PRACTITIONERS' REPORT

Pre-meeting on Adolescent Mental Health and Wellbeing in Eastern Europe and Central Asia:

UNDERSTANDING THE CHALLENGES AND DEVELOPING EFFECTIVE RESPONSES

17-18 January 2018, Almaty, Kazakhstan

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Explanatory note

This practitioners' report is a summary of a meeting on adolescent mental health and wellbeing and suicide prevention, held in Almaty, Kazakhstan, in January 2018. The meeting gathered together experts working on the issue across the Central Asian Region, Eastern and Western Europe to exchange knowledge and experiences to better understand and address the mental health needs and issues of adolescents. The experts included professionals designing, implementing and researching various aspects of adolescent mental health and well-being. The participating country delegations came from Belarus, Kazakhstan, Kyrgyzstan, Tajikistan, Ukraine, and Uzbekistan. The meeting was hosted by the Government of Kazakhstan, and organised by the United Nations Children's Fund in collaboration with the World Health Organisation.

The strongest message that rose from the expert discussion during the two-day meeting was that youth must be placed in the centre-stage of all the interventions. The practitioners, programme designers and implementers, and policy makers must hear the voices of the youth, build their strength and resilience, and involve them in every aspect with dignity, respect and compassion, and pave the way for the youth to thrive. Strengthening the connections between the adolescents and their communities, supporting adolescents' competencies to access relevant and accurate information, strengthening their coping skills and creating protective, safe environments must be at the core of all the interventions. Strengthening the coping mechanisms of the youth results in more resilient, healthy youth of today but also creates generations who will live good, long and healthy lives. Investing in the youth well-being has long approaching effects.

Interventions and approaches must be holistic and all sectors need to work towards the same goals for improved results. Education and health care sectors are the crucial partners and actors in supporting the mental health and wellbeing of adolescents. To be operational, effective and useful, these sectors need supportive, enabling policies to carry on their important tasks and roles. Policy-makers across all sectors must realise their responsibility in creating enabling environments in which the young people's issues are fully considered and taken into an account by multistakeholder coalitions. Communities, parents, the civil society and the media must alike be capacitated and supported to continue fighting the stigma often connected to mental health and suicide, to stand up for the youth and support them to thrive.

1. Introduction

The Alma-Ata Declaration[1] forty years ago stated that all people including youth have the right to participate individually and collectively in the planning and implementation of their own health care, that health is a state of complete physical, mental and social wellbeing, and that governments have a responsibility for the health of their people. Thirty years after,[2] on the same venue, young people reaffirmed that Alma Ata Declaration was still relevant and that Primary Health Care (PHC) was the key towards achieving "health for all", especially for children and young people. All is still relevant today.

UNICEF and WHO organised a meeting on children's and adolescents' mental health and wellbeing in Almaty in January 2018, to create measures, recommendations and goals through dialogue which aim towards guaranteeing that the young generations are healthy, and have the strengths and the mechanisms to cope with mental health challenges. The two-day meeting brought together a wide range of practitioners and professionals working in the area of children's and adolescents' mental health, wellbeing and suicide prevention in the Central Asian and East European regions, and provided a platform to discuss and share the experiences, information on ongoing and recent interventions and programming approaches, and the newest academic research in the area.

The altogether some 60 participants represented a wide array of instances, including UNICEF country offices and national partners from Kazakhstan, Belarus, Kyrgyzstan, Tajikistan, Ukraine and Uzbekistan, UNICEF ECARO and headquarters, WHO Country office in Kazakhstan, WHO Regional Office for Europe, WHO headquarters and collaborating centres, experts involved in Kazakhstan at a national and sub-national level, international experts and practitioners, civil society organisations and adolescents from Kazakhstan.

The meeting developed a shared understanding on the situation, needs and challenges on adolescent mental health and well-being in Central Asia and Eastern Europe. This report bases on the information shared and discussions held during the meeting, providing an overview into the status of children's and adolescent mental health in the covered regions, and highlights the practitioners' approaches and recommendations to guide possible future programming, collaboration and engagement in the area of children's and adolescent mental wellbeing.

1.1. Structure of the report

The meeting covered an array of issue areas connected to children's and adolescents' mental health, well-being and suicide prevention, highlighting the cross-sectoral approach to prevention and care involving education and health care sector and communities, new technologies as a part of prevention and care, and monitoring and evaluation challenges and data issues.

Although it becomes evident throughout the report that the only credibly way is to work across sectors, this report, for the sake of clarity and for the ease of reference, is structured according to sectoral themes and aims to provide a sectoral overview of the issues, challenges, aspects and tools, and recommendations that are the most critical and significant to take into consideration. The report serves as a practical and concrete source of information and provides a realistic view into the current status and needs in the area of AMHW at the practitioner level, and highlights the expert recommendations of the implementers and scholars.

The first part of the report provides a general overview into the adolescent mental health status and discusses the risk and protective factors, stigmatization and data issues. The following sections are organised according to sectors that are the critical agents of change in the AMHW, including education, health care and communities such as families, peers and civil societies. The final two sections discuss the role of new technologies in

[1] International Conference on Primary Health Care, Alma-Ata, USSR, 6-12, September 1978

[2] Young People: Partners for Health, International Conference Celebrating the 30th Anniversary of Alma Ata Declaration on Primary Health Care, October 10 – 16, 2008, Almaty, Kazakhstan

prevention and care, and adolescents in conflict with the law. The sections highlight the effective and evidence-based approaches to promoting mental health and wellbeing.

The second part of the report gathers together the experiences, needs and challenges of the countries that participated at the meeting: Kazakhstan, Tajikistan, Kyrgyzstan, Uzbekistan, Ukraine and Belarus, highlighting the current state of adolescent mental health and wellbeing, the current programming as well as programming needs and opportunities.

The report includes all the practical and detailed information on the meeting in the annexes, including a chronological meeting summary with synopses of the presentations, information of the speakers and presenters at the meeting, the full programme of the meeting, and a full list of participants and participant feedback.

The practitioners' meeting on AMHW took place in Almaty on 17-18 January 2018, and was followed by the 1st International Conference Promoting the Mental Health and Well-Being of Children and Adolescents on 19-20 January 2018. A separate report covering the Conference is an accompanying the report at hand.

2. Approaches to supporting adolescent mental health

2.1. The significance of cross-sectoral approaches

Evidence and experience underlines the importance of cross-sectoral, integrated approach, incorporating and involving specialists, Primary Health Care, schools, communities, youth and families, in both prevention and treatment of mental health disorders. Affective adolescent mental health care and suicide prevention needs to involve the policy level(s), the health care sector, the schools and the communities, as well as have services available over the phone and internet, with the focus on all instances working consistently towards the same goals through a networking manner. Single and separate activities, no matter how carefully thought through, cannot detect, prevent and care for all mental health needs nor self-harm behaviour, but strong, focused, coherent efforts that include all relevant actors have much more opportunities to create healthier youth and save lives.

A concrete example of an integrated model comes from Switzerland which has been built up over two decades into a holistic model that deals with adolescent mental health as a part of overall adolescent health, following the spirit of the Alma-Ata declaration which views health as a state of complete physical, mental and social wellbeing, and realising the adolescents' right to participate individually and collectively in the planning and implementation of their health care. The Swiss model of prevention was started with a focus on adolescent mental health and wellbeing in general, and has over the years developed more specific add-ons such as those focusing on violence and suicide prevention. The model includes a health care system which involves the youth in their own care as well as uses youth as simulation patients in doctor training, schools that have been created into safe environments promoting health and wellbeing through various youth-led interventions, and where trained gatekeepers are operational, and continuous monitoring of lifestyles through anonymous reviews, and individual counselling activities. The model also includes outreach to drop-out youth, peer-to-peer awareness raising and digital mechanisms of support.

2.2. Adolescents and mental health

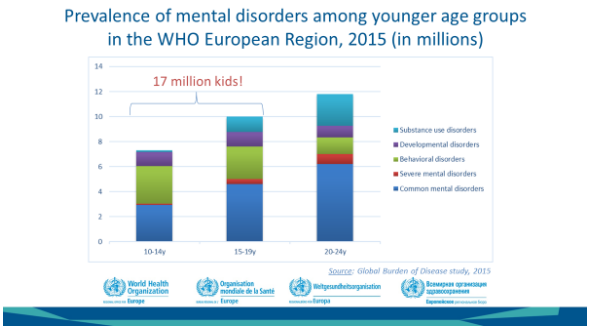
a. General

Adolescence is a time developing skills in self-control and social interaction, and therefore a critically important development stage. It is a time of a lot of mental and physical changes. Impulsiveness and a lack of control are natural parts of adolescent behaviour, which, if combined with mental health challenges, may lead to suicidal behaviour. Maturation of a person lasts until approximately 22 to 23 years of age. By this time youthful behaviour and conduct that does not conform to overall social norms and values, which is often part of the growth process, tends to disappear spontaneously with the transition to adulthood.

Adolescence is also the time of becoming autonomous, searching for one's identity and building relationships - qualities that have huge potential in utilizing in prevention and care of adolescent mental health and suicide prevention. Involving adolescents in all activities and utilizing the open-mindedness of adolescents in changing societal norms, is one of the most critical success factor if any programming in this area. Being in good emotional as well as physical health enables young people to deal with the challenges of adolescence and eases the transition from childhood to adolescence and adulthood. Mental well-being in childhood is associated with social competence and good coping skills that lead to more positive outcomes in adulthood.

Mental health and well-being depend on determinants including but not limited to social circumstances, environmental factors and individual attributes. The youth from Almaty that spoke in the meeting voiced very different stories that lead to their mental health challenges and even to suicide attempts, but all of their stories had certain similar themes: Feelings of being unloved, unwanted, useless, feeling of being a burden and disappointment to others. To remove triggers that may lead to mental health challenges is naturally impossible, as they simply are a part of life, but to focus on strengthening the resilience of the youth, is not only possible but advisable, just as it is advisable to create and strengthen mechanisms of adequate and effective care for those who face challenges. The adolescents who spoke at the meeting had also very similar survival and healing processes, which included possibilities to talk to adults who listened, understood and cared without judgement, having being heard and taken seriously, and through this support, becoming convinced that they were loved and cared for by their families and people close to them.

According to the WHO situation analysis, in the WHO European region, there were 17 million adolescents effected in 2015 by mental disorders, most of which were classified as common mental and behavioural disorders. Statistics show that mental disorders increase by age, especially from 14 years of age onwards. The suicide rate in the European region is 10,9 per 100,000 in boys aged 15 to 19, and 16,1 per 100,000 in CIS countries. The suicide rates among girls the same age is considerably lower (3,6 and 5,8 respectively).



Globally 800,000 people commit a suicide annually. This means 1 death by suicide every 40 seconds. 67,000 adolescents die each year from self-harm, and an estimated 10% of all adolescents have intentionally harmed themselves. For each suicide there are likely to be more than 20 others who attempt suicide. Suicide ranks among the leading cause of death for older adolescents, while depressive disorders, anxiety, behavioural problems and self-harm are among the greatest contributors to young people's burden of disease. The burden of mental disorders is real and critical. Negative experiences, such as at home due to family conflict or at school due to bullying, can have a damaging effect on cognitive and emotional development to children and adolescents. Identification of "causes" to mental health disorders or suicides is impossible, but certain risk factors as well as preventive factors have been identified through research.

b. Risk factors and protective factors influencing the adolescents' mental health

Research has found a number of risk factors that influence the mental health of children and adolescents. The risk factors can be divided into three rough categories of individual attributes, socio-economic factors, and environmental factors.

The individual attributes include genetic and biological characteristics, and emotional and social intelligence. Those with low self-esteem, emotional immaturity and difficulties in communicating have a heightened risk of mental health disorders in comparison to those with good self-esteem and confidence, ability to manage stress and adversity, sound communication skills and good physical health. Poor physical health and medical illnesses increase the person's risk to mental health challenges.

The socio-economic conditions in which children and adolescents grow up can have a profound impact on subsequent choices and opportunities in adolescence and adulthood. For example, poor housing or living conditions may reduce opportunities for productive learning and social interaction, or increase exposure to substance abuse and injury. Protective factors, on the other hand include social support of family and friends, good parenting and family interaction, economic and physical security, and scholastic achievement.

Environmental risk factors include aspects such as poor access to basic amenities and services, and prominent harmful cultural beliefs, attitudes and practices. Social and economic policies can expose risk to mental health, as well as exposure to disasters or war. Protective factors include attributes such as social justice, social and gender equality, physical security and safety, and access to basic services. Macro-environments that offer access to good education, decent housing and standards of living, and physical health, create social cohesion which in turn contributes to the mental well-being of adolescents, with a spill-over effect of health promoting behaviours. This represents itself in low levels of substance misuse, increased healthy eating and physical activity, safer sexual behaviour and low incidence of bullying. Being in a good emotional as well as physical health enables young people to deal with challenges of adolescence and eases the transition into adulthood. Mental well-being is associated with social competence and sound coping skills that lead to more positive outcomes in adulthood. One of the most effective prevention mechanisms of suicide is to reduce the access to the means to commit suicide, which is often possible through policy change. In Switzerland one of the highest rates of suicide has been by fire arms. A reform of fire arm related legislation (ending an old tradition of ex-service men to bring home ammunition together with the fire arm they were entitled to after service) decreased the number of suicides in the country.

