tends to minimize the psychic suffering of M. with the aim of ideally build for her a perfect and happy life. The father, often absent for work, seems to express little sensitivity about her difficulties. All this leads to a high level of pain and psychological discomfort for M., characterized by the need for independence but also by the difficulty in managing it.
• Appearance: the need to always appear well cared for the eyes of others, also encouraged by what for M. is a job in all respects in the world of Social Media, leads her to feel the need to adhere to unrealistic and harmful standards of beauty and thinness, prevalent on online platforms. M. manifests a strong suffering caused by the feeling of inadequacy, given by the experience of never being able to achieve the physical perfection she coveted.
• She often reports a feeling of emptiness within herself that makes her feel nothing, a total apathy, or there are negative thoughts and a strong uncertainty that involves any aspect of her life.
• She claims to be afraid of life outside the social world, in which she constantly feels uncomfortable, generating significant difficulties in dealing with changes.

Consequence

The great situation of emotional dysregulation has led to the implementation by M. of self-harming behaviors, characterized by frequent episodes of self-cutting and the implementation of acts at high risk of suicide. In addition, the strong tendency to perfectionism and the establishment of unrealistic goals have led to the assumption of highly restrictive eating habits, characterized by frequent periods of fasting and a constant restlessness motor, based on excessive physical activity. The seriousness of the situation led to the involvement of the center specializing in DCA (Eating Disorder Department), as well as several hospitalizations in SPDC (Psychiatric Emergency Room) during the periods spent at home.

M. arrives at the Day Care Center (DCC) in March 2021, after the DCAs seek advice from the PIPSM (Public Service of Prevention and Early Intervention Mental Health) to assess the integration of a psychiatric intervention focused on the aspect of emotional dysregulation. The high level of alarm detected at the time of the entry of M., determines for the multidisciplinary team of PIP SM (formed by psychologists, psychiatrists and Youth Worker of the Day Center) the need to structure an intervention project primarily oriented to the containment and monitoring of M.'s behavior. In fact, the implicit objective of the care team becomes that of preventing M. from making self-harming gestures that could undermine his safety. Specifically, the project initially involves attending the DCC every day, with the addition of a Youth Worker outside the service (adult companion), who would support her in the afternoons at home.

Initially, these supervisory interventions generate an increase in self-injurious acts and negative thoughts, fueled by a sense of lack of independence and claustrophobia that M. seems unable to tolerate.

Questions for discussion

- ☐ Given the urgent condition, how can the Youth Worker curb the enactment of self-injurious acts without resulting exclusively a “controller”?
- ☐ What other stakeholders might be involved in the case management?
- ☐ What is the cultural relevance of M.'s role in the world of Social Media?

CASE STUDIES

Identifying best practices of youth workers using their competences to make a difference to the mental health of a young person.

Eating disorder

Key Issues

Mental health; young person; youth worker; eating disorder.

Learning objectives

- Overcoming and healing from mental illness.
- Relapse from mental illness.
- Understanding.
- Understanding the problems and pressures on teenagers and the damage this can cause.
- Do not use a blanket approach to treating mental illness.
- Specialization in treatment plans to best suit the needs of each individual.
- Give people the opportunity to explore each other.

Introduction

- CAMHS (Child and Adolescent Mental Health Services) NHS East London, NHS Foundation Trust. 29 August 2019.
- Young girl who suffered from anorexia, beat it for two years and recently relapsed.

Overview analysis

"I've beaten anorexia once and have lived freely for two years with the help of CAMHS, unfortunately life has been harder recently so that I've relapsed, but again CAMHS have been understanding and helpful in trying through my last journey to beat this horrific demon that has been shadowing my life now for too long now.

CAMHS unlike many others do understand the problems and pressures teenagers go under and the harm this can cause. This is so consolidating when it feels like nobody understands you and your thinking. Anorexia is such a complicated Illness

and there isn't a 'one type fits all' approach in treating it, CAMHS specialise your treatment plan to fit you and your needs, they don't have the same approach for every patient which gives you a great opportunity to explore yourself fully.

Without then I wouldn't have decided that this is my life anorexia, give it back."

Status Report

- Offer assessment and support to young people and especially their families with emotional, behavioral and mental health difficulties from moderate situations that begin as severe.
- To evaluate different ways of working with the young person and their caregivers to understand and address their problems in order to bring about change.
- Provide treatment that respects the beliefs of the youth and is sensitive to their culture, race and gender.

Notes/Reflections

A lot of young people, worry about their weight, shape or food. However, for some, these difficulties can take over and turn into a serious eating disorder.

Someone with an eating disorder might feel they need to be on a strict diet, exercise, or find other ways to lose weight to cope with how they are feeling – and they might not know how to stop..

Regularly overeating and experiencing loss of control over what, when or how much to eat can also be signs of an eating problem. Anyone can develop an eating disorder.

They can happen in young people of all backgrounds and cultures. Eating disorders are not exclusive to girls and young women. Boys and young men can also be affected.

Someone with anorexia nervosa is not eating enough food to be healthy, and may worry a lot about eating, body weight or body shape. Behaviours such as eating very little or over-exercising can lead to them losing a lot of weight.

OCD (Obsessive Compulsive Disorder)

Key Issues

Mental health; young person; youth worker; OCD (Obsessive compulsive disorder).

Learning objectives

- Teach and learn about one's mental illness.
- Learning not to be ashamed of it.
- To learn that we all have different ways of coping.
- To create a space of trust where the young person can easily open up and express their emotions and feelings without fear of being judged.
- Helping to understand thoughts in a supportive and friendly way.
- The importance of confidentiality in these issues.
- Work on the limits of personal safety.
- Helping to manage emotions.

Introduction

- CAMHS (Child and Adolescent Mental Health Services) NHS East London, NHS Foundation Trust. 29 August 2019.
- Nathan, 16, a service user of CAMHS.

Overview analysis

"CAMHS has been a useful service to me for around half of my life (8 years). I was diagnosed with OCD at the age of 9, when I did not understand even what it was, and quickly was put onto a course of CBT, meeting with a psychologist a few times. Years later, at the age of 14, I then again needed treatment for OCD, where I was more severe, perhaps due to stress at the time starting my GCSEs. The only problem was that the waiting list for CBT or even for getting medication with a psychiatrist was a long time – around 6 months, which was a long time, since I was

struggling a lot with my OCD. However, for most free healthcare there is a long waiting list with the NHS, and this cannot be helped. It may have improved since my experience there.

The staff at CAMHS are all very friendly and professional – all ideal and suited for their jobs. One psychologist arranged to meet up with me around once a month during the wait for the CBT the second time around and even came out to my school and met me in a quiet room there. All staff are also very compassionate and empathetic, which is very good. After around 2-3 months, in the November of that year, I was offered a group-session CBT-style course for OCD, which was to start earlier than my place on the waiting list for one-to-one CBT.

Even though, I was reluctant to take up the offer, I eventually accepted it, which was a very good choice for me, and we started this group session in February the following year. There were about 8 people there, all about my age and having OCD. We meet up frequently, and had workbooks, having sessions which sometimes involved our parents, led by two members of staff. This was very successful, and nearly everybody there benefited significantly. I found it very useful and met lots of friends, many of whom were in my age group and from my school!

