CHAPTER 1

Children in the 21st Century: A Brief Overview of Children's Mental Health Issues and Psychological Well-Being in Contemporary Society

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ABSTRACT

In the 21st century, children face a unique set of challenges that were inconceivable a few decades earlier. Daily, children confront heightened stress from social pressures, academic demands, and the pervasive digital environment. The changing dynamics of family functioning, peer relationships, and cultural influences might be challenging for children's well-being and mental health. Recent studies show a significant rise in mental health issues among children in the 21st century. Before we outline how the society can help, it is important to gain some understanding of mental health issues. First, we define mental health issues, and second, we explain how mental health issues arise and develop, and which factors make children vulnerable to the development of mental health issues; third, we provide a detailed overview of the prevalence of the most common mental health issues in children and adolescents. Finally, some strategies that might contribute to the protection of children in the modern era are presented.

KEYWORDS

children, mental health issues, psychological well-being, risk and protective factors, prevention

1. Mental Health and Mental Health Issues

1.1. What Are Mental Health and Mental Health Issues?

Individuals' good mental health is not only important for their own functioning but also a benefit for the whole community. The World Health Organization (WHO)[1] defines mental health as 'a state of mental well-being that enables people to cope with the stresses of life, realise their abilities, learn well and work well, and contribute to their community'. Mental health issues (MHIs) can be defined as difficulties in coping

1 WHO, 2022b, pp. 9–163.

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with stress, realising abilities, learning, working, or contributing to the community. The International Classification of Diseases 11th Revision (ICD-11)[2] defines mental disorders as

> "...a syndrome characterized by clinically significant disturbance in individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes that underline mental and behavioural functioning. These disturbances are usually associated with distress or impairment in personal, family, social, educational, occupational, or other important areas of functioning."

MHIs and mental disorders are heavily intertwined. One distinctive difference between them is that MHIs are often presented on a continuum, while mental disorders have some specific diagnostic criteria that last for a longer time period.[3,4] MHIs can vary in severity and impact a person's daily life, relationships, and ability to function effectively.

1.2. Prevalence of Mental Health Issues

In this chapter, MHIs in children and adolescents are divided into the following categories:

- Internalised problems,[5] which include anxiety and depression
- Externalised problems,[6] which include aggressive behaviour and conduct disorder
- Attention and regulation problems,[7] which include attention-deficit/hyperactivity disorder (ADHD) and specific learning difficulties
- Problems related to digital technology use, which include problematic smartphone use and internet gaming disorder

In 2022, WHO published a *World Mental Health Report* with the subtitle *Transforming Mental Health For All.* In this report, WHO takes a closer look into specific MHIs and points to the worsening of the situation in children's mental health. WHO stated that 22% of children aged 5–19 years have some MHIs.[8] WHO points out that ADHD is the

2 WHO, 2022a, pp. 393–565.
3 WHO, 2022a, pp. 393–565.
4 WHO, 2022b, p. 13.
5 Internalised problems are problems whose effects are not apparent on the outside but rather appear in one's thoughts and emotions.
6 Externalised problems are those that have some effect on other people, such as foul language, aggressive behaviour, and destruction of property; they are focussed on behaviours towards other people, that is, their goal is to harm others.
7 These problems are part of neurodevelopmental disorders because their onset is early in development, before the start of school, and they often influence the school performance of children.
8 WHO, 2022b, pp. 9–163.

most common problem among younger children (4.6% of children); anxiety is the most common problem among adolescents of both genders (around 4.5%) and even more prominent in adolescent girls (around 5.5%), and is sometimes linked to depression.[9] In 2021, according to UNICEF, among children aged 10–14 years, 13.5% of boys and 11.2% of girls had some mental disorder, while among children aged 15–19 years, 14.1% of boys and 13.9% of girls had some mental disorder.[10] When considering both age groups, the most common mental disorders were anxiety and depression (42.9%) in both boys (31.4%) and girls (56.3%).[11]