Exposure to risks can significantly affect mental wellbeing many years or even decades later. For example, family violence in childhood has been proven to be a significant predictor of subsequent problems such as substance use or criminal behaviour in adolescence, which in turn increases the likelihood of exposure to other established risk factors in adulthood such as unemployment, debt and social exclusion. Mental health problems impair adolescents' performance and notably increases the risk for truancy and dropping out of school, leading to many further negative, and potentially life-long and life-threatening implications. Therefore, prevention and minimizing risk factors as well as nurturing protective factors already at an early age is critical, from an individual as well as from the public health view.

Saving and Empowering Young Lives in Europe (SEYLE), funded by the European Union, is an ongoing initiative which has studied preventive interventions in reducing suicide by collecting baseline and follow-up data on health and well-being, healthy and risk behaviour, suicidal behaviour and bullying among 12,000 adolescents across 11 European countries, with an aim to develop and evaluate school-based mental health promotion and suicide preventive interventions. Risk behaviours include illegal drug use, heavy smoking, reduced sleep, overweight and underweight, excessive media usage and truancy. This multi-country European research shows the need for the earliest possible intervention as most of the mental health problems onset at the age of 14 or earlier, and grow two- to three-fold or even four-fold at the age of 16 and above. The study also shows that girls have a much higher prevalence of internalized mental health issues (depression, emotional symptoms) than boys, who have a much higher prevalence of externalized symptoms (hyperactivity, lack of prosocial behaviour). The study has also revealed a significantly sized risk group that scores high on high exposure to media, lack of physical activity and reduced sleep, demonstrating a high prevalence of psychiatric symptoms. Studies on media use reveal that high usage of media *alone* is not negative per se but combined with a sleep loss and reduced physical activity makes it a high-risk behaviour.

c. Stigma

"I want to see a world where no young person will be scared to seek for help", exclaimed an adolescent boy to the participants. Several of the adolescents speaking at the meeting had minutes before explained how shame and the fear of being rejected had stopped them from seeking help and support.

Stigma is one of the strongest barriers, along with lack of knowledge about services and failure to perceive themselves as in need of support, to seeking care.

Stigma connected to mental health is a deep-rooted social phenomenon and needs to be battled through persistent activities towards societal change in which the open-minded adolescents, who are willing to see and work towards that change, must be placed in the driving seat.

Various information campaigns have attempted to create awareness and acceptance of talking about mental health issues and suicide openly and without shame, one of the biggest being the recent (2017) WHO-launched *Depression: Let's talk* campaign aimed towards provision of information on depression, one of the leading causes of self-harm and suicides. There are little examples of interventions that specifically target reducing social stigmatization of mental health, but plenty of awareness-raising activities to accompany mental health and well-being programmes.

A successful example of perception change is within the Kazakhstan pilot programme on Adolescent mental Health promotion and suicide prevention in Kyzylorda oblast. The starting point was a culture of blaming where people would hold different instances guilty of mental disorders and suicide, rather than concerning themselves with trying to change the situation. A lot of effort was put into convincing parents not to resist their children being referred to receiving professional care, and to have appointments integrated into regular health centres to avoid the fear of being stigmatized within their communities. Parents were sensitized and consulted, children and adolescents were given accurate information, and posters were placed strategically to create visibility and awareness. The perception change has been notable during the programme. A recent evaluation found no "blaming culture" left and very little resistance towards the issue. Moreover, the demand for and utilisation of counselling by school psychologists skyrocketed following the project implementation due to changed perceptions, and increased awareness and recognition of their roles.

Talking publicly about mental health and suicide has similarly been a sensitive issue in Switzerland, which provides another good example of reducing stigma connected to mental health. The public discourse has taken a step-by-step approach, and it has over the years become more acceptable to talk openly about the issue. People very often have a perception that talking about suicide will give the youth ideas about it and will push them to attempt suicide. Studies have shown that this is not the case, but in fact, talking about suicide in frank and honest manner, will prevent suicide, and make those with suicide ideation feel better rather than worse.

Researchers distinguish the two-fold impact of stigma: (i) public stigma is the reaction that the general population has to people with mental illness, and (ii) self-stigma is the prejudice which people with mental illness turn against themselves. Both public and self-stigma may be understood in terms of three components: stereotypes, prejudice, and discrimination. While the stereotypes are mainly (negative) beliefs about the group or the self, the prejudice is the agreement with these beliefs and emotional reaction thereon ultimately leading to behavioral reaction or discrimination. Stigma is evident in the way laws, social services, and the justice system are structured as well as ways in which resources are allocated.[3] The existing strategies for changing public stigma as well as for self-stigma all require further research. To understand and overcome stigma, structural understanding of the "attributes of others" is much needed.

d. Data issues

Reliable, consistent and disaggregated data is a powerful tool in advocating for and influencing required policy changes, and a solid foundation for credible and effective programming.

The common challenge in the area of adolescent mental health and wellbeing and suicide prevention is a lack of data, and thus a lot of the programming will need to start by collecting, and analysing collected data. Data collection on adolescent suicide may be attractive as it is often available through health data sets, but assessing

[3] Patrick W. Corrigan, Amy C. Watson: Understanding the impact of stigma on people with mental illness. World Psychiatry: Official Journal of the World Psychiatric Association (WPA) 1(1):16-20, March 2002.

the effectiveness of programmes against the prevalence of suicide is difficult and not sufficient, using it as an indicator to evaluate the overall adolescence wellbeing is questionable, at least in a short time span. A solid programme to enhance adolescent mental health and wellbeing should ideally base on totality of information on adolescent health in general, and preferably include both quantitative and qualitative data that are complimentary.

Prevalence of mental health issues, help-seeking behaviours, coverage of services for adolescents, acceptability and accessibility of services, people's awareness of services, fund allocations and quality of care for service outcomes are fairly easily collectable data and can serve as a solid evidence for programming. This data could be collected through a number of ways including school's regular health check-ups, screenings, facility level reports which are routinely fed into medical information systems, facility based surveys or household surveys, facility mappings, and needs assessments.

In this area of work, schools and health care facilities are perhaps the most natural instances to collect data from. However, the adolescents who have already left schools or are school drop-outs must not be forgotten. To gather data concerning these groups, it may be worth tapping into the welfare services or other instances that naturally reach adolescents, e.g. ante-natal clinics and military service entry check-ups.

In data collection, one size, however, does not fit all. All data collection must be carefully designed according to the each and every unique country setting, considering infrastructural and cultural settings of what is realistic to achieve. For example, patient satisfaction surveys do not give a very realistic picture of service quality in places where it is culturally expected to give polite answers only, or in the environments where stigmatization prevents people seeking services from formal health care or where health professionals have low capacities to diagnose mental health disorders, formal health information systems will likely provide only a limited view into the situation.

e. Adolescents in conflict with the law

Studies conducted in the United States and United Kingdom show that 40-80% of incarcerated juveniles have at least one diagnosable mental health disorder. The prevalence of mental disorders within the general population is approximately 20%. Approximately one in four of incarcerated juveniles suffer from a mental illness so severe it impairs their ability to function as a young person and grow into a responsible adult. Surveys covering a number of developed countries indicate that majority of boys and girls in conflict with the law suffer from conduct disorders, and especially girls from severe depression. Post-Traumatic Stress Disorder (PTSD) is estimated to be 10 to 15 higher in adolescents in conflict with the law than the general public, and youth in the juvenile system are more likely to have been exposed to maltreatment and psychological trauma. Between 30-61% of youth offenders with a mental health disorder have a co-occurring substance use disorder.

Despite the high prevalence of mental disorders, only about 20% of adolescents in conflict with the law receive appropriate mental health care. Promising strategies of mental health promotion for juveniles involved in the justice system are those based on a comprehensive approach, improving children's social skills and behavior change, and involving their families in treatment and education plans. Simple screening tools for routine administration at entry to any juvenile justice facility of service have been developed and used, aiming to identify the youth who may need immediate attention regarding possible suicide risk and emergent mental health and substance use needs. Children and youth with mental health disorders are strongly recommended to be diverted away from the juvenile system and towards an array of community based services and support.

A pilot assessment on the needs of adolescents in conflict with the law in one of the most affected region in Kazakhstan indicate that adolescents in conflict with the law in Kazakhstan are at particular risk for mental health problems, with approximately 60-70% having a mental disorder, suggesting that appropriate treatment and intervention strategies to address mental health needs of adolescent in conflict with the law need urgent development (Further details under section 4.1.)

2.3. The role of schools in strengthening and promoting mental health and suicide prevention

Not a single health care system can detect all mental health risks or suicide attempts. Epidemiological data is not necessarily highly reliable, and most suicide attempts remain undisclosed. The role of schools and trained, competent gatekeepers operational in school environments are crucial.

According to WHO, schools are one of the most important settings for health promotion and preventive interventions for young people. Health and education are intrinsically linked: Healthy children are more likely to learn effectively, education plays a significant role in health and economic status throughout our lives, and actively promoting health in schools can aid schools and policy-makers in reaching their educational, social and economic targets. Promoting health and healthy behaviour may also result in more increased health of staff, more effective teachers, greater work satisfaction and reduced absenteeism. Mental health problems impair children's and adolescents' performance and notably increase the risk for absenteeism from and dropping out of school.

Schools are the places where adolescents spend the majority of their waking hours outside home, and usually represent a familiar and safe context in which even serious and difficult issues can safely be discussed, and are identified as places of self-development and where learning opportunities lie. For these reasons, schools are important instances to promote mental health, and are the places where early detection of those at risk is the easiest. Schools are also often the places where events that have negative implications on adolescent mental health take place, e.g. bullying, and the environments where these issues can be detected, mediated and solved.

Mental health promotion and suicide prevention in schools can take several forms and approaches. The most recommended ones are screenings, gatekeeper trainings and awareness raising initiatives.

a. Screenings

Screenings are used to detect those who require mental health interventions. Academic evidence shows that screenings are more effective in identifying those at risk and in need of mental health interventions, than identification by school personnel and parents. If screenings are done with standardised methods and by well-trained staff, with the informed consent of children/adolescents and caregivers and within the context of available service capacity for those who screen positive, the technique can prove as a useful mechanism for schools to identify and support students with psychological disorders. Successful outcomes of the screening programmes rely on the availability of referral resources for appropriate follow-up of positive screens.

Practise of screening for mental health challenges and suicide risk can also be limited. One issue is the adolescent mood potentially changing rapidly from day to day, and results thereby fluctuating. To overcome this, an important factor is to establish a continuous system, e.g. annual screenings or integrate screenings into general health check-ups. The heightened stress levels of schools rather than of individuals can also give indication of heightened risk of mental health issues. In settings where formal services are not available, no alternative practices can replace the screenings, but structured training programmes can at least help engage volunteers to address mental health issues and engage in preventive activities.

Screenings can be conducted using alternative methods rather than physical, traditional paper questionnaires, e.g. through various digital solutions. Providing students with questionnaires and a common time to fill them in, though, can serve as an opportunity and a tool to communicate to and with pupils about the issues of mental health issues. The earlier mentioned youth and health model of Switzerland, running since 1983, has focused resources on creating safe and health enhancing environments in schools, by training students and staff as gatekeepers and organising health promoting interventions. Rather than screenings, the students fill up a lifestyle review when entering schools. The reviews are done through short, anonymous questionnaires (with yes/no answers) on issues such as social relations, sexuality, and substance use/abuse. They serve as a guidance to school health care providers to discuss issues with youth and reflect the information on the school atmosphere, and provide guidance to students on instances to turn to when and if necessary.

b. Awareness raising programmes

Awareness raising programmes are aimed at strengthening the mental health of children and adolescents in general and at increasing the awareness of mental health and suicide. Effective awareness raising interventions focus on positive mental health, balance universal and targeted approaches, start early on in age and continue over time, and work with a multi-modal, whole-school approach, which links the awareness raising efforts with academic learning, improves school ethos and liaises with parents, community and other relevant partners.

Studies have assessed the effectiveness of different awareness raising models, showing variety of benefits. The *Signs of Suicide* (SOS) model has been found successful in providing the target group with a greater knowledge of depression and suicide, more favourable attitudes toward intervening with friends exhibiting signs of suicidal intent and getting help for themselves. *Good Behaviour Game* (GBG), a programme directed at reducing aggressive and disruptive behaviour, reduced drug and alcohol abuse, regular smoking, and antisocial personality disorders, and significantly reduced the risk of suicide ideation. *Sources of Strength*, a prevention programme which utilizes peer leaders to increase protective factors and encourage adolescents to engage with trusted adults to help distresses and suicidal peers, significantly improved the peer leaders' adaptive norms regarding suicide, their connectedness to adults, and their school engagement, as well as increased the students' perception of adult support for suicidal youths and the acceptability of seeking help. *Saving the Teens Suicide Prevention and Depression Awareness Programme* significantly reduced suicide ideation, suicide plans and attempts and depression symptoms, and increased students' self-efficacy and behavioural intensions towards help-seeking behaviours. *Youth Aware of Mental Health* (YAM), an intervention programme that uses printed materials and interactive meetings with role-play proved to decrease the incidence of suicide attempts, thoughts and ideation of suicide, and incidence and prevalence of depression.

c. Gatekeeper training

Gatekeeper trainings aim to capacitate those in schools who are in positions to recognise the warning signs of adolescents in need of a mental health care intervention or support. The trainings aim to teach gatekeepers – teachers, other school staff or students – how to recognise signs and symptoms of mental health challenges and suicidal behaviour, and how to refer those at risk to appropriate help.