I then finished my therapy and by the summer was quite a lot better. I also then joined the user participation group, which we have been doing for about a year now, meeting regularly, and have made some improvements to the service. Although I continue to have some OCD, I can now better manage this and know that I can always go back to CAMHS for help. My experience at CAMHS, although having a couple of problems, was generally very positive, and I am very thankful for this good service."

Status Report

- Tell them when you identify a young person who is suffering from it.
- Give them the confidence to talk.
- Find a distraction that works for them.

- Accompany them on the leap to go to the family doctor.
- You are not alone in the process. Help them understand that there are many others going through the same situation.
- Let them know that their illness does not define them. Be realistic.
- Help him make the decision to counteract it and know that he is worthy of a life without it.
- There is nothing wrong. No need to worry, take a deep breath, sit down and relax.
- Those negative thoughts are not real, it's hard to control them but ignore them. Your body is just trying to help.

Notes/Reflections

Obsessive compulsive disorder (OCD) is a common mental health condition where a person has obsessive thoughts and compulsive behaviours. OCD can affect men, women and children. Some people start having symptoms early, often around puberty, but it usually starts during early adulthood. OCD can be distressing and significantly interfere with your life, but treatment can help you keep it under control.

If you have OCD, you'll usually experience frequent obsessive thoughts and compulsive behaviours.

- An obsession is an unwanted and unpleasant thought, image or urge that repeatedly enters your mind, causing feelings of anxiety, disgust or unease.
- A compulsion is a repetitive behaviour or mental act that you feel you need to do to temporarily relieve the unpleasant feelings brought on by the obsessive thought.

People with OCD are often reluctant to seek help because they feel ashamed or embarrassed.

OCD is a health condition like any other, so there's nothing to feel ashamed or embarrassed about. Having OCD does not mean you're "mad" and it's not your fault you have it.

There are 2 main ways to get help:

- refer yourself directly to a psychological therapies service.
- see a GP – can refer you to a local psychological therapies service if necessary.

If you think a young person may have OCD, try talking about your concerns and suggest they get help. It's unlikely OCD will get better without proper treatment and support.

It's not clear what causes OCD. A number of different factors may play a part, including:

- family history.
- differences in the brain.
- life events – OCD may be more common in people who have been bullied, abused or neglected, and it sometimes starts after an important life event, such as childbirth or a bereavement.
- personality – neat, meticulous, methodical people with high personal standards may be more likely to develop OCD, also people who are generally quite anxious or have a very strong sense of responsibility for themselves and others.

Theater as a tool for social inclusion: the experience of integrated workshops

Key Issues

Mental health; youth; youth worker; community; volunteers; art workshop; theater.

Learning objectives

1. Interaction and integration.
2. Creation of a protected place in which to rediscover important parts of oneself and others.
3. Help to express one's potential.
4. Creation of a heterogeneous work group in which everyone can feel at ease and not discriminated against.
5. Recognition of the work done.
6. Address issues that are relevant and meaningful to individuals.
7. Creating activities that promote relationship and exchange in the group.
8. Analyzing, listening to and understanding the group.
9. Respect for the individual time and characteristics of each person.
10. Ability to listen and empathize.
11. Balance between being assertive, being directive and listening.
12. Enable the family and population to learn about the different facets and resources of the individuals involved.

Introduction

• Theater Workshop "Strambo Teatro" held at the Don Luigi di Liegro International Foundation onlus.
• Roberto Baldassari: actor, director and conductor of integrated theater workshops.

Overview analysis

The Laboratory, intended as a protected place open to relationships, has as its main objective that of integrating people with and without disabilities through theater, encouraging a path of personal and social growth. The group is composed of users and volunteers who, for personal interest or for study path or opportunities related to internship, are interested in living an educational experience and strong educational growth as that of making integrated theater. An actor and director, Roberto Baldassari, leads the activities of the workshop.

"When it was first proposed to me to lead this workshop, I was a bit afraid because I didn't know what "mental discomfort" could mean. I have led and still lead workshops in schools, day care centers or universities where integrated groups were always created, but where generally one has to deal with physical or sometimes intellectual disabilities, but not with mental distress such as severe depression or other pathologies.

The Laboratory was born in order to create opportunities through art, opportunities for "therapy", but Roberto prefers to speak of "opportunities to meet and reinterpret through art for people who in everyday life are categorized as problematic or otherwise with a mental illness.

The workshop creates the conditions for an exchange between those who play a volunteer role within the Foundation and those who are undergoing a therapeutic rehabilitation process in mental health. This offers an opportunity for confrontation in environments that are not exclusively therapeutic. "For users this occasion should be an opportunity not only to discover aspects of the other with whom you interact, but to know aspects of themselves. The activity of theater is a new activity for everyone, both for those who are and those who are not users and often this aspect of novelty puts all participants in the workshop on the same level. This is an element of growth and discovery for everyone.

The course includes a first phase of personal and group knowledge through theatrical training: exercises and physical and vocal games; the discovery of gesture, space, use of the body and voice; then follows a more purely "theatrical" part with improvisations, performances of small scenes, monologues of narration where, individually, in pairs or small groups, you practice exposure in front of the public/company.

"Integration is a consequence of the work, it's a fallout, a positive counter-indication of the work. The moment you do a movement exercise, maybe you see that person who has difficulties [...] perform that movement with a grace that maybe none of the volunteers can recreate. Then there you have created integration, because a person who does not have disabilities sees the person with disabilities move or perform a gesture within the circle with a grace, a poetry that he does not have. [...] So, thanks to that activity, you discover characteristics of that person that maybe life does not allow you to identify in other contexts of everyday life".

In the third phase of the Workshop, the theme of the final performance is discussed in order to create the final performance with the group. This moment foresees the shared construction of the show through improvisations or the proposal of texts, scenes, stories that, united by a single thread, will constitute the framework of the show.

On the occasion of Disability Pride, the Group of Strambo Teatro, in collaboration with other groups, organized a flashmob in order to raise awareness about disability."We were a group of about thirty people with and without disabilities. When the music started, we began to improvise some dancing movements, but that had nothing to do with dance. There was a lot of amazement, everyone filming and taking pictures, people dancing along with them. We wanted to get across an idea of dignity, of affectivity, of intimacy between people with and without disabilities. It was important that people take home this image" (Link to the video of the flashmob: https://youtu.be/oODvRyHVXvU).

Status Report

- Work on the classic and typical phases of the workshop: group formation; physical

training; games that activate relationships and exchange; improvisation, exploration and communication activities.

- Write a diary page about a theme or a poem with an artistic and emotional strength, so that the user is not only a person who has a problem, but an individual with resources.
- Finding characteristics of that person that maybe life does not allow to identify in everyday relationships.
- Create a final project that represents the path taken in the workshop and its presentation to the citizenship.
- Leave a space to get to know people and listen to them.

Notes/Reflections

"You have to have the awareness that when you do this kind of workshop you are not working with professionals. You're working with people who don't have certain skills, but have other skills. The advice I would give is to listen a lot to the group and what they can do, what they have difficulty in doing, and then formulate requests and structure the work, starting with a precise analysis of the group you have in front of you. The listening phase is very important, it is a sartorial work".