Recent literature reviews[12,13,14,15] have shown that the COVID-19 pandemic highly influenced the mental health of children and adolescents worldwide. Especially, elevation was observed in children's and adolescent's anxiety and depression, as well as in irritability, attention problems, and problematic use of smartphones.[16,17,18] UNICEF points out that, after anxiety and depression, the most prevalent MHIs in children and adolescents are conduct disorder (20.1%) and ADHD (19.5%); both are more prevalent among boys (24.3% and 26.7%, respectively) than girls (20.1% and 19.5%, respectively).[19]

In some cases, severe anxiety and depression can lead children and adolescents to take their own lives, that is, commit suicide.[20,21] Recent data by WHO on children and adolescents worldwide show that suicide is a leading cause of death in adolescents, with UNICEF reporting that 'almost 46,000 children and adolescents between the ages of 10 and 19 end their own lives – about 1 every 11 minutes'.[22,23] Data for the whole of Europe show that suicide is the second most common cause of death in young people aged 15–19 years, right after road injuries, with 6 deaths a year for every 100,000 population.[24] Eurostat data show that in 2020, of all European countries, Estonia had the highest percentage of adolescents aged 15–19 years who committed suicide (18.86%), followed by Iceland (13.47%), while Cyprus and Malta did not report any death by suicide in this age group in 2020.[25] UNICEF reported that suicide in childhood and adolescence is more prevalent in boys (59% and 71%, respectively) than girls (41%

9 Ibid.
10 UNICEF, 2021, pp. 29–174.
11 Ibid.
12 Meherali et al., 2021, p. 3432.
13 Mohler-Kuo et al., 2021, p. 4668.
14 Racine et al., 2021, pp. 1142–1150.
15 WHO, 2023, pp. 5–19.
16 Christner et al., 2021, p.1.
17 Irman et al., 2020, pp. 182–185.
18 Meherali et al., 2021, p.3432.
19 UNICEF, 2021, pp. 29–174.
20 WHO, 2022a, pp. 393–565.
21 American Psychiatric Association, 2014, pp. 155–235.
22 WHO, 2022b, pp. 9–163.
23 UNICEF, 2021, p. 17.
24 Ibid., pp. 29–174.
25 Eurostat, 2023.

and 29%, respectively).[26] On the other hand, conduct disorder is, as will be discussed later, more focussed on doing harm to other people and violating the rights of others; as such, it can be a risk factor for and an early sign of delinquency and some criminal behaviour. Research on this topic shows that adolescents are more prone to some delinquent behaviour (e.g. drinking alcohol or using drugs) than severe criminal behaviour.[27] Data from Europe are somewhat scarce, mainly because children aged below 14 years[28] are rarely sent to prison.[29] The most recent data on all European countries show that there are around 4,000 juvenile or minor inmates, who make up 0.1–6.9% of the total prison population in specific countries.[30,31] European countries are more focussed on the prevention and rehabilitation of child and adolescent delinquents, so most of the offenders are sent to rehabilitation centres for some form of community service.[32,33]

Research has shown that MHIs in children are related to less positive and more negative affects (i.e. daily, weekly, or monthly) and lower life satisfaction and well-being.[34] Well-being is most often defined as an affective and cognitive evaluation of one's life.[35] In this context, affective evaluation refers to the presence of positive affect and absence of negative affect,[36] while cognitive evaluation refers to life satisfaction—cognitive judgement of one's life and life experiences.[37,38] Life satisfaction and the overall well-being of children and adolescents reduced during the COVID-19 pandemic.[39,40,41,42,43,44]

These data should be considered seriously in terms of policymaking and intervention and prevention programmes. This is because childhood and adolescence are crucial life phases in which most mental health disorders begin, usually starting with milder MHIs.

