

Editorial: The Alliance of Mental Health and Education Regarding the Needs for Services for the Young

Following a diagnosis of the global mental health situation and an analysis of the evidence-based data, the World Health Organization (WHO) has recommended ten strategies to address the deficiencies found in a number of areas in the field of mental health. The depth and extent of the application of those strategies vary according to the level of development of each country (1). However, for both developing and developed nations, WHO has wisely recommended the use of an inter-sectoral approach. This is, simply, because the challenge of both providing an equitable answer to the mental health needs of those requiring care and improving services and programs is far too great for the health sector to tackle alone. One alliance which is essential for all levels of mental health action – promotion, and primary, secondary and tertiary prevention – is the mental health-education partnership, particularly for the population of children and adolescents, who spend many hours of the day and many months of the year in school.

Today, no one holds the mistaken notion that psychiatric disorders among the young are rare or have little impact, particularly with regard to education. For example, children with conduct disorders have been shown to generate additional health and education costs between the ages of 10 and 27 (2). The special burden on the educational system has been shown very persuasively in a study conducted in Finland on children aged 8: those with a psychiatric disorder were found to be three times more likely to receive extra tutoring or special education than children free of disorders (3). Previous studies have shown that untreated early disorders may lead to a poor educational track and, subsequently, to a poor work career (4, 5).

The Israel Survey on Mental Health among Adolescents (ISMEHA), a recent community-based study and the first ever to be conducted in Israel on psychiatric disorders in adolescents aged 14 to 17 (N=957), has found a prevalence rate of internalizing disorders (e.g., anxiety, depression, obsessive compulsive disorder) of: girls, 11.6%; boys, 4.8%; and for both genders, 8.1%. For externalizing disorders (e.g., conduct disorders) the respective rates were: 3.0%, 6.6%, and 4.8% (6).

Translating these rates into population figures implies that nearly 33,000 young Israelis in this age group are affected. Studies focusing on substance use have shown that in 2005, 9.9% of high school students – girls, 7.6% and boys, 12.1% – admitted having used illicit drugs in the preceding year (7).

The above rates need to be gauged against the specialized psychiatric resources available today. By 2008, 34.9% of the total population of Israel was less than 18 years of age (8). However, while the rate of psychiatrists in the adult population (aged 18 and over) was 23.8 per 100,000, the respective rate of child and adolescent psychiatrists in the same year was only 8.8 per 100,000 children and youth aged 0-17. Obviously, with our current human resources in the health sector we are far from being able to provide the necessary services for the youth requiring mental health care. This situation is shared by European (9) and most other countries in the world (10).

The above considerations with regard to the role of education in mental health care have been confirmed empirically in Israel, at least with reference to the age group of 14-17 years. The ISMEHA reported that while 4% of mothers of adolescents consulted a mental health specialist and 4% consulted a primary care practitioner or pediatrician about emotional or behavioral concerns regarding the adolescent, a greater proportion – 8% of mothers and 22% of adolescents – consulted a member of the educational system, usually the school counselor or the classroom teacher, for the same concerns (11). The reasons for their help-seeking choices are clear, namely, availability, easy access and little or no stigma.

Thus, two questions arise: First, are the educational staff (school health nurse, guidance counselors, teachers and principals) well prepared to assist the pupils and parents who seek mental health assistance? Second, do the community-based services provide the educational staff with the training and consultation support that they require? As far as we know, no local studies have been conducted thus far; therefore the answers still elude us.

A good example of collaboration between both sectors is the Saving and Empowering Young Lives in

Europe (SEYLE) program (coordinated by Dr. Danuta Wasserman at the Karolinska Institute in Stockholm), that includes Israel. This is a health promoting program for adolescents linked to the educational system, which is currently being assessed in Israel (<http://www.seyle.org>). Its main objectives are to lead adolescents to better health through decreased risk-taking and reduction of suicidal behaviors; to evaluate outcomes of different preventive programs; and to recommend effective, culturally-adjusted models for promoting the health of adolescents in different countries and communities. The program targets students' awareness of healthy/unhealthy behaviors and students' self-efficacy in reducing unhealthy behaviors. Additionally, it attempts to empower mental health professionals in the identification of students at risk, and teachers in the identification and referral of students in need of mental health facilities. Clearly, it is important to follow-up the outcomes of this joint health-education project.

The current limited alliance between the health and educational systems must be extended. The agenda includes advocacy: Costello et al. (12) showed that healthy public policies translate into a reduction of the prevalence of disorders among the young. Therefore, it is incumbent upon both sectors to jointly advocate for social policies seeking to reduce the impact of socio-economic inequalities among the young and their families.

In conclusion, the alliance can take place if the community-based mental health system provides what the education sector requires in order to better fulfill its duties with reference to the mental health needs of the students and, conversely, if the educational sector recognizes and relies on its counterpart through an open and continuous dialogue in order to provide collaboratively what the students and their parents expect. The latter is even more relevant to sectors (e.g., the ultra-orthodox, the Arab-Israelis) that because of cultural or other reasons (13) do not regard the formal mental health services as their preferred source of psychiatric care.

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