Question, Persuade, Refer (QPR) training provides the trainees on information on youth suicide, warning signs and risk factors, and capacitates them on how to ask and discuss suicide with students, how to persuade them to get help and how to refer a student for help. A study assessing the effectiveness of the training concludes that there is an increased likelihood of risk students being approached, and some effect on increasing the participants' accuracy to identify warning signs and risk factors for youth suicide. Effective training should include practical experience and skills, be personally relevant, and consider the individual needs of the participants.

d. An example of a School based suicide prevention programme

Saving and Empowering Young Lives in Europe (SEYLE) is a European Union funded research project which has studied suicide preventive interventions by collecting baseline and follow-up data on health and well-being, healthy and risk behaviour, suicidal behaviour and bullying among 12,000 adolescents across 11 European countries, with an aim to develop and evaluate school-based mental health promotion and suicide preventive interventions. The initiative has empowered teachers through gatekeeper training, health professionals through establishing screening procedures for at-risk-adolescents, and pupils through mental health awareness promotion. The targeted adolescents were between 14 and 16 years of age across 168 randomly selected schools in the participating countries.

The teachers have been trained in QPR method which intends to offer hope through positive action, but is not a form of counselling or treatment. The teachers were provided with general information on suicidal behaviour, risk factors and warning signs, and capacitated to engage in supportive conversation with pupils. The screenings conducted by health professionals aimed to identify the adolescent's-at-risk through questionnaires, resulting

in possible follow-up interviews and referral to the local health care system. The awareness training programme, YAM, for the adolescents included interactive lectures on the issues of suicide and mental health, booklets, and posters in classrooms.

The QPR was well received in schools and the preparedness of the teachers to help pupils contributed towards a greater work satisfaction and general well-being of the teachers. The data analysis shows that the prevalence of depression decreased and those who were depressed at the time of baseline evaluation were less depressed one year later. The screenings faced a problem with roughly half of the pupils refusing to partake, some clearly because of resistance by parents. Help-seeking behaviours were increased with younger pupils, depressive and suicidal pupils as well as peer victimized pupils. The external factor that increased help-seeking behaviour proved to be the positive attitude of the parent(s), the close proximity of the interview location to the school and a short waiting time for the clinical interview. YAM reduced suicide attempts, suicide ideation and incidence of depression, but had no notable effect on the prevalence of depression.

The cost-effectiveness ratio for the YAM calculated in Quality-Adjusted Life-Year (QALY) was approximately 16.000 €, which is considerably below the usual government set threshold. Engaging youth was one of the main strengths of YAM. It provided the adolescents with a safe space where they could act out real-life situations and bring their own content into the scenes, increases awareness and knowledge about mental health and giving opportunities for reflection, improving coping skills and promoting help-seeking behaviour.

It is impossible to demonstrate the reduction of death by suicide through the study, but reduction in the attempted suicide or reduction in suicide ideation has value. The consequences of an attempted suicide have far-reaching, substantial psychological effects, increasing the risk of subsequent suicide attempts and death, has profound negative effects on relatives and significant others in the person's life, as well as the medical, financial and emotional costs to individuals and communities affected by suicide are substantial.

e. Practitioners' recommendations

Whole-school approach. The best and most effective strategies to promote mental health in schools are those taking a multi-component and whole-school-approach, involve all instances and embed the mental health issues into curriculums, liaise with the larger community such as parents, service providers and other instances close to the adolescents. Continuous implementation shows more results, and focusing on promoting mental health in schools over the prevention of mental illness creates a more positive and accepting attitude towards the issue. It is very important that the possible increase in the demand for mental health services is considered in advance, and that adequate help is available when and if the need arises.

Transparent discourse. To talk about suicide is prevention. Talking about mental health or suicide does not encourage suicidal behaviour, but the opposite. Speaking openly, frankly and honestly makes especially those with suicide ideation feel better rather than worse. The youth present at the meeting highlighted the importance of being able to speak about mental health issues and that expressing concerns and worries is crucially important. Adults often tend to consider mental health and suicide as taboos and a stigmatized issue much more than the youth who have not yet been fully integrated into the culture of "forbidden topics", and thus do not have the same reservations and anxieties. Only a couple of decades ago, it was common to believe that talking about sexuality and reproductive health would lead to irresponsible sexual behaviour, where as in reality it was proven that accurate and honest information lead to better informed decisions and more responsible behaviour. In the same manner, accurate and honest information about mental health and suicide will not lead to increased mental health problems and suicide, but will have a preventive effect, and if those suffering from challenges get the right information where and how to receive help and support, it will potentially save lives.

Training is an effective way to overcome resistance of talking about suicide. School staff, for example, must be given accurate and relevant information and concrete tools, methods and skills training on how to address the issue and how to approach the topic with students. In a case of a suicide committed by a peer, the adolescents' throughput the school must be provided with safe and secure opportunities to discuss the event and the issue.

History of suicide in a family is a well-recognised risk factor, and for students their class is often comparable to their family.

An important notion, however, is that glorified reporting on suicide in mass media can be harmful, and can increase suicidal behaviour. Due attention should be given on working with media partners to encourage *responsible* reporting on the issue.

Prevention. Half of all mental health problems have their onset during or before adolescence. The SEYLE research found that most of the mental health problems onset at the age of 14 or earlier, indicating that prevention should be started much earlier. Other research suggests that the age of 14 is the optimal age to start mental health prevention as it is often at the age when adolescents change school and are in a situation where they need to establish new groups of friends and are in one hand weak and prone to negative influences, but also perceptive and more flexible to absorb new ideas and concepts, which are much more difficult to change later on in life. Hence, it is a good time to build their resilience towards mental health challenges during this formative time. Early intervention that would start already during pre-education could be tested in kindergartens and pre-schools. Detection of risk cases would be far too early but it could serve the purpose of sensitizing parents, and teaching children skills and competencies to support their well-being also in future, as well as normalizing the issue already at an early age.

School capacities. Holistic approaches to mental health and suicide prevention are needed and schools are natural places to reach at risk-students. However, schools often become the places through which many interest groups attempt to reach the youth. Placing too much responsibility of suicide prevention and mental health on schools and teachers can easily become an additional burden if no additional resources are allocated to the schools. The health sector and other instances must be truly involved as the driving force.

School-based interventions need to focus on reducing the risk factors such as bullying, but also strengthening life and social skills should be tied into all education, not only to be done by teachers but also principles, directors and all others who are closely connected with schools and students. The mass media needs to be trained and involved in the overall well-being of school students. Strengthening the respect for one another and trust between students and personnel is a large part of a safe school environment that nurtures the well-being of students. Mental health issues must be incorporated into the curriculums of pedagogical institutions so that the new generations of teachers will be aware of the basics of mental health and are already trained as gatekeepers and have the familiarity thereof.

2.4. The role of health care sector in strengthening mental health and preventing suicide

Health care has a major role in care and treatment, but also in strengthening mental health. The earlier mentioned Switzerland model underlines the importance of health care sector's preventive role. In Switzerland a lot of effort has been placed on every health care encounter having a preventive component, and not separate somatic and psychological care. Health care in all its aspects should be accessible, affordable and youth friendly, and adolescents should be involved in their own care. One of the most important areas in health care for the adolescents have been found to be the issue of confidentiality. The medical students in Switzerland are trained in this field through communication training which uses adolescents as simulation patients, and have an opportunity to receive direct feedback on how they were treated and communicated with. This has been proven to be a very effective method in shaping health care into youth friendly.

In the area of care and treatment, injury and self-harm behavior should be decrypted with the adolescents themselves and adolescents should be involved in all aspects of their care. As mentioned above, confidentiality is highly important for the adolescents, and should be respected to the highest degree unless there is a threat to life. However, the counseling always should aim to convince the adolescents to share and open up their experiences with their parents or guardians.

A well-functioning and accessible health care requires enabling policies and legal frameworks that guarantee adequate resources and interventions available for young people. Early prevention and detection, e.g. through

screening, is crucial, both in health care and school settings, as well as early interventions. Low-intensity psychological interventions, such as *Early Adolescent Skills for Emotions* (EASE) and *Help Adolescents Thrive* (HAT), that can be used by lay workers or professionals in low-intensity format, have been developed, but identification of further cost-effective, feasible and affordable intervention should be a top research priority. Evidence suggests that suicide prevention needs both public health approaches (such as policies restricting access to lethal means, school-based prevention, gatekeeper and media training, internet-based interventions, and helplines) as well as health care approaches. The essentials in health care approaches are proper treatment of depression and chain of care that involves different services. Education of primary care physicians to have the capacities to detect and treat patients and screenings at primary health care level are crucial.

An important part of prevention and care is management of child and adolescent disorders in non-specialized health settings, e.g. improvement of child development at maternal health interventions, preventing child abuse, detection of maltreatment of children and youth and management of children with intellectual disabilities all have spill-over effects towards improved mental health of adolescents.

The participants from the Eastern European and Central Asian region identified a number of challenges hindering the prevention and care at the health care level. Challenges include a low capacity of health professionals (including psychiatrists, psychologists, GPs and nurses) in the area of mental health, weak coordination and collaboration between schools and health care instances, making referrals heavy and slow processes, as well as unclear responsibilities within the health care system itself. There is also uncertainty as to what would be the minimum practical skills and knowledge for non-specialists (GPs and nurses) to be able to adequately identify adolescents' mental health conditions and provide care. Situation analysis enjoying political will, commitment and involvement, followed by strategy with a vision and goals that would enjoy cross-sectoral participation, topped up with technical expert assistance, is needed. Similarly, continuous training and capacity building is needed to keep up the capacity of professionals to respond to adolescent health challenges.

2.5. Role of the youth and communities

Adolescent involvement through NGOs, associations and interest groups is a crucial component of effective mental health strengthening and suicide prevention interventions. The youth are naturally resourceful, innovative and most of all, they have the most expertise on adolescence. Adolescents are the agents of change also in changing norms, such as breaking the stigma around suicide. Additionally, adolescent participation is an investment into fostering greater social integration of the youth. Practitioners should be focusing heavily on supporting youth involvement and on provision of adequate resources. Rather than target identified problems of adolescents and solve the problems for them, a much more effective approach is to support the youth to solve the problems themselves.

The youth should be involved in every aspect of adolescent mental health strengthening, suicide prevention and mental health care, from policy level to school based prevention and health care. The Switzerland model is one the most successful ones in having utilized the resourcefulness and expertise of the youth in prevention and care widely. Students have been trained as gatekeepers and capacitated to organize health promotion interventions, adolescents participate in communication training of doctors in order to guarantee the maximum capacity of health care professionals in youth-focused care. A suicide prevention programme which organises awareness raising conferences, works in schools and organises trainings and events is run by youth themselves and builds on the resources and participation of youth.

2.6. New technologies

The reality of treatment of depression is that only about half (57,3%) receive treatment, and only 21,7% of those receive adequate treatment. Available treatment is frequently not evidence-based. Global depression treatment gap conservatively estimated is at 56,3%. The capacity to treat effectively is obviously not even close to satisfactory. In narrowing the treatment gap and increasing the service coverage, usage of digital health in mental health care and treatment is one strategy, which cannot be ignored. It is in line with the principles of

Alma-Ata Declaration, which stipulate the use of appropriate technologies, and not necessarily the high cost ones.

Digital health solutions are the use of digital tools, e.g. web, mobile, sensors and computers, for enhancing existing services and developing new ways of helping people. The aim of digital solutions and tools is not to replace standard patient-provider interaction and therapy, but rather to develop and offer new ways of prevention, information sharing and treatment, and help hard-to-reach patients and populations-at-risk with health problems. Usual barriers for care seeking of mental health by adolescents include stigma, lack of knowledge about services and their location, failure to perceive themselves as in need of mental health support and lack of time, which can be eased through digital solutions. The so-called 'screen time' is one important indicator showing the use of available information channels. Filling "the screen", i.e. the channels with appropriate information from official and trusted sources is important. The youth seeks for information and it is important that they find useful and adequate information and solutions.

Various forms of web-based interactions and e-health services already exist and are in use between healthcare providers and patients. E-health services, i.e. mental health services and information delivered or enhanced through internet and related technologies, are used to provide information, used in screening, provision of social support and different interventions. Early identification tools are needed and can be found in various applications such as virtual clinics.

A number of mental health supporting applications, interactive self-help resources and online counselling services have been developed and are available. New possibilities lie within virtual and artificial reality technologies. Robot sex dolls have been developed for those who, for various reasons, are not able to find real-life partner but naturally have sexual needs. Robot pets have been developed to serve as easy-to-care companions to support the human natural need for nurturing and company. Geminoids and holograms, e.g. of a relative, are being developed and tested for situations where family members' presence is crucial bit not physically possible. Therapeutic online games have been developed to help users to learn about themselves and reduce aggression. The area of digital health solutions and technologies is growing rapidly and is developing fast, and can be expected to be a solid and normal part of health care structures in a decade or two.

There are a number of challenges with digital solutions as a part of mental health treatment, like adjusting each service to different contexts with variations of audiences, language, culture etc. Site maintenance and development takes resources, both in terms of finances and time. However, in comparison to the cost of developing medicine or to the time it takes to train a sufficient number of psychiatrists to be as easily accessible as digital solutions, technological solutions can be hugely efficient and cost benefit ratio is large.

Research has shown that virtual programmes can be just as effective as offline interventions in mental health and suicide prevention, and an effective alternative to e.g. repeated screenings could be virtual monitoring tools, and reaching and identifying those in need of help could happen through various digital solutions developed for social media platforms. In countries where formal systems are not fully developed and the amount of professionals are not sufficient for the users to access physical services without difficulty, it is of even more importance to consider digital solutions while building the capacity of more formal mental health response. Cost of non-action may in these cases be far greater than action. Additionally, digital and new solutions in settings where more traditional and formal structures are poor or insufficient, may be much more easier received by the general public rather than in more developed setting where population is more resistant to new solutions as the existing ones are already highly developed.