26 Ibid.
27 American Psychiatric Association, 2014, pp. 461–481.
28 In most countries, this age limit varies from 12 to 18 years.
29 Aebi and Hashimoto, 2022, p. 1.
30 Children of Prisoners Europe, 2023, p. 1.
31 Aebi et al., 2023, p. 1.
32 Aebi and Hashimoto, 2022, p. 1.
33 Aebi et al., 2023, p. 1.
34 Chen et al., 2017, p. 341.
35 Diener et al., 2002, pp. 63–73.
36 Chen et al., 2017, p. 341.
37 Ibid.
38 Diener et al., 2002, pp. 63–73.
39 Christner et al., 2021, p. 1.
40 Cowie and Myers, 2020, p. 1.
41 Meherali et al., 2021, p. 3432.
42 Mohler-Kuo et al., 2021, p. 4668.
43 Racine et al., 2021, pp. 1142–1150.
44 WHO, 2023, pp. 5–19.

2. Evolution of Mental Health Issues: Understanding Their Development

One most well-known and comprehensive theory for the development of MHIs, which is based on both biological and psychological approaches, is the biopsychosocial model (BPS). This model represents the integration of and interaction between several factors in the aetiology of MHIs: biological, psychological, and social components. The BPS model defines MHIs as emerging from a human system that includes both physiological components (biological nervous system) and psychosocial components (e.g. relationships, family, and community).[45] Biological factors encompass the genetic predisposition to certain mental disorders, neurochemical imbalances in the brain, and other biological elements that may contribute to the development of MHIs (e.g. individuals with a family history of mental health disorders may have higher risk for development of the same disorders). Psychological factors involve the emotional, cognitive, and personal characteristics of an individual, such as stress, trauma, low self-esteem, anxiety, and depression, which contribute to the development of MHIs. Social factors are all environmental factors such as social support, family dynamics, economic circumstances, and cultural factors. Within the BPS model, MHIs develop and result from a complex interplay of multiple factors.

Factors that impact the likelihood of specific MHIs are commonly known in the literature as risk and protective factors. Risk factors are characteristics, traits, or features of an individual that increase the likelihood of them developing a particular problem.[46] Biglan et al. identify fundamental risk factors for the development of multiple MHIs, including individual, family, peer, school, community, and economical factors.[47] Table 1 presents the most common risk factors for MHIs in children in the 21st century.

The mere presence and impact of risk factors do not always result in negative outcomes. Protective factors mediate and/or moderate the effects of risk factors, thereby reducing the incidence of behavioural problems.[48] While there are numerous protective factors, some of them are mentioned and emphasised more frequently in the literature, including individual, family, school, and community strengths.[49] The risk and protective factors coexist, and their dynamic interaction usually leads to the manifestation of (un)favourable patterns and experiences. Table 1 presents the most common protective factors for MHIs in children in the 21st century.

45 Ghaemi, 2011, pp. 451–457.
46 Garmezy, 1992, p. 50.
47 Biglan et al., 2004, pp. 1–318.
48 Garmezy, 1992, p. 50.
49 Bašić, 2009, pp. 200–250.

Table 1. Some risk and protective factors for the development of MHIs among children today[50]

	Personal characteristics	Family dynamics	School environment	Community influence
Risk factors	Genetics[51,52,53]	Insecure attachment	High academic pressure[54]	COVID-19 pandemic[55,56,57,58,59]
	Onset at a young age[60]	Low socioeconomic status[61]	Unsupportive and abusive teachers[62]	Poverty[63,64]
	Female gender[65,66]	Parental conflict[67]	Financial barriers[68]	War
	Personality traits (neurotic, irritable, depressive, and affective temperament)	Parental divorce[69]	High peer pressure[70,71,72,73]	Easily available digital technology[74,7576]

50 Source: Author's own work.
51 Rayner et al., 2019, p. 1.
52 Zhang et al., 2021, pp. 1267–1281.
53 Yuan et al., 2021, p. 1.
54 UNICEF, 2021, pp. 15–174.
55 Ibid.
56 Gardner et al., 2019, p. 104082.
57 Gilsbach et al., 2021, p. 1.
58 Nearchou et al., 2020, pp. 8479.
59 Oliva et al., 2021, p. 1.
60 NHS England and Department of Health, 2015, pp. 13–75.
61 Reiss et al., 2019, p. e0213700.
62 UNICEF, 2021, pp. 15–174.
63 Bøe et al., 2017, pp. 1–11.
64 Adjei et al., 2022, p. 1.
65 Mendolia et al., 2022, p. 110458.
66 Giota and Gustafsson, 2016, pp. 253–266.
67 Cumming and Koss, 2010, p. 503.
68 Ibid.
69 Leturcq and Panico, 2019, pp. 921–951.
70 Ford et al., 2021, pp. 1467–1478.
71 Patalay et al., 2020, p. 106292.
72 Zhou et al., 2020, pp. 2090–2108.
73 UNICEF, 2021, pp. 15–174.
74 Kelly et al., 2019, pp. 59–68.
75 Twenge and Farley, 2021, pp. 207–217.
76 Twenge et al., 2022, p. 103512.