"Our StramboTeatro workshop during the Covid-19 pandemic always stayed open; couldn't we see each other live? We met online, every Wednesday for two and a half hours. So we exchanged our stories, told and talked, shared the solitudes of each with those of all, to defeat the anxieties, fears, monsters that crowded the days and nights. Our theater workshop became a storytelling workshop: kitchens and bedrooms became many stages, all different; cell phones and computers were the cameras with which to film, photograph, communicate, observe. A unique experience condensed into a video-story: we presented it in June when we finally met again live; it was a feast to see us again and to see in those images, at times ironic and at times moving, all that we had experienced together. What would have become of them, of us if we hadn't done it?"

Web Radio Project. Radio PonteRadio

Key Issues

Youth work; Mental health; Empowerment; Psychosocial rehabilitation; Web radio.

Learning objectives

1. Support people in group mediation.
2. Foster personal and team goal achievement.
3. Reconstitute motivations and expectations.
4. Create a protected place in which to rediscover important parts of oneself and others.
5. Provide information on "knowing how" and who to ask for help.
6. Acknowledgement of the work done and respect for the timing of activities.
7. Allow the population to learn about the different facets and resources of the users involved.
8. Overcome prejudices related to mental health issues.

Introduction

• Social-rehabilitation project" Radio Bridge" at the Department Of Mental Health of ASL Roma 6 by the Social Cooperative Elma.
• Dr. Maria Pompa: Psychologist, Psychotherapist, expert in job orientation for people with social distress and psychiatric disabilities.

Overview analysis

The PONTE RADIO Project was born in 2017, initially to give space to a small group of young people sent by the Centers of Mental Health of ASL Roma 6, district of Anzio-Nettuno, and their need to experiment and share activities such as Electronic

Music, Videomaker and interest in communication through social networks. It was born within paths of nature of social inclusion, in collaboration with the Social Co-operative Elma directed by Maria Pompa, Psychologist Psychotherapist, expert in job orientation and Individual Placement Support.
"The web radio is an opportunity, for young and not so young people, to be more and more included in the community they belong to and, for the latter, to approach and share opportunities with the beneficiaries of our services; Radio Ponte Radio is above all the instrument to develop one and more personalized therapeutic-re-habilitation projects, which will be able to obtain an exceptional occasion of social animation and work inclusion."
The initiative is proposed as a Radio with programs and content of various kinds but at the same time maintaining the aspects of the radio "thematic", centered on the theme of Mental Health of the community present in the territory.The very name of the radio is significant and reconstructs the history of the area of Anzio.During the Second World War, in fact, there was a radio station that united the communication between the Italians and the Americans. The latter, as Allies, landed on the Tyrrhenian coast in front of the towns of Anzio and Nettuno.

The radio container can be considered a "protected setting" for all beneficiaries.

The editorial staff of the radio is composed of young people aged between 16 and 28 years who live the experience of psychological distress, such as personality disorders or autism spectrum syndromes. There is also the presence of psychologists, educators, computer technicians and sound.

Talking about the interaction of the radio with the territory or the community, over the years, a synergy has been created within the projects concerning the school-work alternation. This activity, promoted by ASL RM 6, since 2018, has allowed the students of one of the high schools in the area to enter the Mental Health Center to know and understand the reality of mental health, which very often remains in the shadows.

The young people experienced firsthand and shared with the users the activities carried out in the workshops.

It proved to be an experience of profound growth and contact for all, in which the fundamental role of communication to create integration was rediscovered.

Imagining the figure of the youth worker, and the skills necessary for a project of this type, we can mention the ability to mediate between the territory, the users and the Mental Health Centers; this is because the educational function can be provided not only through specific techniques, but also through being a citizen who knows the opportunities and orientations, with respect to their own territory.

In addition, it becomes essential to know how to help in the use of the computer tool, with the aim aimed at the user, to use their skills in a concrete way, to know the world.

The youth worker can have, thus, a real function of "bridge", of someone who creates connections." Creating a connection, just as a Radio Bridge does.

Status report

- Work through the steps of the radio workshop.
- Researching news or topics useful for outreach.
- Having a common goal.
- Expressing ideas through different modes of communication.
- Offer support to young people with emotional, behavioral and mental health difficulties through the art of radio broadcasting and managing a radio newsroom.
- Create concrete skills for possible scenarios of school and work reintegration.
- Help and train in the use of the computer tool.
- Encourage confidence in expressing oneself.
- Foster shared knowledge to overcome prejudices related to mental health issues.

Notes/Reflections

"Radio Ponte Radio is a meeting point that gives the opportunity to meet and express oneself, a real bridge to others. This allows to bring "out" ideas, to create an opportunity for listening and reflection through different forms of communication such as music, artistic expression, photos and drawings. One of the goals is to overcome the stigma of mental health by opening up to others and allowing those outside to learn about that reality."
"When we cure ourselves we also cure the world and to cure ourselves we need to live and share with the world. The social network unites realities, like bridges connect opposite shores so as not to isolate, not to abandon anyone."

Active Media Education for Disabled Youth

Key Issues

Youth European Project; Young People; Intellectual Disabilities; Digital Competences; Victimization; Cyber Bullying.

Learning objectives

- Empower young people with intellectual disabilities to become media literate;
- Help young people too become active citizens;
- Raise awareness of the needs of children and young people with intellectual disabilities and their pedagogical support.

Introduction

The European project AMEDY (Active Media Education for Disabled Youth) deals with the challenges of the digital world for young people with intellectual disabilities and with the requirements of the professionals working with this target group. The project is funded by Erasmus+ and is carried out by the german project coordinator Stiftung Digitale Chancen together with partner organisations UC Leuven-Limburg from Belgium and IASIS NGO from Greece.

Overview analysis

Although young people with intellectual disabilities show high interest in digital technologies and use digital media intensively during socialisation, they are highly affected by cyber bullying and victimisation. For them, it is often difficult to take advantage of the opportunities offered by digital technologies, likewiese, they also need special support to cope adequately with the risks they might encounter while using them.

Therefore, the aim of the project is to support these children and youngsters to become well informed, empowered and media literate European citizens. As European society turns more digital, the project wants to counteract the digital divide. The focus is on a strength-oriented approach for the work with young people with regard to the digital chances and challenges concerning their personal and professional development and an active participation in society.

The results of the project are three:

a. Online Training: Active Media Education for Disabled Youth
The free online training "Active Media Education for Disabled Youth" addresses educational professionals who work with children and young people with intellectual disabilities. On the basis of three modules, the opportunities of digital media are being explored and awareness of potential online risks is raised:
Module 1: Media Usage and Privacy
Module 2: Trends and Risks
Module 3: Creation and Participatio

b. Paper: Support Strategies
The aim of the paper is to provide a better overview of the needs of young people with intellectual disabilities. What do they need to navigate safely through the online world and what support can or must caregivers provide? Using two examples, the method of Design Thinking is shown in its application and demonstrates how action and support strategies for practice can be derived from it.

c. Toolbox: Awareness Raising Activities
With the toolbox, the project consortium aims to raise awareness of the needs of children and young people with intellectual disabilities and their pedagogical support. It offers a collection of best practice activities across Europe that raise awareness of the situation of people with intellectual disabilities in our digitalising society. In addition, the toolbox includes a catalogue of concrete tips, practical guides and useful resources that can be used to implement own ideas or actions.