Adolescents specifically are relatively easy to reach through different social network platforms, as they spend a lot of time and are active online, and are often naturally open for digital solutions and virtual care. For the youth, finding information online is not a problem, but assessing the credibility of the publisher or the relevance and accuracy of the information is often more of a challenge. It is crucially important that the youth find correct, useful and quality information on especially issues that are intimate in nature. Designers and implementers of adolescent mental health programmes cannot ignore the existence of web-based solutions and should identify

solutions that are worth investing in, in collaboration with other actors, duty-bearers, developers, and academia, and have the capacity to provide relevant solutions to service providers and governments. Research on innovative methods that can reach people in need of mental health support online and offer safe, secure and efficient solutions must be explored further and tested.

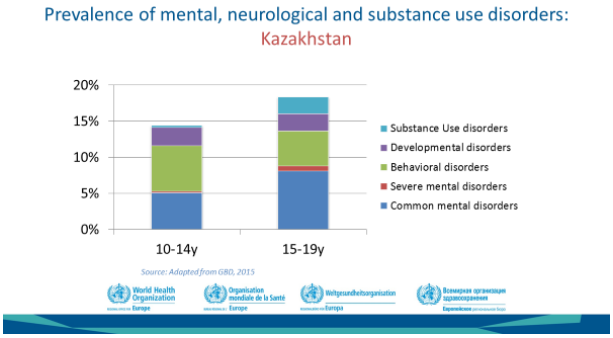
Some of the challenges that hinder the usage of new technologies as a part of traditional health care is a natural resistance of people. However, younger generations are more willing to test and adapt to new and innovative ways of health care and change will likely happen slowly. In locations where health care systems are well established and have long history, the change to new technologies is probably going to take more resistance than in developing environments where the health care systems are also still in constant development. New technologies may, thus, open up completely new solutions to care in settings that are not fully established in more traditional ways and in settings where physical infrastructure hinders the access to physical health care locations.

3. The country experiences, programmes and challenges in the region

3.1. Kazakhstan

a. Quick glance

According to WHO statistics, suicide rate of adolescent girls (aged 10-14) is 2,1% and boys (aged 10-14) 5,9%. The suicide rate of adolescent in the age group 15-19 is for girls 11,4% and for boys an alarming 29,2 %, which is the highest incidence of all of the Central Asian region.



Prevalence of mental, neurological and substance use disorder in Kazakhstan in adolescents aged 10-14 nearly 15%, and in adolescents aged 15-19, 19%, majority of disorders being common mental disorders and behavioural disorders. In other words, nearly one fifth of the adolescents aged 15-19 in the country suffer from a mental disorder.

b. Programmes, Challenges and Needs

A multitier programme on Improving Adolescent Mental Health and Well Being in Kyzylorda region, Kazakhstan, started in 2015, and has focused on reducing anxiety and depression of adolescents, strengthening mental wellbeing and reducing suicide ideation and suicide attempts, building on raising awareness of adolescents, and training health and education staff on mental health and identifying students at risk. The programme was initiated in the Kyzylorda oblast and has been launched in 11 regions of Kazakhstan with four regions being at the advanced stages of implementation.

The school based component combines early identification of adolescents at risk, gatekeeper training for school staff, and raising adolescent awareness regarding mental health. The programme has involved nearly 300 schools and 50,000 pupils. The health care based component focuses on increasing the readiness of mental health and PHC services to respond to adolescents at risk for mental health problems and suicidal behaviour.

The assessment of the programme in Kyzylorda Oblast has shown positive changes in adolescents, such as improved mental health status and wellbeing, decreased anxiety, stress, negative emotional symptoms, conduct problems, hyperactivity, peer problems and risk behaviours (alcohol/drug use), and 50% reduction in suicide ideation. Adolescents at risk showed 80% decrease in suicide ideation, the prevalence of depression decreased from 9.1 to 1.1%, anxiety from 60.7% to 6.8%, and stress from 13.5% to 2.3%. Notable improvement was observed in psychological well-being, deliberate self-harm, conduct and peer problems, hyperactivity, and prosocial behaviour. Significant increase was identified in cohesiveness and satisfaction, as well as substantial

decrease of friction and difficulties, better inclusion in the class environment, and reduced level of perceived barriers to help-seeking. Importantly, trust increased between adolescents and psychologists, adolescents and parents, and parents and school staff.

The new perspectives and ideas conveyed by the project require major efforts to change also education and health sectors, in order to provide timely and appropriate response to the increased demand of support and treatment that the new awareness can generate. The first year of the pilot project revealed the need for better coordinated processes of referral to ensure treatment. Changing attitudes towards mental health and suicide requires the involvement of specifically trained and committed professionals, and the close collaboration of health and school professionals. The programme of this kind can have sustainable effects only if it is not implemented as an isolated action but as a part of a larger strategy of mental health promotion in the general population, i.e. reducing the overall stigma. One of the biggest strengths of the programme is in the participatory character thereof gathering the groups and organisations which have never worked together before and otherwise would have not been working together. The project brought mental health to the agenda of decision makers in the country and raised the mental health issues in the minds of people in the country. It proved that different groups of people working together may be effective and capable of bringing results. The preliminary findings from the evaluation by ITAD reveal also some unintended outcomes of the pilot such as improved sociability and performance in school, reduction in bullying, overall self-development, parental support, improved status of school psychologists, and changes in other areas of social development.

To sustain the successes of the programme requires engaging the whole country to use the single, worked out methodology and models, and conduct the same activities throughout the health care and education system, continue developing different aspects that have revealed inadequate or needed during the programme, and continue and accelerate training. The programme must not allow fragmentation of its components and should be implemented in an integrated manner to provide for continuity of the process.

There is a hand-over of the well-established components to NGOs rolling out the project throughout the country. The National Center of Mental Health continues to work on the methodology and is advocating the integration of it to public policies.

An on-going research should be considered for the programme to be further elaborated and improved. The positive results in the area of changing perceptions could be replicated in other fields, e.g. in the fields of sexual violence and child protection.

A curricula development for clinical psychology is being planned as an add-on component to the programme, as challenges in the capacities of mental health professionals in the country have become evident during the programme. Another out-of-necessity add-on was capacity building of the national and local help-line staff on responding to suicidal behavior.

The health care system is slowly moving towards being more patient-centred and primary health care services increasingly integrate mental health, but there is a need for continuous development. The health care system has a practice in place where the information of mental health challenges remains in medical records, and may have implications in the future, when a person has to present their medical record at acquiring a university place or a drivers' licence. This practice is a major obstacle for help-seeking behaviour.

Pilot assessment of needs of adolescents in conflict with the law. A pilot assessment was carried out of the needs of adolescents in conflict with the law in one of the most affected regions of Kazakhstan, which is East Kazakhstan Oblast Kazakhstan. According to official statistics 2,944 completed criminal cases were committed by minors in Kazakhstan in 2015, and total number of prosecuted cases was 3,338, of which the vast majority, 91%, were committed by males, 79% between the ages 16-17.

The objective of the study was to identify adolescents in conflict with the law who may be at risk of mental health problems or suicidal behavior, and to provide useful indicators in order to establish common strategies for the use of valid and reliable screening, assessment and treatment practices in the juvenile justice services in

Kazakhstan. Preliminary results indicate that Kazakh adolescents in conflict with the law are at particular risk for mental health problems, with approximately 60-70% having a mental disorder. Somatic complaints, 42%, followed by depressive-anxious symptoms, 30%, were the most common problems, and 8% of the sample scored at risk for suicidal ideation. Girls seem to be at greater risk for mental health problems than males, while boys reported more physical aggressive behavior than girls. Results suggest that appropriate treatment and intervention strategies to address mental health needs of adolescents in conflict with the law need developing in the country.

3.2. Tajikistan

a. Quick glance

A UNICEF-commissioned research conducted in Tajikistan in 2012 reveals a high prevalence of suicide among adolescents, and reveal an apparent distortion with global statistics, such as alleged parity of female to male suicide prevalence and a reversed ratio of completed cases of suicides to the attempts. The rate of suicide of adolescents aged 15-19 in Tajikistan increased 63% from 2,8 to 4,5 (per 100,00) between 2008 and 2010 in Tajikistan (UNICEF TrasnMoEE, 2012), and the prevalence of suicide in 2012 per 100,000 is 12,2 for males and 41,6 for females A large number of female suicides is suspected to have linkages with unwanted pregnancies and/or domestic abuse.

According to the Tajikistan Global School-based Student Health Survey (2007), 20% of children and adolescents suffer from a disabling mental illness including anxiety disorders, depression and other mood, behavior and cognitive disorders.

b. Programmes, Challenges and Needs

Youth Friendly Services. A concept of Youth Friendly Services (YFS) has been under development in Tajikistan and aims to embed adolescent- and family-centered service model in schools and communities. The programme will involve 300 schools, community leaders, the Human Rights Council, youth councils and parent associations Youth Friendly Service centres will be providing counselling, information and guidance on reproductive health, and provide access to psychologists' services. The YFS programme is jointly developed with the Ministry of Health, Ministry of Education and UNICEF. Youth are engaged in all components as partners. It will focus on early learning, inclusive education and shift towards competency based education, including investing in the capacity of professionals in contact with adolescents.

Mental Health Support. A project focusing on providing mental health support to adolescents has been developed by UNICEF as a follow up to the 2011 suicide survey in selected regions of Tajikistan. The project aims at establishing an early warning system and student support teams in schools to prevent absenteeism and student drop-out as well as provide quality support to students with mental health challenges and prevent suicide within the above Youth / Adolescent Friendly Services at the PHC level.

3.3. Kyrgyzstan

a. Quick glance

According to WHO, the suicide rate of adolescent girls aged 10-14 is 1,6 and for boys the same age 4,9%. The suicide rate of adolescent in the age group 15-19 for girls is 6,4% and for boys 12.1%. Little reliable data on mental health exists.

b. Programmes, Challenges and Needs

The health reform is underway. Currently the psychiatric services do not specialize in adolescent mental health. Ministry of Health has been reforming the health care towards reaching greater inter-sectoral cooperation with an emphasis on local governance and integration of mental health in Primary Health Care services.

Housing for vulnerable population. Currently no specific programme targeting adolescents and mental health is operational in Kyrgyzstan. However, a Joint UN programme by UNODC, UNFPA and UNICEF, focusing on

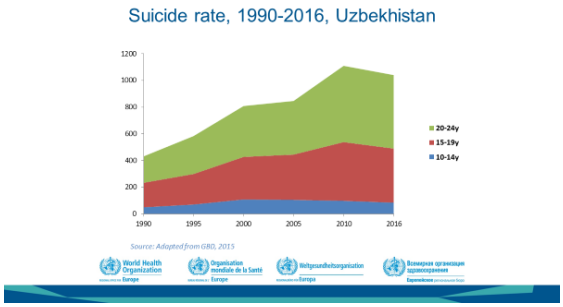
providing housing to the vulnerable population in the new suburban development areas around the capital city Bishkek, has been recently launched. Mental health services including for adolescents and specifically adolescent girls, will be an integral part of the initiative. The initiative aims to enhance women's and girls' participation in decision-making processes, well-fare services and social protection services. Adolescents are a focus group in an employment and skills development component, which includes a health component.

The challenges in the area of mental health in Kyrgyzstan include an inadequate number of trained and qualified school psychologists and psychologists in general. The schools and teachers do not have adequate competence to detect or strengthen the mental health status of students.

3.4. Uzbekistan

a. Quick Overview

According to WHO, the suicide rate of adolescent girls aged 10-14 is 2,1 and for boys the same age 4,5. The suicide rate of adolescent in the age group 15-19 for girls is 11,2 and for boys 19,8.



Uzbekistan is a country of young people. Out of the total country's population of 32 million those aged 0-24 account for 60 per cent. Mental health of young people is becoming increasingly important in the country although data on mental health issues is largely lacking.

b. Programmes, Challenges and Needs

The remarkably young population of Uzbekistan places the health of young people as one of the main priorities for the Government. The health and development needs in 0-24 age group are covered by more than a hundred regulatory and legislative documents.

The schools of the country accommodate about five million children. School psychologists are placed in every school of the country, except for those where recruitment has been unsuccessful and vacancies remain open. There is a need for increased number of specialists which is prompting the use of undergraduates, and a certain lack of competency to work with adolescents and need for further training. The psychologists are responsible for monitoring the psychological status of the students as well as provide career counseling.

The state has elaborated the youth policy in 2017, and established the Union of Youth of the Republic of Uzbekistan as country's political body for young people followed by organization of the Centre for provision of social and psychological services to young people. The policy stipulates the need for establishing centers for mental health to assist the youth with their issues and provide various psycho-social services throughout the country. However, the centers lack qualified staff and are not yet fully operational. A study on Health Behaviour in School-Aged Children (HBSC) has recently been launched which will cover at least some of the data gaps concerning the mental health and well-being of adolescents.

No programmes focusing on adolescent mental health and wellbeing are in place.

3.5. Ukraine

a. Quick Overview

According to WHO, the suicide rate of adolescent girls aged 10-14 is 0,8 and for boys the same age 2,6. The suicide rate of adolescent in the age group 15-19 for girls is 3,8 and for boys 15,0.

b. Programmes, Challenges and Needs

Systematic, regular data on adolescent mental health and suicide is lacking. The conflict in the Eastern Ukraine has put a number of challenges on service provision and urgently needed interventions. The need for mental

health support in the conflict zone is apparent, but accessibility and sustainability of possible interventions create major challenges.