	Personal characteristics	Family dynamics	School environment	Community influence
Protective factors[77]	Intelligence	Positive family communication	School connectedness	Effective prevention policies
	Positive self-image	Parental support	Active participation in school activities	Clear norms and values
	Empathy			
	Problem-solving skills			

3. Overview of Mental Health Issues in Children and Adolescents

3.1. Internalised Problems

In most cases, internalised problems affect just the person with the problem and are sometimes harder to detect. The most common internalised problems in children are anxiety and depression, which are related to feelings of stress and loneliness.

3.1.1. Anxiety

The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (American Psychiatric Association, 2013) defines anxiety disorders as problems 'that share features of excessive fear and anxiety and related behavioral disturbances'.[78] What defines generalised anxiety disorder in both children and adults is persistent and excessive anxiety about various life domains, with the combination of some physical symptoms, such as difficulty concentrating, sleep disturbance, and muscle tension, for at least six months.[79] The prevalence of generalised anxiety disorder in children is relatively small, as about 4–5% of children and adolescents are diagnosed with it.[80,81] This is because children often have some other forms of anxiety (i.e. separation anxiety or social phobia) that are more prevalent in specific stages of childhood and adolescence and have to be distinguished from generalised anxiety disorder. The general prevalence of anxiety symptoms in children and adolescents is 15–25%, depending on the sample and country. It is also observed in research and diagnostics that girls are more prone to experiencing anxiety symptoms and being diagnosed with a disorder than boys.[82]

77 Bašić, 2009, pp. 200–250.
78 American Psychiatric Association, 2014, p. 189.
79 Ibid.
80 Gale and Millichamp, 2016, p. 1002.
81 Steinsbekk et al., 2021, pp. 527–534.
82 CDC, 2023a, p. 1.

3.1.2. Depression

According to the American Psychiatric Association (2013), the 'presence of sad, empty or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function'[83] is a sign of some depressive disorder, such as major depressive episode or disorder.

When people suffer from some depressive disorder, they experience no pleasure in daily activities, have trouble sleeping, lose energy daily, and feel worthless or guilty. To diagnose a child or adolescent with a depressive disorder, symptoms must be present for at least one year.[84] The prevalence of depression in childhood is rather small. Research shows that around 2% of children suffer from some form of depression or experience some depressive syndromes.[85,86,87] Any type of depression symptoms, including disorders, is more prevalent in adolescence. Research has shown that during adolescence, 15–20% of boys and girls suffer from some type of depression, which is more prevalent among girls.[88,89,90] Results also confirm gender differences in the prevalence of depression in adolescents: In one sample, 29.2% of girls and 11.5% of boys had at least one major depressive episode in the previous year.[91]

3.2. Externalised Problems

In children and adolescents, the most prominent form of externalised problems is aggressive behaviour, usually in the form of bullying. However, some children can also be diagnosed with conduct disorder.