Status Report

Building upon the results of the European project Digital Skills for You(th), which Stiftung Digitale Chancen carried out in cooperation with partner organisations in Czech Republic and Spain, the blended learning training offer developed for professionals working with socially and educationally disadvantaged young people shall now be adapted to the needs of the target group young people with intellectual disabilities and be provided in four different languages (English, German, Greek, Dutch). Additionally, a Support Strategy Paper for all involved target groups will be developed that contains different strategies for supporting the young people as well as the professionals and their organisations. Also, a toolbox with awareness raising guidelines will be created.

Notes/Reflections

Even if project’s professional target group are not clearly Youth Workers, this case study iis significantly relevant to them.

Assessment of Mental Health of Refugees and Asylum seekers by Youth Workers

Key Issues

Youth European Project; Youth Project; Young Refugees; Young Migrants; Young Asylum Seekers; Mental Health; Assessment.

Learning objectives

- Enhance mental health assessment skills of Youth Workers;
- Expanding their knowledge about the mental health of YMRA;
- Developing their reflective capacity, confidence, and resilience;
- Promoting self-care strategies and reduce probability of burnout;
- Improve cultural competences.

Introduction

AMORAY, Assessment of Mental Health of Refugees and Asylum seekers by Youth Workers, proposes a training and development program for Youth Workers, aiming to recognize their role in the mental health provision to Young Migrants, Refugees and Asylum seekers (YMRA). Based on a needs analysis at the beginning of the project, the partnership will develop the 'Training Curriculum for mental health assessment of refugee and asylum seekers by Youth Workers', following the European Credit System for Vocational Education and Training (ECVET) and ensuring that the training can lead to a vocational certification at EU level. The curriculum will set the groundwork for developing the content of the training. The AMORAY platform will provide access to the training content, introduce a communication forum, and a gateway to relevant psychoeducation material.

The implementation pilot will take place in United Kingdom, Greece, France and Spain.

Overview analysis

The results of the Project are three:

1. Training Curriculum for mental health assessment of refugee and asylum seekers by Youth Workers

Aim of this intellectual outcome is to design the training curriculum for mental health assessment in Youth Work, following the European Credit System for Vocational Education and Training (ECVET) standards. This output will be developed in two phases: Design and development of AMORAY training curriculum and Piloting and evaluation.

2. Training combo: Handbook, learning assessment tools, instructional package

The Handbook provides a training manual with clearly defined learning activities that relate to the curriculum structure. It provides a modular approach, not a linear, book-like structure, which allows training schemes to adopt to different needs in the EU.

The learning assessment methodologies will include formative assessments (e.g. a form stating the minimum number of mental health assessments, to which the youth worker has contributed), self-(learning) assessments tools (e.g. learning diaries), activities for reflection on youth workers' current practice or cases, and opportunities for reflection with peers and supervisors.

The instructional package for the trainers will include the rationale of the training, the pedagogical approach, the structure and rationale of the Handbook and selected case studies. This package will be presented in the training course (train the trainers) – capacity building event what will take place in London with the whole consortium.

3. AMORAY platform: Open Educational Resources (OER)

The aim of this output is to create an open resource for the Youth Workers to be able to have access in the materials and tools of the project.

The AMORAY platform will include Open Educational Resources (OER), which support ICT-based teaching for youth workers. It will provide opportunity for innovative and attractive e-Learning based on the structure of the Training Curriculum.

An online chat/forum, using encrypted protocols for data protection, will give the space to Youth Workers to be able to communicate and explore issues concerning the development of knowledge in mental health assessment.

Status Report

In the second part of this two year project, 100 youth workers will be trained and 500 Young Migrants, Refugees and Asylum seekers will benefit from mental health assessments and tailored psychosocial interventions.

Notes/Reflections

The mental health assessment tools are applicable to different target group of beneficiaries as well, apart from young migrants and refugees.

A. & I. - The Twins.

Paranoid disorder, symbiotic bond, and social withdrawal.

Key Issues

Mental health; adolescence; Youth Worker; paranoid disorder; social withdrawal; psychosocial rehabilitation; network intervention; relational development.

Learning objectives

- Creation of an informal climate where socializing is encouraged.
- Understanding of individual difficulties and dysfunctional aspects.
- Reinforcement of resources and functional aspects.
- Recognition of individual competencies.
- Facilitation of the opportunity to know and explore oneself, both individually and in relation to others.
- Creating a space of trust and non-competition, where each girls can open up and express their emotions without fear of being judged.
- Providing help in managing emotions in relationships.

Introduction

Venue: The Day Care Center (DCC), semi-residential service of PIP SM - Prevention and Early Intervention Service, ASL Roma 1, Via Plinio. Admission occurred in May 2021.

Two 23-year-old twin sisters arrived at the PIPSM with a request formulated by their father. The girls complain of a conflictual parental and family situation, characterized by continuous changes of residence. In addition, they show a strong state of social withdrawal, anhedonia and a paranoid tendency. After an initial phase in which the team worked on trust and compliance to treatment, the therapeutic proposal was enriched by suggesting inclusion in the Day Care Center to facilitate socialization and offer the girls a space “other” than their own home.

Overview analysis

During the first psychotherapeutic phase of reception, the girls manifest a strong tendency to withdraw with frequent references to the feeling of exclusion from the peer group. In fact, they state that they never go out of their rooms, that they feel like "hikikomori" and report feeling unsatisfied and constantly invisible to others, unable to build meaningful relationships.

OBJECTIVES OF THE CHARGE OF DAY CARE ENTER.

The care team proposes an inclusion in the Day Care Center where, through organized activities and the informal atmosphere that characterizes the work of the Youth Workers involved, they have the opportunity to express their abilities without feeling judged, creating for them a space that goes beyond that of therapy. It was also hoped that the stimulation of socialization skills in order to understand how to relate, question themselves and possibly create new emotional relationships, facilitating the exit from the condition of extreme withdrawal.

INTERVENTIONS

The agreements made with the YW team provide that the girls follow the Colourway activity, a space designed for sharing thoughts and events that happened to the users during the week, the singing lab, the film lab and the theatre lab; supporting and encouraging their interest in activities in which they can give space to their creativity. The admission to the Day Care Center is characterized by a threshold of uncertainty, given by the fear that the other boys do not want to socialize with them and may exclude them. Despite this, they declare that they feel immediately involved in the activities attended, finding them interesting and claiming that the moment of the activities seems to be one of the few in which they do not think about external problems. In all activities the girls seem to show a strong involvement, participating actively and constantly, even if with some initial perplexity related to the relationship with peers.

RESULTS ACHIEVED

With the passage of time, thanks to the informal climate and the constant presence of peers with whom they relate during the activities, the girls rely on establishing friendly ties that go beyond attendance at the Day Care Center, organizing themselves with users for external trips and independent trips. It can be reported, therefore, a reactivation of their socialization skills coming out of the condition of isolation in which they were. This has slowly allowed the recovery of the will to do, the establishment of new goals and a future perspective that was previously absent. To date, they say that the Day Care Center sounds like a “home” for them, a space where they can feel themselves without the fear of being judged, a micro reality where they feel protected to the point of putting themselves on the line and trying to face their difficulties.