Ukraine participates in the Health Behavior in School-aged Children (HBSC) study, which preliminarily shows a need for a greater attention on adolescent mental health. Political will exists but enabling legislation to lay foundation for the system dealing with adolescent mental health needs to be elaborated. Opportunities lie in a well-developed structure of pedagogical education network both practical and academic; existing cadre of 14,661 practicing psychologists and 7,003 social pedagogues, NGOs, international projects.

3.6. Belarus

a. Quick Overview

According to WHO, the suicide rate of adolescent girls aged 10-14 is 0,7 and for boys the same age 2,3. The suicide rate of adolescent in the age group 15-19 for girls is 3,2 and for boys 15,6.

b. Programmes, Needs and Challenges

Study on mental health. Belarus is preparing to launch a UNICEF-supported study of mental health issues and suicidal behavior of adolescents. The findings of the study will lay the foundation for an action plan.

Adolescent Suicide Prevention Programme. Currently Belarus implements its second program on prevention of suicidal behavior among adolescents. The multi-sectoral program is headed by the Ministry of Health. Ministry of Health provided statistics show that during the last five years only 5% of the total of 124 adolescents who attempted suicide had sought help or care. 85% of suicide attempters receive some form of care. Universal programme on suicide prevention among adolescents in educational institutions is being implemented, including awareness raising for students and parents. School specialists and care personnel at PHC level are being trained in adolescent mental health issues. A national suicide prevention help line has recently become operational with regional lines also available, as well an internet based information platform. A resource center, providing training for school psychologists and pedagogical professionals, placed in the Research Institute of Psychology is being planned. Also a system of conducting screenings in schools is currently being planned.

The political climate places certain challenges onto the operational space. A suicide awareness month as an advocacy campaign has been observed in schools and other institutions for more than a decade. Recently, however, the word “suicide” had to be removed from the campaign content as currently it is prohibited to talk about suicide. This deepens the stigma of suicide in the society.

Another challenge is the adequate number of psychologists versus the need. Although approximately 120 school psychologists graduate yearly, the numbers are not sufficient and psychologists across the country are over-loaded with work.

The new Minister of Education has pushed for a return to a six-day school week where the sixth day would be dedicated for social issues, trainings and nurturing skills development. This would be a good opportunity to include suicide prevention, anti-bullying programmes, and awareness activities in the school setting. However, the change to a longer school week has been strongly contested by the society and the issue remains open.

School staff need training at identifying those at risk and schools need more resources to actively be able to work on prevention and mental health strengthening.

Another window of opportunity for adolescent mental health initiatives is an increased interest in working in an inter-sectoral manner.

4. Conclusions and way forward

The meeting concluded to a common recognition that adolescent mental health and wellbeing are crucial issues that need to be addressed with a sense of urgency.

It was recognized that although there are obstacles, every life saved is a valuable one and worth fighting for, and although we may not have the easy solutions or means to reach a situation where every single young person lives a happy and healthy life, it should not stop us from consistently work towards that. Often no-action costs more than some action. Practitioners need to be innovative, persistent and forward-looking.

The meeting showcased that a plethora of valuable work is being done and a lot of effort is being put into preventing losing more young, valuable lives to mental ill health across the region and across different actors, instances and agencies.

The discussions and presentations covered a whole array of subjects and points of views into the issue, giving an outstanding learning opportunity and a forum to discuss the different aspects of interventions, thoughts, ideas and experiences. It became obvious that there is not one single correct way to design and implement, but that programmes can take a number of approaches and innovative forms, and be just as successful.

However, there were two aspects that were underlined in each and every discussion and presentation that are the necessary foundations for any programme or intervention:

1. Successful programmes will make sure of youth participation both at an organizational and individual levels, and utilize the resources that the youth have, in building safe environments, adopting a positive vision, raising awareness and training gatekeepers, and
2. Successful programmes use holistic approaches, work in inter-sectoral manner and engage all relevant partners to work towards the same goal.

The region has a lot of expertise on the issue. Joining forces across borders and agencies to support the adolescents to thrive, will result in healthier, happier and brighter future for all. A commitment was made to continue the discussion, and to explore the possibilities of putting the expertise into practice in the region where strengthening the mental health and wellbeing of adolescents is direly and urgently needed.

4.1. UNICEF, WHO and Adolescent Mental Health

The co-organisers of the meeting, UNICEF and WHO, consider adolescent mental health as one of their priority areas, and include it in their current strategies.

The adolescent mental health issues are reflected in UNICEF's Strategic Plan 2018-2021. The strategic goal of "Every child survives and thrives" includes a result area of "enhanced country action in support of gender-responsive adolescent health and nutrition", and a specific indicator "Number of countries having an inclusive, multi-sectoral and gender responsive national plan to achieve targets for adolescent health and well-being" measures the result in the plan.

The key strategies are a cross-sectoral action, youth participation and community engagement, addressing underlying determinants of health, system strengthening, and policy and service delivery support. To enhance programming, UNICEF offers gender responsive and multi-sectoral guidance on adolescent health and well-being, intervention and management packages for promotion of adolescent mental health and prevention of mental ill-health, will improve data collection on adolescent mental health, including introduction of new indicators into MICS reflecting adolescent mental health, and will provide case-studies with examples of mental health programming from development and emergency contexts. Programming will focus on four levels of interventions: 1) Universal preventive interventions which are largest in scale and are directed at the general public, for example mental health curriculums in schools; 2) Selective preventive interventions which are for individuals or sub-groups who exhibit risk factors; 3) Indicated preventive interventions which are interventions for high-risk individuals who are identified as having detectable signs or symptoms, and finally 4) Treatment which is an intervention for individuals who have a diagnosable disorder. The strategy is that most focus is given to preventive interventions as it will reduce the need for the more individualized interventions. The strategy gives a number of recommendations focusing on data generation, research, gender norms in the media, adaptation of successful programming into different country contexts, engaging adolescents in all phases of programming, and developing evidence on the cost of inaction targeting policy making.

The WHO Mental Health Action Plan for 2013-2020 calls upon international and national partners to: 'Explicitly include mental health within general and priority health policies, plans and research agenda, including non-communicable diseases, HIV/AIDS, women's health, child and adolescent health, as well as through horizontal programmes and partnerships, such as the Global Health Workforce Alliance, and other international and regional partnerships. WHO has developed guidelines through the Mental Health Gap Action Programme (mhGAP) to assist non-specialists in school and community settings in assessing and managing mental and behavioural disorders among children and adolescents, based on a systemic review of evidence and favouring integrated approaches. A new initiative by WHO, *Helping Adolescents Thrive* (HAT) is an evidence based intervention package focused on promotion and prevention, aiming to facilitate joint efforts between UNICEF and WHO and other agencies working towards adolescents mental wellbeing.

5. Annexes

Annex 1. Chronological Meeting Summary

Day 1 (17 January 2018)

Adolescent mental health and well-being: understanding the challenges and the opportunities

1. **Youth Panel** sharing experiences and perspectives from adolescents on adolescent mental health and well-being: problems, priorities, needs and preferences.

A group of 10 adolescents from Almaty presented on challenges that affect the mental health of adolescents and challenges that have affected their own mental well-being. The stories varied from exposure to criticism and negative scrutiny directed at the looks, character, and opinions of a social media influencer, resulting in severe depression and an attempted suicide, an adolescent losing a grandparent who had been the safe and close adult throughout her life, and a young boy becoming the victim of consistent bullying in a new school, resulting in suicidal thoughts.

Although reasons leading to mental health challenges were very different, all the stories had similar themes in common: Feelings of being unloved, unwanted and not being useful and good enough to others, feelings of being a burden and disappointment to their parents and families. All of the stories also had similar survival and healing processes: A possibility to talk about the situation with an adult who listened and understood, becoming convinced they were, in fact loved and cared for by their families and/or people close to them. They reflected on the importance of being able to express themselves and be heard, and on the other hand, the crushing feeling of adults who seemed not to care or take them seriously – in one case a school psychologist, a parent in another – decreasing the general trust towards adults and help being available.

Seeking for help was recognised by the adolescents as difficult because of shame that derives from the fear of not being accepted, stigma, and becoming bullied. They declared their wish to see a world of a different kind where no young person should be scared to seek for help, where others would be attentive of changed behaviour and intervene, and their willingness to drive towards change with the knowledge deriving from their own experiences.

2. **Welcoming Remarks**

Nina Ferencic, Senior Regional Adviser on Adolescent Health, Development and Participation, UNICEF Regional Office for ECAR;

Laura Akhmetniyazova, Director of the Department of Organization of Medical Care, Ministry of Health;

Oleg Chestov, Permanent Representative to Kazakhstan, World Health Organisation, Kazakhstan Country Office.

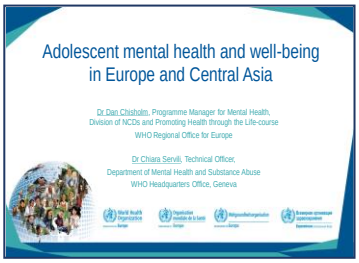
Youth must be placed in the center-stage of all the interventions. The practitioners, programme designers and implementers, and policy makers must hear the voices of the youth, build on their strengths, focusing on the strengthening the resilience, and involve them in every aspect with dignity, respect and compassion. Strengthening the connections between the adolescents and their communities, supporting adolescents' competencies to access relevant and accurate information and strengthening their coping skills should be at the core of all interventions. Interventions need to be holistic and all sector need to work towards same goals.

3. **Introduction of Participants**

The participants introduced themselves and had a possibility to ask one question each about the adolescent mental health that they would like to find an answer for during the meeting. The questions are listed below:

Prevention and detection of mental health challenges and supporting adolescents' well-being

What can we do today to support the children and youth to create a healthier and more resilient future generation of adults? How do we hear the youth?



How to identify youth in extreme situations?
How to do an early diagnosis of depression?
What age is the most critical to start prevention of mental health problems?
Are there different approaches of prevention methods to different mental health challenges?
Are the youth provided with material that is useful and what they are looking for on the mental health?
Are there differences in male and female mental health issues? Are the differences in the way we show feelings?
How to detect the child needing mental health support?
How to create favourable, preventive environments that would reduce the risk factors of mental health challenges?
How does the market environment impact the mental health of the youth today?
What is effective prevention of relapses?

Community support

How can public organisations and communities approach the issue of mental health beyond its medical aspects?
How is mental health integrated into the "adolescents as agents of change"-concept?
How to equip and able parents to better identify mental health challenges?
How can adolescents help themselves to address mental health issues and challenges?
How can adolescents help one another in addressing mental health issues?
What can public in general to do to help children in the area of mental health?
How to create a whole of society shared competence to address mental health issues?

School support

How can teacher students be prepared to become the trusted adult for their future students and pupils?
How to reach out-of-school children/youth?

International experiences

What are the best practices of other countries in addressing adolescents' mental health?
How have mental health been integrated into health policies in other countries?
What concrete ways are there to address mental health issues in Central Asia region?

What can be done for the school psychologists actually take care of our problems?

How to deal with the immense stress caused by the uncertainty of future (getting into university, the cost of studying, entering independent adult life)?

How to prevent further depression/relapses?

What can do to help younger children with mental health issues?

What can schools do to support children in becoming more resilient or immune to mental health challenges?

How can we help to improve the situation in Kazakhstan? How to improve the trust of adolescents toward adults?

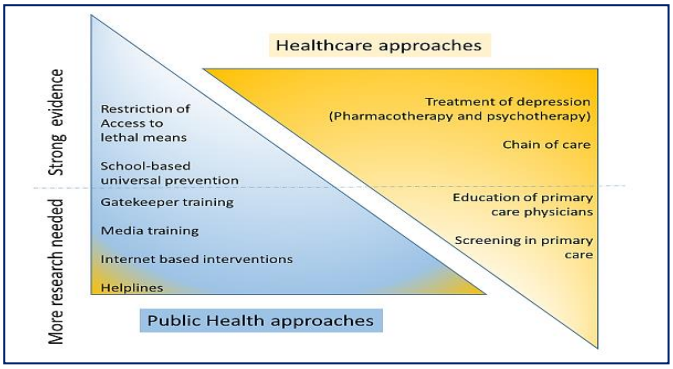
How to detect the mental health challenges among peers?

4. **Presentation: Adolescents mental health and well-being in Europe and Central Asia: Regional Overview**, *by Dan Chisholm, Programme Manager for Mental Health, WHO Regional Office for Europe, and Chiara Servili, Technical Officer, Department of Mental Health and Substance Abuse, WHO Headquarters*

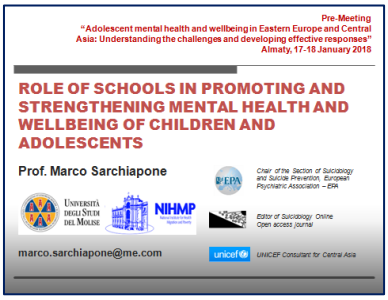
This introductory presentation outlines (i) the fundamental values of mental health particularly that of adolescents, vulnerability and risks affecting mental health and well-being. The situation analysis shows that up to 17 million children at the age 10-19 years have been affected by mental disorders in the WHO European Region with higher prevalence rate in the CIS countries. The presenters outlined effective interventions for promoting children and adolescents' mental health and wellbeing and preventing mental health problems with focus on low resource interventions implemented by non-specialists in school and community settings and through digital platforms.