According to the American Psychiatric Association (2013), the most basic symptom of conduct disorder is a repetitive pattern of behaviour that is marked with a violation of basic rights or societal norms for at least 12 months.[92] This behaviour is described as physical cruelty to people or animals, deliberate engagement of fire, breaking into someone's house, staying out late despite parental rules, bad relationships with peers, and so on. Regarding externalised problems and conduct disorder during childhood and adolescence, boys are more likely to express this type of behaviour and be diagnosed with conduct disorder.[93,94] Generally, conduct disorder is diagnosed in 5–10% of children, mainly boys. Different research points to the fact that the ratio

83 American Psychiatric Association, 2014, p. 155.
84 Ibid.
85 Juul et al., 2021, pp. 64–72.
86 Pataki and Carlson, 2016, pp. 10–14.
87 SAMHSA, 2022, pp. 1–72.
88 Juul et al., 2021, pp. 64–72.
89 Pataki and Carlson, 2016, pp. 10–14.
90 SAMHSA, 2022, pp. 1–72.
91 Ibid.
92 American Psychiatric Association, 2014, p. 461.
93 Dellazizzo et al., 2020, pp. 619–626.
94 Mohammadi et al., 2021, pp. 205–225.

of conduct disorder is 2:1 for boys, with around 7% of girls and 11% of boys having conduct disorder.[95,96]

3.3. Attention and Regulation Problems

ADHD is an impairment involving inattention, disorganisation, and hyperactivity-impulsivity. Children often have problems with focussing on certain tasks; have problems with listening, sitting still, and waiting; and often intrude on other people's activities. In diagnosing ADHD, it is very important for the symptoms to significantly interfere with everyday activities and normative development. Research shows that ADHD is more prevalent in boys than girls, in both childhood and adolescence. The global prevalence of ADHD is 7.2%. Different national surveys and global research show that its prevalence is around 2% in young children (i.e. aged 3–5 years), around 10% in older children (i.e. aged 6–11 years), and 5–13% in adolescents (i.e. aged 12–17 years).[97,98,99,100] It is also noticed that around 13% of boys are diagnosed with ADHD, compared to around 6% of girls, with the ratio being consistent in all age groups.

Children can also have other problems affecting their schoolwork and academic achievement, known in the literature as specific learning difficulties.[101] The most common ones are dyslexia, dysgraphia, and dyscalculia. These problems or difficulties are the result of neural development and/or brain functioning and are related to problems in reading or writing (dyslexia[102] and dysgraphia)[103] and mathematics (dyscalculia).[104] Research has shown that the general prevalence of specific learning disabilities is relatively high (around 20%).[105] Literature shows that 15–20% of children have dyslexia, 10–30% have dysgraphia, and 3–7% have dyscalculia.[106,107,108] The literature also suggests that specific learning difficulties are more prevalent in boys than girls, more during the childhood than adolescence. Moreover, specific learning difficulties are highly related to ADHD: Around 40% of children with some learning

95 Dellazizzo et al., 2020, pp. 619–626.
96 Mohammadi et al., 2021, pp. 205–225.
97 Polanczyk et al.,2014, p. 434.
98 Bitsko et al., 2022, pp. 1–42.
99 CDC, 2023b, p. 1.
100 Salari et al., 2023, p. 1.
101 Al-Qadri et al., 2021, p. 1.
102 A syndrome wherein a person has problems with reading certain letters (e.g. b, p, and d) because their brain cannot fully distinguish similarities in the look of these letters.
103 A syndrome where a person has problems with writing certain letters because of how they look.
104 A syndrome where a person has problems with recognising and writing numbers and distinguishing between them and generally has problems with mathematics.
105 Al-Qadri et al., 2021, p. 1.
106 Ashraf and Najam, 2020, pp. 1659–1663.
107 Haberstroh and Schulte-Korne, 2019, pp. 107–114.
108 Wagner et al., 2020, pp. 354–365.

difficulty also have ADHD, and around 25% of children with ADHD will be diagnosed with some learning difficulty.[109]

3.4. Problems Related to Digital Technology Use

Recent research shows that around 25% of older children (i.e. aged 7–11 years) and nearly 90% of adolescents (i.e. aged 12–17 years) have their own smartphones and use them for long periods during the day.[110,111] These percentages were even higher during the COVID-19 pandemic, as children attended school via online platforms and spent even more time in front of screens, with some data pointing to a rise in screen time for 50% of children compared to the time before the pandemic.[112,113,114] Previous studies identify two major concerns when discussing technology use and children's mental health: problematic smartphone use and excessive online gaming.