COMPETENCIES IMPLIED

From the analysis of this case, it is believed that the introduction into the Day Care Center played a key role in the recovery of socialization skills and recognition of the girls' competencies. The absence of a competitive context and the presence of a non-formal climate where to weave meaningful relationships, facilitated by the presence of Youth Workers - able to restore greater security where the girls showed insecurities - has allowed to intervene not only on the symbiotic closure and the respective relational withdrawal, but also on the condition of general dissatisfaction of both, opening new perspectives on the future. The Youth Workers, in particular, were able to recognize and highlight the skills of the girls also as individuals, allowing their expression within a protected and non-formal space, where they had the opportunity to expose themselves and recognize themselves in the experiences of others. The competence most used in this intervention can be summarized in the possibility of redefining dysfunctional and functional aspects of the girls directly within the experiences of relationship developed in the DCC, mediated by a function of listening and recognition of emerging relational desires.
On the one hand, in fact, the work of the Youth Workers allowed the two girls to experience the sharing of aspects that they had always experienced as factors of ex-

clusion in relationships with peers; on the other hand, their presence allowed the remodulation of some approaches recognized as dysfunctional in the development of effective relationships, for example by implicitly encouraging a distinction between the two, who had always been immersed in a symbiotic relationship. The Youth Workers involved demonstrated the ability to think in an open and flexible way, to recognize dysfunctional socio-relational aspects according to the different relational contexts and objectives, to know how to integrate their theoretical knowledge with practical experience, to value the comparison with other colleagues in order to support the complexity of the case.

The case of N.

Relational difficulties and school support.

Key Issues

Culture; school; school support; networking; family problems; dysfunctional behaviors.

Learning objectives

To give the girl a scholastic support as an aid to study; to help her to succeed in having social relationships, both in and out of class; to increase her self-esteem; to prevent a hypothetical development of dysfunctional/self-harming behaviors.

Introduction

N. was born in Bangladesh in 2004, living with her parents and three brothers. She arrives in Italy in 2018 and the insertion in the new country begins for her. She finishes middle school and starts the linguistic high school.
The family situation looks very complex, her father is looked after by the CSM – Public Mental Health Centre – for psychiatric problems (substance use, gambling, episodes of aggressive behavior, attempted robbery).
At school N. is not able to bond with anyone, she isolates herself completely and starts not attending lessons almost anymore, in order to take care of both the family store and to help his mother with household chores; these factors determine the physical and mental overload with which she presents herself.

Objectives of the charge of day care enter

She is sent to the Day Care Center (DCC), the semi- residential service of the PIP SM – Public Prevention and Early Intervention Service, ASL Roma 1, by the team of the psychiatric outpatient service, with the following goals:

- Offer an alternative environment to the family one where to stay, to prevent a possible development of dysfunctional/self-harming behaviors;

• Scholastic support: development of a study method more in line with the limits/resources available;
• Help in developing social and relational skills.

Interventions

The Day Care Center is presented to N. and her family, who are initially skeptical about the service because they believe they are in an environment characterized by a purely psychiatric/medical dimension. After presenting the service, the family changes its mind: the Youth Workers explain in detail the functions and activities of the DCC and reassure the parents that they intend to make this space a place where N. can feel welcome and supported in her scholastic and relational development. The parents express their appreciation and agree to take charge of N.
The individualized project, conceived and structured together with N., foresees her presence at the Day Care Center at specific times per week.
Initially, the project has as its primary objective the school support, intended as an improvement of the study method, school performance and the relationship with school in general. It is agreed that N. will come to the Day Care Center three times a week and, with the help of a psychologist trainee (an additional resource within the DCC), will work on the development of a study method more appropriate to her needs and the limits that this period of difficulty necessarily imposes on her. They will then repeat together the subjects to be prepared for the oral exams, to improve her command of the Italian language as well. This first phase lasts about a year, at the end of which N. is now ready to experience studying independently; it is decided, then, to focus more on developing relationships with the other young people of the DCC. The individualized project was then modified on the basis of the redefinition of the demand: the frequency remained the same but participation in some of the laboratories offered by the DCC - afternoon labs and outdoor labs - was added. One day a week remains dedicated to school support.

Results achieved

Thanks to the Youth Workers' teamwork of the Day Care Center, N. has managed to:
• Better understand her own emotions;

- Having school help has allowed her to improve both her language - therefore also the level of integration with the territory - and her school grades, finishing the first school year with grades above average and without any fail;
- Participating in the non-formal DCC laboratories has allowed N. to establish relationships with other peers without fear of being judged and experiencing, on the contrary, the possibility of feeling welcomed and being able to compare herself with other young people with similar difficulties/fragilities;
- Participating in outdoor activities has given her the opportunity to experience the city in which she lives, discovering different places and opening up more and more to others. This exploration of the territory, shared within reliable and supportive relationships, has also improved the sense of belonging to the Italian context, so the integration challenge.

Competencies implied

The Day Care Center carries out activities of prevention and promotion of mental health thanks to the knowledge and exchange it maintains with the territory and the various social, educational and health services aimed at young people.
In the case presented, it is important to highlight the great network work mobilized by the Day Care Center in terms of mediation between family, psychiatric service and school, but also between the culture of origin and the host culture.
The Day Care Center functioned as an intermediary with the school service, taking charge of accompanying N. in his evolutionary path both from a scholastic and relational point of view. During the process, in fact, the Day Care Center has maintained regular contact with the school, carrying out a shared monitoring of school progress: absences and delays, but also progress - in grades and attitude - that N. gradually achieved. In this sense, the service has also played a support function to the family role.
From a relational point of view, the Youth Workers' team intervened contributing to the formation of a shared caretaking (composed of psychologists, psychiatrists, school operators, social workers) that would allow to deal with the multiplicity of aspects characterizing N.'s demand: from the improvement of cognitive skills and learning to the desire for socialization and development of a sense of belonging.

Maternal centre for young mothers.

Key Issues

Early motherhood; young mothers; family dysfunction; counselling; psychological support; social integration.

Learning objectives

- To offer a refuge to mothers in situation of risk to abandon their children;
- To offer a child the opportunity to grow up with his mother;
- To provide care for women with an unwanted pregnancy, preparing them for childbirth and educating them in matters of childcare, diet, health, faith etc.
- To help them become independent and capable of supporting themselves: helping them plan and live on a budget, complete a course of training, find a job, recover from psychological trauma.

Introduction

- Casa Mitspa – Home Mitspa, Timisoara, founded by Missio Link International Foundation.
- Daria, young mother and victim of human trafficking.