5. **Presentation: Risk Factors and protective factors influencing adolescent mental health – what is the evidence saying?** *By Vladimir Carli, Co-Director of the WHO Collaborating Centre for Research, Training and Methods Development in Suicide Prevention.*

The presentation introduced SEYLE (Saving and Empowering Young Lives in Europe), a study of 12 000 adolescents from 11 European countries. The study revealed major risk groups for developing mental health issues and among them a significant in size the so-called invisible risk group demonstrating a high prevalence of psychiatric symptoms. It shows importance of physical activity and sleep as protective factors and high/pathological exposure to media particularly Internet, alcohol, bullying as risk factors for psychopathology and destructive behaviours among adolescents. In summary the presentation showed the evidence-based strategies to prevention of suicides in mental health care and public health approaches concluding the need for universal and early prevention with schools identified as a suitable arena for reaching young people.



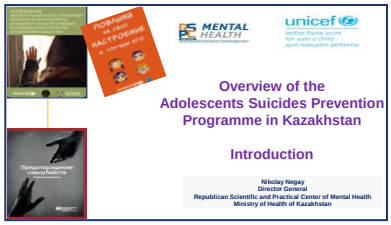
6. **Presentation: Role of schools in strengthening and promoting adolescent mental health,** *by Marco Sarchiapone, Chair of the Section of Suicidiology of the European Psychiatric Association*



The presentation justifies the importance of school based mental health promotion and suggests mental health initiatives, namely, screening, awareness raising programme and skills training, and gatekeeper training. It provides the evidence for each of the aforementioned initiatives; provides successful examples and outlines the best strategies for promoting mental health in schools concluding the need for:

- Whole-school approach
- Continuous implementation
- Focus on promotion of mental health more than on the prevention of mental illness
- Multi-component interventions more than focus on specific problem behaviours
- Social and emotional learning
- Including family, community and services

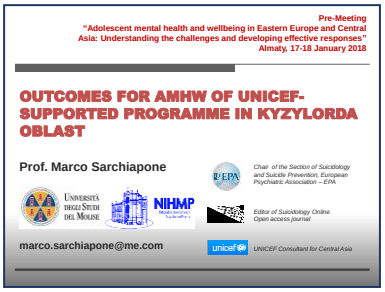
7. **Presentation: Introducing the Kazakhstan's initiative on Improving AMHW**, *By Nikolay Negay, General Director of the National Centre for Mental Health*



The presentation outlines the process of the Adolescent Suicide Prevention Programme development in Kazakhstan. It introduces the main components of the programme, namely school school- and healthcare-based

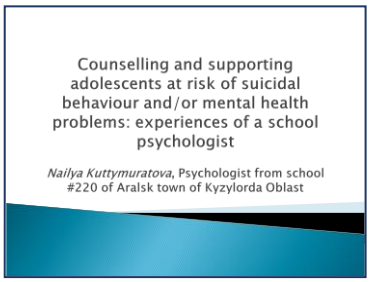
components, provides the milestones of the pilot programme in Kyzylorda Oblast and demonstrates the provisional outcomes thereof.

8. **Presentation*: Key outcomes for AMHW of the UNICEF-supported programme on the prevention of suicide among adolescents*, by** *Marco Sarchiapone, Chair of the Section of Suicidiology of the European Psychiatric Association*



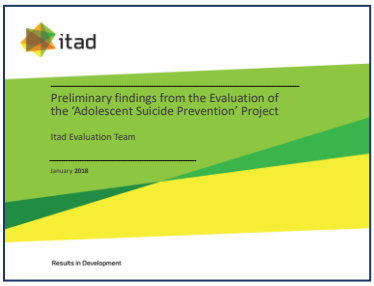
It introduces theoretical framework for development of mental health disorders in late childhood and adolescence, and provides details of Kyzylorda programme implementation and its outcomes. The presentation concludes that the Kyzylorda mental health promotion and suicide prevention programme demonstrated somewhat positive effects on the target group, including early identification of those at-risk of suicide; it revealed the need for more responsive health and education sectors, better referral, capacity building and collaboration of school and health professionals, and most importantly, an imperative for a larger mental health promotion strategy covering general population thereby reducing overall stigma related to the subject matter.

9. **Presentation: Counselling and supporting adolescents at risk of suicidal behaviour and/or mental health problems: Experiences of a school psychologist,** *By Nailya Kuttymuratova, Psychologist from School 220 of Aralsk, Kyzylorda.*



The reporter gives the details of implementation process and outcomes of the programme in Aralsk city of Kyzylorda Oblast including follow-up. It provides the worked out algorithms and the results of each programme component, and outlines the school perspectives.

10. **Presentation: Preliminary Results of the evaluation of the adolescent mental health promotion and suicide prevention programme in Kyzylorda Oblast,** *By Alexis Palfreyman, ITAD.*



The expert presented the details of the evaluation including objectives, data collection tools, sampling characteristics, and outlined preliminary findings of the on-going evaluation. The findings included the feedback of stakeholders and beneficiaries both positive and negative in relation to the programme topics and programme interventions. The evaluation also revealed the unintended effects of the pilot not initially aimed for through the project and concluded that the project brought together the different organizations and groups which otherwise would have never been able worked together.

11. **Presentation: Uptake by civil society and roll out of the adolescents' mental health promotion and suicide prevention approach in other regions of Kazakhstan***, by Yerlan Aitmukhambetov, President of Public Foundation "Bilim Foundation".*

The Head of NGO described the current process of the programme dissemination in Kazakhstan, pointing out that at present the NGO is implementing the project in 3 regions of the country with initial emphasis on capacity building followed by early detection of those at risk of mental disorders development, raising mental health awareness among adolescents and addressing the issue of the associated stigma. The use of new technologies including on-line professional development modules for professionals and quality assurance has been on the immediate implementation agenda.

12. **Presentation: The role of the health sector in supporting prevention, care and treatment of adolescents with mental health - what can PHC and mental health services do? Referring**

adolescents to PHC and mental Health Services. Inclusion of these issues within health sector reforms. *By Chiara Servili, Technical Officer, Department of Mental Health and Substance Abuse, WHO Headquarters and Vladimir Carli, Co-Director of the WHO Collaborating Centre for Research, Training and Methods Development in Suicide Prevention.*

The experts outlined a significant role of supporting policies and enabling legal framework for promotion of mental health and prevention of mental health disorders. There were presented the existing effective interventions such as EASE (Early Adolescent Skills for Emotions) and HAT (Help Adolescents Thrive). Issues: Identification of cost- effective, feasible and affordable intervention is a top research priority.

Day 2 (18 January 2018)

13. **Presentation: Twenty Years of Adolescent Mental Health and Suicide Prevention in Switzerland.** By *Pierre-Andree Michaud, Honorary Professor in Adolescent Medicine, University of Lausanne***.**

The presentation outlines a successful highly-developed country experience of adolescent mental health and suicide prevention which has been built over two decades. The example highlights the importance of cross-sectoral cooperation, policy change, involvement and participation of youth in all aspects of prevention, and the importance of safe environments.

14. Situation, experiences and key challenges in addressing AMHW in countries of Eastern Europe and Central Asia

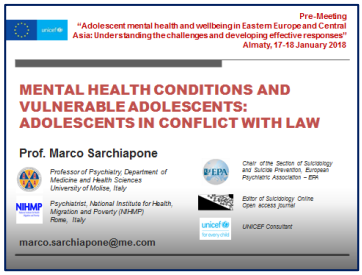
Country teams from Tajikistan, Kyrgyzstan, Uzbekistan, Belarus and Ukraine shared brief remarks on the situation and needs related to adolescent mental health, including self-harm in their countries, and reflections on some of the key opportunities and possible entry points for developing an effective response to the AMH situation.

15. **Presentation: Expanding adolescents' access to services through digital and virtual on-line services: Experiences in e-mental health and other internet based approaches.** By *Ruslan Malyuta, UNICEF ECARO.*

The presentation covers the types of interactions between patients and care providers, and how digital solutions can ease and rationalize the different type of interaction. Digital Health Solutions that rely on new technologies that have or are being developed is a fast growing area, and the presentation covers a wealth of examples of various technologies and solutions used in e-mental health, and of tools developed for various mental health needs. The presentation underlines the digital health solutions are not to replace standard patient-provider interaction and therapy, but rather to help reach, prevent and care more effectively.

16. Presentation: Mental Health conditions and vulnerability: The situation and needs of adolescents in contact with the law. By *Marco Sarchiapone, Professor of Psychiatry at University of Molise.*

The presentation covers the latest international evidence on mental health needs of adolescents in conflict with the law, and gives a brief analysis of the results of an assessment of needs of adolescents in conflict with the law in the most affected parts of Kazakhstan. The presentation concludes that the assessment indicates that Kazakh adolescents in conflict with the law are at particular risk for mental health, and appropriate treatment and intervention strategies should be developed in the country.



17. **Presentation: UNICEF's program for health and wellbeing in the Second Decade of life: A focus on Mental Health.** By *Christina de Carvalho Eriksson, UNICEF MNAH Unit, Health Section, New York.*

The presentation gave an overview of how adolescents and adolescent mental health and well-being are reflected in UNICEF's Strategic Plan 2018-2021. The strategic goal of "Every child survives and thrives" includes a result area of "enhanced country action in support of gender-responsive adolescent health and nutrition", and a specific indicator "Number of countries having an inclusive, multi-sectoral and gender responsive national plan to achieve targets for adolescent health and well-being" measures the result in the plan. The key strategies are cross-sectoral action, youth participation and community engagement, addressing underlying determinants of health, system strengthening, and policy and service delivery support.

18. **Discussion: Translating evidence into action: Outlining the key elements of the "intervention package" for programming with adolescents to address adolescent mental health and well-being, including suicide prevention.**

The participants divided themselves into four thematic groups to discuss multi-sectoral approaches and the way forward. The theme groups were 1) Role of the Health Sector in prevention and care, 2) Role and opportunities to promote AMHW through the education sector, 3) Engagement of communities, including adolescent participation, working with parents, peers, CSOs, and working with media and social networks on influencing public narratives, social norms, perceptions, and responsible reporting, and 4) Issues of data availability, collection and accessibility to support programming in AMHW.

19. **Agreement on the way forward**

Agreement on the way forward was made, committing to continue the valuable experience sharing in the region, and explore possibilities of combining forces to create cross-sectoral and cross-border AMHW interventions in future.

Annex 2. Concept Note of the Pre-meeting

1st INTERNATIONAL CONFERENCE
"PROMOTING THE MENTAL HEALTH AND WELLBEING OF CHILDREN AND ADOLESCENTS"

CONCEPT NOTE of the PRE-MEETING on Adolescent mental health and wellbeing in Eastern Europe and Central Asia: Understanding the challenges and developing effective responses

Almaty, 17-18 January 2018

Venue: Conference Hall "Altyn Emel", Hotel "Kazakhstan", 52/2 Dostyk Avenue

Background:

Globally, an estimated 67 000 adolescents die each year from self-harm, and far more – an estimated 10% of all adolescents have intentionally harmed themselves. Suicide constantly ranks among the leading causes of death for older adolescent girls and boys, while depressive disorders, anxiety, behavioural problems and self-harm are among the greatest contributors to young people's burden of disease (www.thelancet.com/child-adolescent. Published online on November 27 20017 http://dx.doi.org/10.1016/S2353-4642(17)30152-9).

Over the past few years, there has been an increasing recognition of the importance of adolescent mental health as a key component influencing the wellbeing and resilience of adolescents. Scientific advances in the fields of neurosciences and epi-genetics have provided a much greater understanding of the growth and development of the human brain from birth to adulthood. The adolescent period is particularly important because it provides a chance to reverse some of the negative influences experienced in earlier years. A large proportion of adult mental health disorders have their onset during adolescence. Yet, it is also clear that the transformations that take place during adolescence are deeply influenced by the interactions between the evolving adolescent brain and the environment in which it develops. Factors such as poverty, conflict, violence, maltreatment, stress, nutrition, socio-emotional issues, family and peer relationships, sexuality, gender norms and identity, learning, spirituality, beliefs – are just some of the factors that may have positive or negative influences on adolescent health and development throughout the life-course.

Adolescent mental health and wellbeing (AMHW) is a complex, multi-faceted area of work which is gaining increased attention in many countries globally. Effective approaches to address AMHW require a multi-disciplinary perspective informed by science and practical experiences and placed within a broader context of adolescent development. Effective approaches to AMHW require the involvement and collaboration between the health, education, protection, justice, public information and other sectors of government as well as the full involvement of civil society and communities, including parents/caregivers, and the adolescents and young people themselves.

AMHW is an area that will receive extra attention in the new UNICEF strategic plan 2018-2021. UNICEF will be working together with WHO and other key partners on developing an intervention package for risk reduction/prevention of mental & behavioural disorders and the promotion of mental health and wellbeing among adolescents, with due attention given to key issues related to gender-sensitivity and reduction of inequities. The package will be developed based on a review of the status of evidence of what is known about adolescent mental health published in peer-reviewed journals, the grey literature but also based on the experiences of practitioners working with adolescents and on the ongoing programming at country level around issues of AMHW.

The meeting in Almaty provides an opportunity to review some of the experiences in addressing prevention and promotion of AMHW in the ECA Region. As such, it is expected to contribute towards developing the global guidance.

Objectives of the meeting:

- To develop a shared understanding on the situation and needs for adolescent mental health and wellbeing (AMHW) in Eastern Europe and Central Asia;
- To share experiences on selected interventions and programming approaches to address AMHW, including prevention of self-harm and suicides;
- To develop a roadmap for effective implementation of AMHW programming and inter-sectoral collaboration so as to make a difference at country level.