Problematic smartphone use is defined as the use of a smartphone for longer time periods during the day, which affects daily functioning and basic needs (e.g. eating and sleeping).[115,116] The prevalence of children who can be categorised as problematic smartphone users is 10–30%. This problem is more prominent in adolescents than in younger children, as they gain more independence as they grow older and tend to disobey parental rules. Problematic smartphone use affects different aspects of functioning in children and adolescents and can trigger MHIs.

Research shows that online gaming is an upcoming problem for mental health in children and adolescents as it shows high correlation with some MHIs.[117,118] In the latest version of the *Diagnostic and Statistical Manual of Mental Disorders*, internet gaming disorder has been categorised as 'other condition that may be a focus of clinical attention',[119] but it has not yet been classified as a disorder. It is defined as 'a pattern of excessive and prolonged Internet gaming that results in a cluster of cognitive and behavioral symptoms, including progressive loss of control over gaming, tolerance, and withdrawal symptoms, analogous to the symptoms of substance use disorders'.[120] Similar to any other addiction, basic human needs, social relationships, and daily functioning are generally affected in people with an online gaming problem.[121,122,123,124]

109 Al-Qadri et al., 2021, p. 1.
110 Auxier et al., 2020.
111 Sohn et al., 2019, p. 1.
112 Hedderson et al., 2023, p. e2256157.
113 Mokhtarinia et al., 2022, p. 681.
114 Serra et al., 2021, p. 1.
115 Park and Park, 2021, p. e0244276.
116 Sohn et al., 2019, p. 1.
117 Alrahili et al., 2023, p. 1.
118 Putra et al., 2023, pp. 196–204.
119 American Psychiatric Association, 2014, p. 783.
120 Ibid.
121 American Psychiatric Association, 2014, p. 784.
122 Alrahili et al., 2023, p. 1.
123 Putra et al., 2023, pp. 196–204.
124 Yang et al., 2023, p. 100609.

Even though gaming addiction is not yet classified as a disorder, research shows that around 3% of children and adolescents worldwide meet the criteria for gaming addiction, and this is more prevalent among boys than girls.[125,126,127]

4. What Can We Do?

4.1. Promoting Children's Well-Being and Preventing MHIs

Poor mental health has significant negative consequences on the global society and the overall economic situation because it leads to job loss, which in turn brings poverty, stigma, and discrimination. Social exclusion, violent victimisation, and human rights violations are more common among individuals with MHIs compared to the general population according to WHO.[128] A study on 30 countries in the European Union revealed that the total cost of mental, neurological, and neurodegenerative disorders in 2010 amounted to 798 billion euros.[129] A study in the United Kingdom calculated that total expenses over a person's lifetime reach 97,490 euros per child for a moderate behavioural issue and 2,981,190 euros for a severe behavioural problem.[130] Because of such consequences, it is of great importance to work on promoting mental health and well-being at an early age and on prevention, which includes timely recognition of symptoms of mental illnesses, as well as on reducing risk factors and strengthening the effects of protective factors among vulnerable groups. Mental health is a necessary precondition for the development of a sustainable society.[131,132] To protect the mental health of children and adolescents, it is necessary to invest in the promotion of mental health and prevention of MHIs.

Promotion of mental health involves all efforts to strengthen an individual's ability to respond to developmentally appropriate tasks as well as develop competencies, a sense of self-confidence, abilities, well-being, social inclusion, and the strength to cope with adversity.[133] It entails creating individual, social, and environmental conditions that are empowering and thus enable optimal health and development. Promotion that relies on a competence-enhancement model that is aimed at enhancing competencies and positive mental health should be implemented.[134] Such initiatives seek to involve individuals in processes to achieve positive mental health and improve the quality of life.

125 Alrahili et al., 2023, p. 1.
126 Putra et al., 2023, pp. 196–204.
127 Yang et al., 2023, p. 100609.
128 WHO, 2012, pp. 1–14.
129 Gustavsson et al., 2011, pp. 718–779.
130 Parsonage et al., 2014, pp. 8–33.
131 WHO, 2013, pp. 2–27.
132 WHO, 2014, pp. 11-128.
133 WHO, 2002, pp. 7–30.
134 Barry, 2001, pp. 25–34.