Overview analysis

Daria had no hope for the future. She grew up in an orphanage, being one of several brothers in the protection system but separated from them all at the age of three. After turning 18 and without any support from the state, she decided to get hired but because things were still difficult and she decided to go to work abroad as she had seen many other young people do, and at first everything seemed wonderful. Being young and naive, she entered an inappropriate entourage and ended up being trafficked by some bad people who posed for her friends.
With the help of good people, she managed to get rid of the nightmare and return

to Romania. Here she met a young man who promised her love and a bright future, but then found out she was pregnant.
At that moment, everything changed. The boy did not want to have anything to do with her or their baby and began to put pressure on her to go back abroad to work. Due to constant pressure and daily needs, she agreed to leave. She was again the victim of human trafficking, the same people, the same nightmare. Hope began to fade slowly. Nothing seemed to work for her and her life. She was desperate.
But life gave her another chance. The police were involved in her case and managed to get out of that situation and the people who trafficked her were punished according to the law. On her return to Romania, she received support and counselling through an organization that works with victims of human trafficking.
After a while she came to the Mitspa House. Things have not been easy for a while, adapting to life with a new born, with many changes and on top of that and the trauma experienced. But the support and care she received at Mitspa House as well as the community around Mitspa House helped her on her journey to healing and finding a new purpose in life. Hope began to blossom slowly in her heart.
She began to trust again, to believe that there was a plan for her and her baby's life. She began to want more from life and from herself. She is about to graduate from vocational training and now has a part-time job, all while being a mother who strives to be devoted to her baby. Daria is an example of resilience, courage and encouragement for many other young mothers.

Status Report

In Timisoara several organisations care for women who are faced with unwanted pregnancies and offer counselling. The new mothers are rejected by their families and find themselves homeless when they decide to keep their babies. Most are placed under great pressure by their families to have an abortion. They need a place where they can find safety and care for themselves, help and support to take care of their babies, the time they need to recover and learn to take responsibility for themselves and their children.
Casa Mitspa offers support for:

- Pregnant women in need of protection from family pressure to abort.
- Homeless single mothers with babies.

Notes/Reflections

Without having a place at disposal to welcome them, it is very difficult to encourage the mothers to keep their child. Counselling without offering real help and practical support is like putting them under even more pressure and increasing their distress, given the pressure they are already under to abort. Some of them are suffering abuse because of their pregnancy and it's very difficult to let them return home to the same situation knowing they will be abused again. They need to be offered real help and practical support.
Most of the mothers in risk situations come from difficult family backgrounds where they have never received emotional support, or the basic education they need to be able to take care of themselves and their own children. The aim would be to help them through a crisis situation and offer them a shelter where they can learn step by step to become independent and regain control of their lives. In providing them with a peaceful and secure environment, they can stand back from their immediate circumstances and think through the decisions they need to make.

There is life after abuse.

Key Issues

Young girls; abuse; sexual abuse; trauma; post trauma recovery; psychotherapy; social inclusion.

Learning objectives

- Provide housing and protection to victims of sexual abuse;
- Counselling and assistance for the inclusion of young victims of abuse;
- School dropout and child exploitation prevention;
- Programme for counselling and non-formal education of young people.

Introduction

- Casa Debora – House Debora, Timisoara, founded by Missio Link International Foundation.
- Beatrice, victim of sexual abuse.

Overview analysis

Beatrice grew up in a modest, low-income family. Due to lack of money, her parents quarreled a lot and were even separated for a while, leaving Beatrice with her mother.
When she was in her teens, due to financial problems, her father left home and never returned. After her father left, her mother could not take proper care of her and often left her alone at home while working long shifts.
Since she had no one, she trusted a friend of hers who was married and they started spending a lot of time together. Gaining her trust, her friend and her husband began to visit her around the house, bringing her the things she needed and behaving in a friendly manner. Until one day, when her friend's husband came to her alone and raped her.

The moment she realized she was pregnant, she had to tell her mother, who decided that she was no longer able to take care of her.
This is the girl's past, but not her future. At Casa Debora she found a place where he felt safe and where he could recover from all those tragic events that happened to him at such a young age. She started counselling and therapy, continued her education and, with help, began to raise her child beautifully and become independent. The “Casa Debora” Residential Centre was established in 2002, being the first centre in Romania specialized in assisting minor victims of severe abuse, including human trafficking. In a healthy family environment, with the help of social parents and a team of specialists, up to 24 underage girls benefit from education, health care, social care and post-trauma therapy. So far, more than 140 girls have found rehabilitation and hope at Casa Debora. With two family-type units, Casa Debora is a licensed child protection service.

Status Report

“The project There is life after abuse is a continuation of the project started in 2020, but also an extension of it, through which we propose that at least 24 underage girls victims of severe abuse and at least 10 young women between 18 and 22 years old regain their self-esteem and develop professional skills and life skills that increase their chances of an independent adult life. The project will ensure our girls' access to group and individual therapies, customized to the needs of each of them. Psychotherapy sessions will be combined with art therapy, personal development workshops, life skills development workshops and will facilitate access to counselling and vocational training for at least 10 young survivors of severe abuse. We also propose that the end of the project be marked by an event that draws attention to the phenomenon of child abuse, but also to present publicly, in a creative way, the results of the project. It is a new piece that we will add together with the local community and that will complete the portrait destroyed by abuse.”

Notes/Reflections

During the pandemic, the number of sexually exploited minor victims increased by 30% (ANITP Report, Romania). No matter what form the abuse takes, it destroys the child's self-esteem. It does not come alone, it always involves emotional abuse. The victim is blamed. She is the one who caused it. She feels that he has no value, that she does not belong to any community. She feels alone, abandoned, that she is not capable of anything good. Her whole being is overwhelmed by a visceral, permanent fear, because abuse is seldom a single act, but it is repeated over and over again. With low self-esteem, she develops emotional disorders and often behavioural disorders, being convinced that no one cares about her so it doesn't matter what she does. School performance decreases, and in most cases the abused child drops out of school or is encouraged to do so in order to reduce the risk of abuse being discovered. Lack of professional and life skills and abilities make the victim even more vulnerable and favour the development of a cycle of abuse.

GLOSSARY

A

Advocate
Someone who will represent you and speak on your behalf. An advocate can help advise you on your rights and help you to communicate your needs to your care team.

Affective disorder (also known as mood disorder)
A category of mental health problems that include depressive disorders.

Anorexia nervosa (also called anorexia)
An eating disorder characterized by low body weight (less than 85 percent of normal weight for height and age), a distorted body image, and an intense fear of gaining weight.

Attention-deficit/hyperactivity disorder (ADHD)
A behavior disorder, usually first diagnosed in childhood, that is characterized by inattention, impulsivity, and, in some cases, hyperactivity.

Autistic disorder
Today we speak of Autistic Spectrum Disorders to define a set of conditions in which people have difficulty establishing normal social relationships, use language abnormally or not at all, and exhibit limited and repetitive behaviour.

Adolescence
It is a period of development that represents the transition from childhood to adulthood, i.e. from about the age of 12 to 19/20. The term adolescence, in fact, means GROWING UP.The adolescent years are the years of self-experimentation, of basic uncertainty, during which it is not always clear who you are, what you want, what you like, what you believe in and above all what your goal is.

Assertive Community Treatment
Assertive community treatment (ACT) is a form of community-based mental health care for individuals experiencing serious mental illness that interferes with their ability to live in the community, attend appointments with professionals in clinics and hospitals, and manage mental health symptoms. The mission of ACT is to help people become independent and integrate into the community as they experience recovery.

B

Bipolar disorder
Classified as a type of affective disorder (or mood disorder) that goes beyond the day's ordinary ups and downs. It is characterized by periodic episodes of extreme elation, elevated mood, or irritability countered by periodic, classic depressive symptoms.
Borderline personality disorder
It is one of the most clinically and epidemiologically significant in the youth age group. It is characterised by a high degree of emotionality and usually oscillates between extreme positions in many areas of life such as interpersonal relationships and self-concept.