Participants:

- UNICEF Country Offices and National partners from Belarus, Kazakhstan, Kyrgyzstan, Tajikistan, Ukraine and Uzbekistan
- UNICEF ECARO and HQ
- WHO: Country Office in Kazakhstan, Regional Office for Europe, HQ, and WHO collaborating centres
- Kazakhstan experts involved in AMHW at the national and subnational level
- International experts
- Civil Society Organizations
- Adolescents from Kazakhstan

Agenda of the Meeting:

The Agenda of the meeting is structured around several key themes. The meeting will start with a dialogue with a group of adolescents from Almaty, Kazakhstan who have been reflecting about adolescent mental health issues and suicide among children and young people in Kazakhstan. They will express their views and share their experiences on key elements of responding to the situation.

The **morning of Day 1** will focus on understanding the current situation, including an analysis of available data and needs of adolescents in Europe and Central Asia. This will present an opportunity to discuss what is known and what is missing in relation to existing information and data gaps, and their implications for implementation of programmes and policy decisions. The session will include information on the prevalence of mental and behavioural disorders, on burden of disease estimates – disaggregated by age and sex and by sub-region, it will also summarize what data are available through sources such as the surveys on health behaviour of school aged children. The session will also provide information on the current evidence about the main facilitating factors influencing AMHW, including life satisfaction, violence and maltreatment, sexual violence, family and school environments like stress, bullying, social networks and support, socio economic and other risk factors for mental health and well-being. The sessions will provide an opportunity to identify the main obstacles and facilitating factors for addressing AMHW and discuss some of the opportunities for intervention through the education sector.

The **afternoon of Day 1** will include an in-depth learning session about the experiences of Kazakhstan in addressing the high incidence of suicide ideation and attempts among adolescents. It will provide information on how the programme was developed and rolled out in more than 2000 schools. It will discuss the main features of the programme and the process through which the programme was scaled up. The programme will be presented from the perspectives of policymakers, practitioners, implementers and evaluators.

The day will end with a discussion on the roles and opportunities for incorporating AMHW into broader public health and health sector reforms processes.

On the **morning of Day 2** the meeting will look into experiences of other countries. It will start with a long-term view of a programme in a highly developed country (Switzerland) that has accumulated more than twenty years' experience in addressing AMHW through a broader and integrated approach to adolescent health and wellbeing involving multiple sectors of society. After this presentation, the other participating countries will have a chance to present their own challenges and concerns in the areas of AMHW and/or reflect on some of the pathways that may be appropriate as entry points for developing AMHW interventions in their own countries.

The morning session will also look into the opportunities offered through innovative technologies, including internet-based and other apps that have been developed and/or are required to ensure that adequate support

and referrals to services are accessible to adolescents in need. There will also be a chance to learn about the mental health needs of adolescents in conflict with the law, many of whom have a history of maltreatment and/or develop serious mental health conditions.

The **afternoon of Day 2** will focus on outlining some of the key elements of what would constitute an effective and implementable package of interventions for addressing AMHW in line with the specific contexts, needs and opportunities that are in place in the participating countries from Eastern Europe and Central Asia. The session will identify key elements for action in relation to data, policies, and identify possible entry points for action and cross-sectoral work with the health, education and protection sectors as well as through the engagement of civil society and communities. The session will also discuss the importance of addressing gender and equity aspects of AMHW. It will also discuss how to seize opportunities to introduce innovations and internet based technologies for reaching adolescents and accelerating service provision.

Follow up to the meeting:

The meeting will identify some of the key areas that need to be addressed in order to strengthen programming on AMHW in countries of Eastern Europe and Central Asia, as well as globally. It will identify the areas in which further work is needed and further international and cross-country cooperation should be supported – including in terms of data and evidence generation, advocacy and engagement at policy level, cross-sectoral work for enhancing AMHW programming through the health, education and protection sectors, and through community systems – including by involving parents/caregivers and supporting participation of adolescents themselves. The meeting will also agree on follow up needed in the areas of capacity building, guidance development and cooperation on use of innovations and information-based technologies for reaching and engaging with adolescents.

The meeting should contribute towards the development of more specific practical guidance on AMHW for countries to implement. It should also identify ways in which collaboration can be strengthened between WHO, UNICEF, and other international and national partners so as to facilitate further work in the area of AMHW in follow up to the meeting.

It is expected that the meeting will also result in the establishment of a technical working group composed of some key experts and country partners who can commit to taking the agenda of AMHW forward in the Region over the next two years.

Annex 3. Speakers of the Pre-Meeting

SPEAKERS of the PRE-MEETING on Adolescent mental health and wellbeing in Eastern Europe and Central Asia: Understanding the challenges and developing effective responses

Nina Ferencic, MA, PhD
United Nations Children's Fund

Nina Ferencic is an expert on HIV/AIDS, adolescent health and development, communication for social change, child rights and gender sensitive approaches to human development. She has thirty years of experience working on influencing policies and programmes designed to improve equity, resilience and health outcomes among marginalized, socially excluded populations. She has built partnerships and programmes that reach out to and improve the quality of health, education and social services which provide prevention, treatment, care and protection to populations facing multiple deprivations that are most vulnerable to HIV infection, particularly women, children and youth.
The geographic focus of her work has been on poor and middle-income countries, mostly in Latin America & the Caribbean and Eastern Europe & Central Asia.
During her career, Nina has held senior positions with the World Health Organization, including as Monitoring and Evaluation Adviser in health promotion; with the Joint United Nations Programme on HIV/AIDS (UNAIDS) as Team Leader for the Financial Initiatives section responsible for collaboration with the Global Fund to Fight AIDS, Tuberculosis and Malaria. She is currently with the UNICEF Regional Office for Europe and Central Asia where she is the Senior Advisor and Head of the section covering HIV/AIDS and Adolescent Health, Development and Participation.
Nina holds a University degree in Sociology from the City University of New York; a Masters and a PhD in Communication, Arts & Sciences from the Annenberg School of Communications, University of Pennsylvania, USA. She is fully fluent in English, Spanish, French and Croatian and has basic knowledge of Russian.

Dr. Dan Chisholm
World Health Organization (WHO)

Dr. Dan Chisholm is Programme Manager for Mental Health at the WHO Regional Office for Europe (Copenhagen, Denmark). He was formerly a Health Systems Adviser in the Department of Mental Health and Substance Abuse at WHO's headquarters office (Geneva, Switzerland). His main areas of work in WHO have included development and monitoring of global mental health plans and activities, technical assistance to WHO Member States on mental health system strengthening, and analysis of the costs and cost-effectiveness of strategies for reducing the global burden of mental disorders and other non-communicable diseases. He has published widely in these areas over the last twenty years, including as part of the Lancet's earlier series on global mental health. Most recently he co-edited the mental, neurological and substance use disorders Volume of the third edition of Disease Control Priorities (DCP-3). Dan is actively involved in the Mental Health Innovation Network, and supporting a number of NIMH International Hubs for Collaborative Research on Mental Health.

Dr. Chiara Servili
World Health Organization (WHO)

Dr Chiara Servili, is a child neuropsychiatrist and focal point for child and adolescent mental health in the Department of Mental Health and Substance Abuse at the WHO's headquarters office (Geneva, Switzerland).

Her main areas of work in WHO have included development of tools to guide the planning, implementation and evaluation of interventions and services for early detection and management of childhood-onset mental disorders and technical assistance to Member States on strategies to address children's and youth's mental health needs.

Among recent major tasks, she led efforts towards development of a number of guidelines and psychosocial intervention packages targeting non-specialist providers in primary health care, school and community settings, youths and their families, including the mhGAP module on child and adolescent mental health, being used in more than 50 countries. She is currently coordinating the field testing and evaluation of a WHO caregiver skills training program for developmental delays/disorders, working closely with international research experts and civil society organizations in 31 low-and middle-income and high-income countries. Prior to joining the WHO Department of Mental Health and Substance Abuse in Headquarters in 2010, she served the organization in the African and Eastern Mediterranean regions.

Professor Vladimir Carli
(Sweden)

Senior Lecture at the National Centre for Suicide Research and Prevention of Mental Ill-Health (NASP) at Karolinska Institutet, Co-Director of the WHO Collaborating Centre for Research, Training and Methods Development in Suicide Prevention; He collaborated with WHO and developed a section on Suicide for the mhGAP Intervention Guide; Project Leader of the Suicide Prevention through Internet and Media Based Mental Health Promotion (SUPREME) Project, funded by the European Agency for Health and Consumers (EAHC); Assistant Project Leader of the EU-funded, 7th Framework Programme projects, Saving and Empowering Young Lives in Europe (SEYLE) and Working in Europe to Stop Truancy Among Youth (WE-STAY);

Co-chair of the Working Group on "Risk Factors and Evidence Based Interventions" for the corresponding section of the WHO World Report on Suicide (Preventing Suicide: A Global Imperative); Vice President of the International Association for Suicide Prevention, Executive Board member of the Suicidology Section of the World Psychiatric Association (WPA), Secretary General of the Network on Suicide Prevention of the European College of Neuropsychopharmacology (ECNP) and the Section of Suicidology and Suicide Prevention of the European Psychiatric Association (EPA).

Professor Марко Саркьяпоне (Marco Sarchiapone) (Италия)

Associate Professor at the University of Molise (Italy); conducted research in the field of suicidology for more than 20 years, utilizing an interdisciplinary perspective, ranging from biological aspects to social and psychological correlates; Chairman of the Section on Suicidology and Suicide Prevention of the European Psychiatric Association (EPA); General Secretary of the Section on Suicidology of the World Psychiatric Association (WPA); Italian representative at the WHO/Euro Network for Suicide Prevention; former Deputy Coordinator of SEYLE (Saving and Empowering Young Lives in Europe) and WE-STAY (Working in Europe to Stop Truancy Among Youth), two research projects on the prevention of suicidal and other risk behaviours in adolescence, funded through the EU 7th Framework Programme; one of the promoters of SUPREME (Suicide Prevention by Internet and Media Based Mental Health Promotion), funded by the European Agency for Health and Consumers; Site Leader on the European project, Monitoring Suicide in Europe (MONSUE); in Italy, responsible for a large research project on psychological and genetic factors associated with violence and self-harm behavior in prisoners; former President of the 13th European Symposium on Suicide and Suicidal Behaviour.

Dr. Nikolay Negay (Kazakhstan)

Nikolay A. Negay, Ph.D., General Director of the Republican Scientific and Practical Centre for Mental Health of the Ministry of Health of the Republic of Kazakhstan (the National Mental Health Centre), Ph.D. in Psychiatry, Master of Business Administration, Economist. He participated in the working groups of several draft laws in the national healthcare; he is one of the drafters of normative legal acts in the field of mental health. Over the years, he was the Chief Psychiatrist (on the prevention of suicide) of the Ministry of Health of the Republic of Kazakhstan. He is one of the ideologists and organizers of changes in the mental health service in terms of increasing its accessibility and integration with PHC. The field of scientific interests is the prevention of suicidal behavior, forensic psychiatry and organization of the mental health service.

Professor Ppierre-Andre Michaud (Switzerland)

University Honorary professor, Faculty of biology and medicine, Lausanne
Consultant, school and adolescent health and medical education. Professor in adolescent medicine (1998-2014. Former Head of the Multidisciplinary Unit for Adolescent Health
Department of Pediatric, University hospital / CHUV, Lausanne, Switzerland. Vice Dean for Curricular Affairs (2007-2014).
His research has focused on the epidemiology of health and lifestyles of adolescents, including areas such as mental health and self-harm/suicidal conducts, as well as sexual & reproductive health, sports and physical activity, eating disorders, substance use, and youth friendly health services. Over the years, he has developed expertise in the area of school and public health, preventive interventions and policies as applied to young people. He regularly works as adviser for the WHO, UNICEF and UNFPA and has

delivered training courses in many countries (Georgia, Moldova, Russia, Saudi Arabia, Madagascar, etc.). He has written several chapters of books, including a chapter on adolescent health in the Oxford Textbook of Public Health (2014) and has published over 160 papers in peer-reviewed journals. Since the end of the nineties, he is heavily involved in the coordination of a European training curriculum in adolescent medicine and health (www.euteach.com) and has developed a strong interest in medical education. In 2012, he has received the Lifetime Achievement Award in Clinical Medicine of the Faculty of Biology & Medicine of Lausanne.

Annex 4. Programme of the Pre-meeting

1st INTERNATIONAL CONFERENCE
"PROMOTING THE MENTAL HEALTH AND WELLBEING OF CHILDREN AND ADOLESCENTS"

AGENDA of the PRE-MEETING on
Adolescent mental health and wellbeing in Eastern Europe and Central Asia: Understanding the challenges and developing effective responses
Almaty, 17-18 January 2018
Venue: Conference Hall "Altyn Emel", Hotel "Kazakhstan" (1st floor), 52/2 Dostyk Avenue

Hosted by: Government of Kazakhstan

Organized by: United Nations Children's Fund (UNICEF) in collaboration with WHO Regional Office for Europe and the Kazakhstan National Centre for Mental Health

Objectives of the pre-meeting:

- To develop a shared understanding on the situation and needs on adolescent mental health and wellbeing (AMHW) in Eastern Europe and Central Asia;
- To share experiences on selected interventions and programming approaches to address AMHW, including prevention of self-harm and suicides;
- To develop a roadmap for effective implementation of AMHW programming and inter-sectoral collaboration so as to make a difference at country level.