Prevention is defined as the process aimed at reducing the incidence and prevalence of behavioural problems and risky behaviours in children and youth.[135] It focusses on reducing modifiable risk factors and strengthening protective factors, with the goal of such preventive interventions being risk reduction. It focusses on specific MHIs, with the aim of reducing the frequency, prevalence, and severity of problems.[136] Foxcroft (2014) outlines three functions of universal, selective, and indicated prevention, which are environmental, developmental, and informational.[137] Environmental prevention includes interventions aimed at limiting the availability of opportunities for risky behaviours through various policy programmes and legal restrictions. Developmental prevention aims to promote adaptive behaviours and prevent maladaptive ones by supporting the development of skills crucial for adequate functioning in everyday life. Informational prevention relates to education and raising of awareness, thus increasing awareness of the consequences of specific risky behaviours.

Foxcroft (2014) assumes that environmental prevention will be effective for various risky behaviours.[138] It is often equated with universal prevention, but these constructs are not synonymous, primarily because environmental prevention can take on the characteristics of selective and indicated prevention. An example of environmental prevention in the context of digital technology is the introduction of a ban, legal restrictions, or activation of social media profiles for individuals aged below 18 years (children and adolescents) to prevent the negative effects of social media on the well-being of children. In this way, environmental prevention is universal but also takes on characteristics of selective prevention as it targets a specific, vulnerable group.

4.2. How Can We Protect Children in the Modern World?

Certain subgroups are at higher risk of MHIs due to increased exposure and susceptibility to unfavourable social, economic, and environmental conditions.[139] Such disadvantages are usually persistent and accumulate throughout a person's life.

Below are some recommendations and ways in which we, as a society, can contribute to promoting children's well-being and preventing MHIs in childhood. First, it is important to emphasise the significance of early intervention for children who are at higher risk of developing MHIs. Early intervention involves identifying and addressing MHIs in children as soon as possible through regular screenings and assessments in schools and healthcare settings.[140] Schools are ideally positioned to identify and address MHIs because they provide lots of opportunities for contact with children and they have staff who are familiar with children and their families and are likely to

135 WHO, 2002, pp. 7–30.
136 Barry, 2001, pp. 25–34.
137 Foxcroft, 2014, pp. 818–822.
138 Ibid.
139 WHO, 2002, pp. 7–30.
140 Guralnick, 1997; , pp. 391–345.

notice some changes in a child's behaviour.[141] They also have access to most children, including hard-to-reach groups and children, and children identified in schools are more likely to receive support and have better outcomes. In this context, there are two types of screening: universal and selective.[142] Universal screening involves assessing all students using questionnaires that provide an indication of a person's MHIs. These questionnaires can also be completed by their parents or teachers (using one or multiple gates). Selective screening, on the other hand, assesses only students known to school staff as being at higher risk. One recommendation regarding this question is the development and implementation of a systematic method of identifying children with mental health problems in schools or healthcare institutions. However, numerous obstacles hinder the implementation of screening in schools, including (1) inadequate financial resources, (2) inadequate training and supervision staff, (3) difficulty coordinating a full continuum of prevention and intervention services, (4) maintenance of quality and empirical support of services, and (5) limited evaluation of outcomes of services to improve programmes and contribute to policy improvement.[143]