C

Care plan
This document is created to outline why you are in hospital and what treatment will be provided to help you get better. You may have more than one care plan, outlining different support needs and interventions that will be put in place to support you. Your care plan should be shared with you and you should be notified about any changes made to it.
Chemist
Pharmacist. A health professional working in a community pharmacy or hospital who is trained to give advice about medicines.
Cognitive behavioural therapy (CBT)
CBT is a type of talking therapy used to help patients understand how they think about things and change any unhelpful behaviours. A course of CBT normally lasts

between 12 and 20 sessions.
Cognitive development
Development of the ability to think and reason.
Communication disorders
Communication disorders are developmental disorders that include expressive language disorder, which focuses on developmental delays and difficulties in the ability to produce speech, and mixed receptive- expressive language disorder, which focuses on developmental delays and difficulties in the ability to understand spoken language and produce speech.
Conduct disorder - a persistent and repeating pattern of violating the rights of others. chronic bullying, intimidation, physical fighting, cruelty to animals and people, and stealing are characteristics seen in this disorder.
Clinical psychologist
Licensed mental health professional (Ph.D. or Psy.D.) who specializes in the evaluation, diagnosis, and treatment of mental disorders. Training prepares clinical psychologists to treat adults and children either individually, as part of and involving the family unit, and/or in a group setting. Psychologists also conduct cognitive, academic, and personality testing.
Confidentiality
Confidentiality means that somebody won't tell anybody else what you tell them. Doctors, therapists and counsellors keep what you tell them confidential. However, they may have to tell somebody else to make sure you get the help you need, or if they are worried you are at risk of hurting yourself or somebody else. They will always try to tell you before talking to somebody else about what you have told them.
Counsellor
Someone who has been trained to support people with their mental health by helping them to think and talk about their feelings and experiences in a safe space
Creative therapy
Creative therapies like art, music or drama therapy can be used to help people express difficult feelings. These types of therapy are often done in groups.

D

Depression

A mood disorder characterized by extreme feelings of sadness, lack of self-worth, and dejection.

Dyslexia

A processing disorder characterized by difficulty in reading, writing, spelling, and sometime articulating words.

Dialectical behaviour therapy (DBT)

DBT is a type of talking therapy designed to help people understand their feelings and change unhelpful behaviour. It also helps people learn to accept themselves. DBT is normally done for around six months. It also often involves working with groups. DBT is most often recommended for people with borderline personality disorder (BPD), but it can be helpful for anybody who feels emotions very intensely.

E

Electrocardiogram (ECG)

A medical test which records the electrical activity of the heart.

Electroencephalogram (EEG)

A medical test which records the electrical activity of the brain.

Eating disorders

Abnormal eating behaviors.

Euphoria

A feeling of elation or well-being that is not based on reality and is commonly exaggerated.

Emotional dysregulation

Emotional dysregulation is defined as the difficulty in regulating one's emotions, i.e. the inability, once the emotion has been activated, to take the necessary actions to reduce its intensity and return to a state of emotional equilibrium.

F

Family therapy

In family therapy, a therapist works with people in close relationships with each other, explores their views and helps to understand the problems they are having. It helps family members communicate better with each other. It can help families to change, develop and resolve conflict.

Family therapy may be offered if the whole family is in difficulty. This may be because one member of the family has a serious problem that's affecting the rest of the family.

G

Generalized anxiety disorder (GAD)

A mental disorder characterized by chronic, excessive worry and fear that seems to have no real cause. Children or adolescents with generalized anxiety disorder often worry a lot about things such as future events, past behaviors, social acceptance, family matters, their personal abilities, and/or school performance. Hallucinations - a strong perception of an event or object when no such situation is present; may occur in any of the senses (i.e., visual, auditory, gustatory, olfactory, or tactile).

General Practitioner

Is the co-ordinator of your healthcare. Assesses and treats all sorts of common health problems and can refer you on to other services for specialist support. They can also offer advice about what local support is available to you.

H

Health visitor

Specialised nurse who works in the community, usually focusing on the health and care of young children (under the age of five) and their parents or primary carers.

Healthcare assistant

Supports nurses in the day-to-day running of an inpatient unit. A healthcare assis-

tant will often support patients with their day-to-day routine and may help to facilitate groups on the unit.

Healthcare chaplain

A healthcare chaplain can provide spiritual and pastoral support if you are a patient in hospital or care. Each chaplain will represent a different faith or belief.

Hikikomori

It is a condition that mainly affects adolescents and young adults and is characterised by an extreme form of social withdrawal: people lock themselves in their rooms and refuse any form of contact with the outside world, even for long periods of time, voluntarily breaking off relations with others and putting an end to all forms of communication, including with their families.

I

Identity

Self knowledge about one's characteristics or personality; a sense of self.

Interpersonal therapy (IPT)

IPT focuses on helping people address problems in their relationships with important people in their life. It is normally suggested for people struggling with depression who have already tried other types of treatment. A course of IPT normally lasts between 12 and 16 sessions.

Intermediate facilities

They belong to Mental Health Services and are day or residential services. These services aim to enable rehabilitative treatment for social inclusion.

L

Learning disorder

Learning disorders are characterized by difficulties in an academic area (either reading, mathematics, or written expression) such that the person's ability to achieve in the specific academic area is below what is expected for the person's age, schooling, and level of intelligence.

M

Major depression *(also known as clinical depression or unipolar depression)*
Classified as a type of affective disorder (or mood disorder) that goes beyond the day's ordinary ups and downs. It presents with sadness, tearfulness, irritability, low self-esteem, lack of interest or motivation, sleeping and eating problems, and possible thoughts of self harm.

Mania
A mood disorder which may be characterized by extreme elation, impulsivity, irritability, rapid speech, nervousness, distractibility, and/or poor judgment.

Mood disorder *(also known as affective disorder)*
A category of mental health problems which includes depressive disorders.

Mental Health Services
It is the set of structures and services whose task is to prevent, treat, assist and protect patients with mental health disorders. They include different levels of intervention: outpatient, residential, home-based. These services are generally integrated and in communication with each other.

N

Nurse
Trained to care for and support people with their medical or mental health needs by monitoring how they are doing, giving them their medication and helping them to take care of their basic needs. They mostly work in hospitals, but sometimes see patients at home or in other settings. They may also prescribe medicine.

Neurotransmitters
Chemicals in the brain that regulate other chemicals in the brain.

O

Occupational therapist
Helps people who have been unwell or had problems to build the confidence and skills to lead a normal life.

In an inpatient unit, occupational therapists are generally responsible for creating and implementing the timetable for the unit, which might include therapy groups, exercise groups and educational time. They may also do individual work with you to look at what support would be most helpful for you, either individually or in a group.

Obesity

A generalized accumulation of body fat.

Obsessive-compulsive disorder (OCD)

An anxiety disorder in which a person has an unreasonable thought, fear, or worry that he/she tries to manage through a ritualized activity to reduce the anxiety. Frequently occurring disturbing thoughts or images are called obsessions, and the rituals performed to try to prevent or dispel them are called compulsions.

P

Panic disorder

Characterized by chronic, repeated, and unexpected panic attack bouts of overwhelming fear of being in danger when there is no specific cause for the fear. In-between panic attacks, persons with panic disorder worry excessively about when and where the next attack may occur.