Participants:

- UNICEF Country offices and national partners from Belarus, Kazakhstan, Kyrgyzstan, Tajikistan, Ukraine and Uzbekistan;
- UNICEF ECARO and HQ;
- WHO: country office in Kazakhstan, Regional office for Europe, HQ, and WHO collaborating centres;
- Kazakhstan experts involved in AMHW at the national and subnational level;
- International experts;
- Civil society organizations;
- Adolescents from Kazakhstan.

DAY 1, Wednesday, 17 January 2018 (09.00-18.00)

08.30-09.00 Registration of participants

09.00-09.45

Youth Panel – sharing experiences and perspectives from adolescents on adolescent mental health and well-being: problems, priorities, needs and preferences.

09.45-10.30

Welcoming remarks:

- **UNICEF**
- **WHO**
- **Kazakhstan Government**

Introduction of participants

10.30-11.00

1. **Adolescent mental health and wellbeing in Europe and Central Asia: regional overview**
   Dan Chisholm, Programme Manager for Mental Health, WHO Regional Office for Europe

Chiara Servili, Technical Officer, Department of Mental Health and Substance Abuse, WHO Headquarters

Break – 11.00-11.30

11.30-12.00

2. **Risk factors and protective factors influencing adolescent mental health – what is the evidence saying?**
   Vladimir Carli, Senior Lecture at the National Centre for Suicide Research and Prevention of Mental Ill-Health (NASP, Karolinska Institutet), Co-Director of the WHO Collaborating Centre for Research, Training and Methods Development in Suicide Prevention

12.00-12.30

3. **Role of schools in strengthening and promoting adolescent mental health.**
   Marco Sarchiapone, Chair of the Section of Suicidiology of the European Psychiatric Association

12.30-14.00 Lunch

AFTERNOON SESSION:

Responding to the adolescents' mental health needs: engaging education and health sectors in strengthening AMHW

14.00-15.30

4. **The Kazakhstan initiative and UNICEF-supported programme to strengthen adolescent mental health and wellbeing and address mental health needs of vulnerable adolescents: achievements, lessons learned and remaining challenges.**

   - **Introducing Kazakhstan's initiative on improving AMHW:** overview, role of the education and health sectors, progress up to now
     Nikolay Negay**,** General Director of the National Centre for Mental Health
   - **Key outcomes for AMHW of the UNICEF-supported programme on the prevention of suicide among adolescents**
     Marco Sarchiapone, Chair of the Section of Suicidiology of the European Psychiatric Association
   - **Counselling and supporting adolescents at risk of suicidal behaviour and/or mental health problems: experiences of a school psychologist**
     Nailya Kuttymuratova**,** Psychologist from school #220 of Aralsk town of Kyzylorda Oblast
   - **Preliminary results of the evaluation of the adolescent mental health promotion and suicide prevention programme in Kyzylorda Oblast**
     Nicolas Avril and Alexis Palfreyman**,** ITAD (Monitoring and Evaluation for International Development)
   - **Next steps: Uptake by civil society and roll out of the adolescent mental health promotion and suicide prevention approach in other regions of Kazakhstan**
     Yerlan Aitmukhambetov, President of Public Foundation "Bilim Foundation"

Break– 15.30-16.00

16.00-17.00

5. **The role of the health sector in supporting prevention, care and treatment of adolescents with mental health – what can PHC and mental health services do? Referring adolescents to PHC and mental health services. Inclusion of these issues within health sector reforms.**
   Chiara Servili, Technical Officer, Department of Mental Health and Substance Abuse, WHO Headquarters

- ***Vladimir Carli*****,** Senior Lecture at the National Centre for Suicide Research & Prevention of Mental Ill-Health (NASP, Karolinska Institutet), Co-Director of the WHO Collaborating Centre for Research, Training & Methods Development in Suicide Prevention
- ***Nikolay Negay***, General Director of the National Centre for Mental Health

17.00-18.00

Reflecting on Day 1 – Identifying the main elements of an effective response to AMHW.

DAY 2, Thursday, 18 January 2018 (09.00-16.30)

MORNING SESSION:

Sharing experiences across countries. Definition of key elements of an effective regional response to adolescent mental health and wellbeing.

Agreement on way forward

09.00-09.45

6. **Twenty years of Adolescent Mental Health and Suicide Prevention in Switzerland**
   Pierre-Andre Michaud**,** Honorary Professor in Adolescent Medicine, University of Lausanne
   Q&A

09.45-11.00

7. **Panel discussion on the situation, experiences and key challenges in addressing AMHW in countries of Eastern Europe and Central Asia**

Each country team is invited to share some brief remarks on:

a) the situation and needs related to AMH mental health, including self-harm, in their countries
   or
b) reflections on some of the key opportunities and possible entry-points for developing an effective response to the AMH situation:

10 min each

- Tajikistan
- Kyrgyzstan
- Uzbekistan
- Belarus
- Ukraine

Discussion

11.00-11.30 Break

11.30-12.15

8. **Expanding adolescents' access to services through digital and virtual on-line services: experiences in e-mental health and other internet based approaches**
   Ruslan Malyuta**,** UNICEF ECARO

   Q&A

12.15 -13.00

9. **Mental health conditions and vulnerability: the situation and needs of adolescents in conflict with the law.**
   Marco Sarchiapone, Professor of Psychiatry at University of Molise

13.00-14.00 Lunch

AFTERNOON SESSION:

Agreement on key elements of AMHW programming and way forward.

14.00-14.15

10. **UNICEF's program for health and wellbeing in the Second Decade of life: A focus on Mental Health**
    Cristina de Carvalho Eriksson, Adolescent Health Specialist, Maternal, Newborn & Adolescent Health Unit, UNICEF Headquarter (NY)

14.15-16.00

11. **Discussion on translating evidence into action: outlining the key elements of the "intervention package" for programming with adolescents to address adolescent mental health and wellbeing, including suicide prevention**

- Role of the **health sector** in prevention, care, treatment and support for AMHW (including early intervention)
- Role and opportunities to promote AMHW through the **education sector** (information, awareness, screening)
- Engagement of **communities** – including adolescent participation, working with parents, peers, civil society organizations; working with the media and social networks on influencing public narratives, social norms, perceptions, responsible reporting.
- Seizing opportunities offered through **innovations and digital** technologies: e-mental health for broadening reach/access to services, internet-based approaches
- Incorporating AMHW into **national policy** agendas through data, evidence and advocacy, and enhancing inter-sectoral cooperation

16.00 – 16.30

12. **Enhancing regional cooperation on adolescent mental health and wellbeing and Closing of the meeting**

- Agreement on inter-agency and cross-country collaboration and way forward
- Wrap up and Closure

Annex 5. List of Participants

1st INTERNATIONAL CONFERENCE
"PROMOTING THE MENTAL HEALTH AND WELLBEING OF CHILDREN AND ADOLESCENTS"

PRE-MEETING ON
Adolescent mental health and wellbeing in Eastern Europe and Central Asia: Understanding the challenges and developing effective responses
Almaty, 17-18 January 2018

LIST OF PARTICIPANTS

##	NAME	ORGANISATION	TITLE
BELARUS			
1.	Volha Litvinava	Ministry of Health	Chief children's psychiatrist
2.	Viktoryia Khryptovich	State Institute of Higher Education under the Ministry of Education and Science	Faculty of Psychology and Pedagogical Skills
3.	Dzmitry Dziakau	Belorussian State Pedagogical University named after M.Tank	Director of the Institute of Psychology
4.	Victoria Lozuyk	UNICEF Country Office	Youth and Adolescent Development, HIV/AIDS Specialist
KAZAKHSTAN			
5.	Laura Akhmetniyazova	Ministry of Health	Director of the Department of Organization of Medical Care
6.	Dinara Mukhatayeva	Ministry of Education and Science	Chief Expert of the Department for the Protection of Children's Rights and International Cooperation
7.	Nikolay Negay	National Centre for Mental Health of the Ministry of Health	General Director
8.	Zhanna Kalmataeva	al-Farabi Kazakh National University	Dean of the Medical Faculty, High School of Public Health
9.	Gulnar Kapanova	al-Farabi Kazakh National University	Head of the Department of Health Policy and Organization of the Medical Faculty
10.	Yerlan Aitmukhambetov	NGO "Bilim Foundation"	President
11.	Gulnur Dzheksembayeva	NGO "Bilim Foundation"	Expert
12.	Symbat Abdrakhmanova	Training Center of the Department of Education of Kyzylorda Oblast	Head of the Unit of Social and Pedagogical Activities
13.	Svetlana Stelmah	East-Kazakhstan State University	Head of the Department of Psychology and Correctional Pedagogy

14.	Nailya Kuttymuratova	school #220 of Aralsk town of Kyzylorda Oblast	School psychologist
15.	Sholpan Karzhaubayeva	Kazakh Medical University of Continuing Education	Head of Chairman Office
16.	Yuri Oksamitniy	UNICEF Country Office	Representative
17.	Fiachra McAsey	UNICEF Country Office	Deputy Representative
18.	Aigul Kadirova	UNICEF Country Office	Youth and Adolescent Development Officer
19.	Kanat Sukhanberdiyev	UNICEF Country Office	Health Officer
20.	Zarina Nurmukhambetova	UNICEF Country Office	Communication Specialist
21.	Saltanat Zhumanbayeva	UNICEF Country Office	Programme Associate
KYRGYZSTAN			
22.	Gulasyl Sutueva	Ministry of Health	Chief Specialist on Menthal Health
23.	Cholpon Imanalieva	UNICEF Country Office	Health Specialist
24.	Gulzhigit Ermatov	UNICEF Country Office	Youth and Adolescent Development Officer
TAJIKISTAN			
25.	Gulnora Gulmirzoeva	UNICEF consultant	National leading expert in psychology and AMH project in Tajikistan.
26.	Nisso Kasymova	UNICEF Country office	Youth and Adolescent Development, HIV/AIDS Officer
27.	Parviz Boboev	UNICEF Country office	National Education Officer
UKRAINE			
28.	Olena Kheylo	UNICEF Country Office	HIV/AIDS Specialist
UZBEKISTAN			
29.	Akobr Abdullaev	Department on Youth Issues, Ministry of Public Education	Head of Department
30.	Bakhtiyor Mamadaliev	Department on Social Protection of Youth, Youth Union	Head of Department
31.	Gulmira Tleuova	Women's Committee	Leading specialist
32.	Inobat Akhmedova	Republican specialized scientific-practical medical Center of Pediatrics	Specialist
33.	Sharifjon Akbarov	Department on oversight of legislation implementation with regard to minors, Prosecutor General's Office	Prosecutor
34.	Fakhriddin Nizamov	UNICEF Country Office	OIC Chief of Health
35.	Yulia Oleinik	UNICEF Country Office	Chief of Social Policy
UNICEF REGIONAL OFFICE FOR EUROPE AND CENTRAL ASIA			

36.	Nina Ferencic	RO in Geneva, Switzerland.	Regional Advisor, Adolescent Development
37.	Ruslan Malyuta	Almaty RO Sub-Office	Regional HIV/AIDS Specialist
38.	Amirhossein Yarparvar	Almaty RO Sub-Office	Regional Health and Nutrition Specialist
39.	Zarema Khassenova	Almaty RO Sub-Office	Programme Assistant
UNICEF HEADQUARTER (NEW YORK)			
40.	Cristina De Carvalho Eriksson	Maternal, Newborn & Adolescent Health Unit (MNAH). Health Section, Programme Division	Adolescent Health Specialist
RESOURCE PERSONS AND PARTNERS			
41.	Chiara Servilli	WHO Headquarters, Department of Mental Health and Substance Abuse	Technical Officer
42.	Dan Chisholm	WHO Regional Office for Europe	Programme Manager for Mental Health
43.	Marco Sarchiapone	University of Molise / Section of Suicidiology of the European Psychiatric Association	Professor of Psychiatry / Chair of the Section
44.	Oleg Chestnov	WHO Country Office in Kazakhstan	Permanent Representative to Kazakhstan
45.	Pierre-Andre Michaud	Lausanne University, Faculty of biology and medicine	Honorary professor / Consultant, school and adolescent health and medical education
46.	Saltanat Yegeubayeva	WHO Country Office in Kazakhstan	National Professional Officer
47.	Vladimir Carli	National Swedish and Stockholm Centre for Suicide Research and Prevention of Mental Ill-Health (NASP). WHO Collaborating Centre for Research, Training and Methods Development in Suicide Prevention	Senior Lecturer. Co-Director
48.	Nicolas Avril	ITAD (Monitoring and Evaluation for International Development)	Team Leader
49.	Alexis Palfreyman	ITAD (Monitoring and Evaluation for International Development)	Deputy Team Leader
50.	Sini-Tuulia Numminen	Chief Rapporteur	
51.	Konstantin Osipov	Rapporteur	
52.	Alexey Radovsky	Interpreter	
53.	Raushan Nukezhanova	Interpreter	
Participants of Youth Panel			
54.	Alisher Kabylbekov	Nazarbayev Intellectual School of the Chemical-Biological Area, Almaty	

55.	Altynbek Mukhambetov	Esik "Bilim-Innovation" lyceum for young men
56.	Amina Zhaksylyk	Grammar school №56, Almaty
57.	Arman Nurbek	Esik "Bilim-Innovation" lyceum for young men
58.	Assel Sadykova	"Bilim-Innovation" lyceum for girls in Almaty
59.	Danel Sadikov	"Bilim-Innovation" lyceum for girls in Almaty
60.	Diara Bagaeva	Grammar school №56, Almaty
61.	Chingis Utegenov	Specilaized school lyceum №165 of Almaty
62.	Marya Lykova	"Bilim-Innovation" lyceum for girls in Almaty
63.	Sarah Bilgen	KIMEP, Faculty of International Relations