The next recommendation is to educate and inform the public, as well as children, about factors that pose risks to mental health and those that provide protection, in addition to raising awareness about the symptoms and prevalence of MHIs. We can promote mental health literacy which is defined as knowledge and beliefs about MHIs that aid their recognition, management, and prevention.[144] A possible effective approach is the integration of mental health education into school programmes. Education increases awareness but also fosters empathy, reduces the stigma surrounding mental health, and equips children with healthy coping skills. Through such educational initiatives, individuals might become more proficient at identifying signs of distress, which may manifest as alterations in behaviour, mood swings, withdrawal from social activities, or a decline in academic performance. Moreover, creating an environment where open discussions about mental health can take place and reducing the associated stigma are essential. Moreover, such education has a pivotal role in sensitising the public to the importance of seeking professional help promptly, thus mitigating the potential development of severe MHIs. Nearchou et al. (2018) showed that young people's beliefs about other people's stigma towards MHIs were a stronger predictor of help-seeking intentions than their own stigma beliefs.[145] Furthermore, ensuring that children and parents have access to mental health services and eliminating barriers that hinder them from seeking help (e.g. lack of information about services, inflexible services, wait times, complex pathways, and cost) when needed are crucial. This ensures that appropriate support is readily available.

Another important recommendation is to consider the implementation of programmes designed to cultivate resilience in children, enabling them to effectively

141 Weist et al., 2007, pp. 53–58.
142 Ibid.
143 Weist et al., 2008, pp. 1–363.
144 Jorm et al., 1997, p. 186.
145 Nearchou et al., 2018, pp. 83–90.

cope with challenging life circumstances. Resilience is usually defined as a positive or protective process that reduces maladaptive outcomes under conditions of risk.[146] Resilience is nurtured by providing children opportunities to confront challenges and learn from their experiences.[147]

It is important to provide parents resources and support to enhance their parenting skills and create a nurturing family environment through some evidence-based prevention programmes. Prioritising quality family time and being free from screens can strengthen familiar bonds and reduce screen dependence.[148] Promoting physical activity and a healthy family lifestyle is also paramount, as these factors are linked to improved mental health outcomes. Establishing tech-free zones or designated times during the day and modelling healthy tech habits for children foster a balanced approach to technology.

Community engagement initiatives, such as educational campaigns and support groups within the community, are needed. Encouraging children to participate in clubs, sports, volunteering, and hobbies that may facilitate social connections with local communities can significantly contribute to their mental health and overall well-being.[149] Such activities provide opportunities for social interaction, development of socio-emotional skills, and a sense of belonging, all of which may contribute to a positive mental health outcome.

Lastly, advocating for policies and legislation that prioritise children's mental health is essential. The developed systematic mental health policy refers to the future vision of the population's mental health defined by action plans, guidelines for actions and strategies, measurable objectives, and detailed areas to which activities relate.[150] Modern mental health policy should be holistic and multisectoral, consisting of five areas that encompass

- prevention and
- treatment of MHIs,
- positive mental health and promotion,
- social policies for the equality of people with MHIs, and
- the fight against stigmatisation and discrimination.[151]

The implementation of such a policy requires the collective efforts of all organisations and sectors with the responsibility for mental health such as professional associations, prevention research groups, international organisations, governments, nongovernmental organisations, the health industry (e.g. pharmacy industry), and donors (e.g. volunteers).

146 Greenberg, 2006, pp. 139–150.
147 Southwick and Charney, 2018, pp. 1–214.
148 Roxburgh, 2006, pp. 529–553.
149 Liu et al., 2020, pp. 347–349.
150 Novak and Petek, 2015, pp. 191–221.
151 Novak and Petek, 2015, pp. 191–221; Novak and Petek, 2018, pp. 343–371.

Preventive interventions/programmes are often not comprehensive and are directed towards individual programme investments, making it challenging for them to address the existing needs of the society and achieve the desired or expected outcomes.[152] Prevention efforts are typically targeted at individuals (children), families (parents), schools (peers and teachers), or the community or neighbourhood. Such preventive activities that focus on isolated systems reflect occasional pressures and crises a community may face at a particular time, resulting in a perception of the situation's severity and the problem's prevalence. At times, issues may escalate into more significant crises that communities must subsequently grapple with. These crises, which shed light on the challenges confronting communities, serve as catalysts for the development of preventive programmes. To prevent issues from evolving into larger crises, it is crucial to proactively investigate both the risk and protective factors within the community. Efforts should be directed towards mitigating risks while enhancing protective factors. By doing so, we can not only address the immediate concerns but also work towards fostering a more resilient and mentally healthy community.

152 Novak and Petek, 2015, pp. 191–221.

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