Phobia

An uncontrollable, irrational, and persistent fear of a specific object, situation, or activity.

Post-traumatic stress disorder (PTSD)

An anxiety disorder characterized by a terrifying physical or emotional event (trauma) causing the person who survived the event to have persistent, frightening thoughts and memories, or flashbacks, of the ordeal. Persons with PTSD often feel chronically, emotionally numb.

Psychiatric nurse

Often a Masters-level clinical specialist in psychiatric mental health nursing. A psychiatric nurse is educationally and clinically trained in psychopathology, individual, group, family therapy, and crisis intervention. they may also be licensed to prescribe psychotropic medications.

Psychiatrist
A licensed physician (M.D. or D.O.) who specializes in the evaluation, diagnosis, and treatment of mental disorders. Their medical and psychiatric training prepares them to treat adults and children either individually, as part of and involving the family unit, and/or in a group setting. Psychiatrists can prescribe medications, if needed.

Psychologist
A licensed mental health professional (Ph.D. or Psy.D.) who specializes in the evaluation, diagnosis, and treatment of mental disorders. Training prepares clinical psychologists to treat adults and children either individually, as part of and involving the family unit, and/or in a group setting. Psychologists also conduct cognitive, academic, and personality testing.

Prescription
An instruction written by a medical practitioner (usually a doctor) that authorises a patient to be issued with a medicine or treatment. Prescriptions are then taken to a pharmacy to get the medicines dispensed.

Psychotherapist
A trained professional that oversees your talking therapy, providing more in-depth treatment than a counsellor. Psychotherapists aim to help you explore and understand why you feel the way you do, what's behind the way you act towards other people and why some things happen to you. They usually aim to bring about helpful change by doing this.

Personality disorders
Disorders that are not characterised by specific symptoms or syndromes, but by the exaggerated and rigid presence of certain personality traits.

Personality
Personality has been defined in many ways, but it can be said to be the set of characteristics that represent the way each of us responds, interacts, perceives and thinks about what happens to us.

Peer support
It occurs when people provide knowledge, experience, emotional, social or practical help to each other. It commonly refers to an initiative consisting of trained supporters (although it can be provided by peers without training), and can take a number of forms such as peer mentoring, reflective listening (reflecting content and/or feelings), or counseling.

Psychotherapy
It is a treatment for psychological disorders that takes the form of a series of meetings with a professional psychotherapist. Psychotherapy can help people cope with illness by helping them discover new ways and resources to cope psychologically and socially.

Psychosocial interventions
Refer to different therapeutic techniques, usually classified as non-pharmacological (not involving drugs), that address the psychological aspects of an individual or group and consider the situation of the person or group from a social and family perspective.

Psychiatric medication
A psychiatric or psychotropic medication is a psychoactive drug taken to exert an effect on the chemical makeup of the brain and nervous system. Thus, these medications are used to treat mental illnesses.

R

Risk assessment
In inpatient care, this is an assessment carried out by staff to assess what your risk level is. This will usually involve asking you a number of questions to assess how you are currently feeling. It will usually take into account any previous risk you have shown. This may be used to assess things such as your observation level and suitability for leave.

Rehabilitation
It encompasses all activities aimed at reintegrating and recovering skills and/or competences that have undergone modification, deterioration or loss or at facilitating the construction of compensatory strategies in cases where recovery is not possible. Psychosocial rehabilitation aims to help people suffering from a disability, impairment or mental health disorder to achieve their highest level of independence within their community.

Recovery
Recovery in Mental Health is a profound and unique process of changing attitudes, values, feelings, goals, skills and roles. Feeling fulfilled by living a fulfilling, hopeful

life despite the limitations caused by illness. Recovery involves the development of new meanings and learnings in the life of a person who grows and develops beyond the effects of the disease condition.

S

Self-help/support group

Group where you meet up with people in a similar situation to you. They help you realise you are not alone and you can end up feeling better by being able to support someone else.

Social worker

Not a medical professional, but helps and supports people facing different problems.

Social inclusion

It is the condition in which all individuals live in a state of equity and equal opportunities, regardless of the presence of disability or poverty. The aim of social inclusion is to comprehensively improve the living conditions of individuals, to provide them with the same educational, employment and economic opportunities as the rest of society.

Schizophrenia

one of the most complex of all mental health disorders; characterized by distorted thinking, strange feelings, and unusual behavior and use of language; involves a severe, chronic, and disabling disturbance of the brain.

Self-esteem

Feelings about one's self.

Social phobia

An anxiety disorder in which a person has significant anxiety and discomfort related to a fear of being embarrassed, humiliated, or scorned by others in social or performance situations.

Suicidal behavior

Actions taken by one who is considering or preparing to cause his/her own death.

Suicidal ideation

Thoughts of suicide or wanting to take one's life.

Suicide
The intentional taking of one's own life.
Suicide attempt
An act focused on taking one's life that is unsuccessful in causing death.

T

Tourette's syndrome *(also called TS or Tourette's disorder)*
A tic disorder characterized by repeated involuntary movements and uncontrollable vocal sounds. This disorder usually begins during childhood or early adolescence.

CONCLUSIONS

At YouProMe we know how important youth workers are in the development of young people. Youth workers play an invaluable role in promoting young people's mental health.

They help young people access supports that contribute to their personal, emotional, social and educational development.

This Handbook contains practical mental health information, case studies and terminology for youth workers on how to identify and manage young people with mental health problems and support young people's mental health by helping to create a safe place where it is promoted.

The role of youth workers in young people's mental health is fundamental.

• They are **trusted people** a young person can turn to for support if they need it, giving them time and space to open up, and listening without judgement, providing guidance, helping to find solutions to problems, accepting young people for who they are, or just being there. Trust must be built over time. In most cases young people will usually feel more comfortable confiding in a youth worker than in their parents or siblings, mainly because they know that the youth worker has chosen to work with them, believes in them and values them.

• They are **a vital link to the community** and can make young people aware of additional supports and services available by helping to break down barriers and stigma associated with accessing these services.

• Because of the **training and interpersonal and listening skills** they possess, they may be the first to notice that a young person is experiencing a mental health problem. They can pick up signals in young people's interactions and so can offer support and refer young people to another service if necessary.

• **The environment can influence communication.** Youth workers often work with young people in informal, relaxed settings with natural opportunities for more personal conversations, such as mental health issues. These spaces provide opportunities for youth workers to see the signs that a young person may be struggling with their mental health, and so it can be easier to meaningfully interact with and support them.

• Learn to **recognise signs, changes or signals** that something is going on for that young person (appetite, mood, sleep, signs of self-harm, social relationships), analysing their behaviour is fundamental to this process. What you see is often the tip of the iceberg.

• **Be present and prepared.** Listen actively and be flexible with your time.

• **Be informed** (training on mental health issues, services offered in the community, where to refer a young person if needed, intervention skills, prevention, support, professional development...etc).

• **Use terminology that is appropriate and accessible to young people.** Be aware of the language young people use in case some words or phrases are overused or used incorrectly..

• **Know your professional limits.** Support and supervision of youth workers by the supervisor is important.

• **Practice self-care.**

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HANDBOOK

On social and emotional competences of young people with mental health disorders.

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