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VIEWPOINT

Adaptive leadership in the promotion of youth mental health

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Abstract

The aim of this paper is to discuss if adaptive leadership in the promotion of youth mental health can be one driver of cultural change not only among mental health workers and patients, but also in the society as a whole, including different sectors such as health, social service, justice, and education. I present a qualitative approach both to categorise leadership practice in Europe in traditional and adaptive styles and to understand if adaptive leadership is more effective than traditional leadership in the promotion of child and youth mental health. The attempt to increase social inclusion of people with mental health problems has posed a posed significant challenges in Europe, particularly in giving priority to services for children, adolescents, and older people. Stigma appears to continue to be a significant barrier to the effective promotion of mental health. In many European countries, there is lack of political will to implement evidence-based, sustainable policies and programs concerning mental health issues. The potential practical implications for the adaptive leadership approach are significant, considering the increasing mental health issues in Europe and worldwide.

Keywords: Mental health promotion, Stigma, Youth, Adaptive leadership.

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Introduction

Nowadays, young individuals are facing new pressures and challenges in their daily lives as result of the socio-cultural and economic transformation Europe is experiencing: higher rate of divorce, lower rate of marriage, limited employment, increased mobility and competition, faster daily rhythm, more difficulties in interpersonal relations, more passive leisure activities, more obesity, among others. These constitute risk factors at individual, family, and community/societal level [1]. The associated distress can compromise their actual and future development or even end up in suicide, one of the three leading causes of youth death [2]. Promote youth leisure activities with aims, outdoor activity, interpersonal cooperation, and values, such as, sacrifice, patience (e.g. scouts, sports team, music band) can add great value to the enhancing of youth mental health care capacity and competencies in primary care and school setting [3]. Qualitative [4] and quantitative [5] data, including national and immigrant samples, from Portugal showed many similarities regarding the perspective of children/youth, and caregivers with the results from Switzerland [6,7]. For example, «Not taking drugs» was a consensual concept regarding mental health among children and caregivers in both countries as well as the perception of mental distress as «something that has to be taken seriously». Exploring mental health representations, help-seeking behaviours and perceived access barriers not only among national and immigrant families, but also among expatriate families in large samples, including professionals preparing and serving expatriate families can lead to a better adjustment of expatriates in international assignments [8].

According to the World Health Organization, by 2030 mental disorders will be the leading cause of disease burden globally [9]. Mental and substance use disorders are already leading causes of years lived with disability worldwide [10], being only half of them treated [11–14] and many not immediately treated [15–18]. In the European Union, every year more than a third of the population suffers from mental disorders [19]. Between half and three-fourths of mental disorders start during adolescence and young adulthood [20–22]. When compared to older adults, adolescents and young adults are less likely to get treatment and if they get treatment they are less likely to do so on time [15–17]. Given the need to improve access to mental health treatment for those in need, quick and low cost stigma reducing interventions that easy to administer in school settings show promise in reducing stigma across a number of measures [23,24]. These include programs to help school professionals like health education coordinators, other teachers, and psychologists working with adolescents with emotional and behavioural problems [25].

The aim of reviewing the European context concerning leadership styles in child and youth mental health is ambitious as it requires combining the powerful Harvard adaptive leadership model [26–29] with the complex issue of mental health promotion in a changing society with multiple stakeholders, conflicting interests, and no obvious solutions. It requires studying leaders at various levels in government, private, and non-profit sectors: politicians, health managers, education managers, health professionals, education professionals, and event the general civil society. Although high risk, as it might highlight effective and non-effective current leadership styles in child and youth mental health in Europe at different levels, there is a need 1) to categorise leadership practice in Europe in traditional and adaptive styles and 2) to understand if adaptive leadership is more effective than traditional leadership in the promotion of child and youth mental health in Europe Adaptive leadership is the practice of mobilising people to cope with difficult challenges and to progress. It differs from authority, power, and influence and can be practiced by anyone independently of function, status, or position. Czabanowska and colleagues [30] found that from 2000–2011 fifty-three public health leadership frameworks originated in or involved a European country on constructing then—through the Delphi method with senior public health professionals interested in education and educational leadership—an evidence-based thematic framework for leadership curriculum for public health professionals with the following areas: 1) systems thinking, 2) political leadership, 3) collaborative leadership: building and leading interdisciplinary teams, 4) leadership and communication, 5) leading change, 6) emotional intelligence and leadership in team-based organizations , 7) leadership, organizational learning and development, 8) ethics and professionalism. These authors believe in this framework to shift the focus to a more collaborative and shared leadership style, contributing to develop an adaptive leadership. According to the authors adaptive leadership is the practice of leading in uncertain and ambiguous contexts without enough evidence on problem nature and respective solution.

The effects of child and youth mental health promotion [31] as well as its financial benefits [32] are confirmed. Child and youth mental health promotion is an investment for the present and future, being recognised by the WHO Europe [2] as an important factor for the prosperity as well as social and economic stability of the WHO European Region.

Qualitative Approach in Adaptive Leadership

The concept of adaptive leadership is a practical leadership framework that helps individuals and organizations adapt and thrive in challenging environments gradually by looking at the essential and not at the expendable and bringing about a real challenge to the previous stage. This practice includes coping processes, i.e. processes to face and deal with responsibilities, problems, or difficulties, especially successfully or in a calm or adequate manner. This practice, which mobilises people to cope with difficult challenges and to progress, differs from other coping processes by enhancing the ability to perform reliably in the face of dynamically

changing task requirements.

Both to categorise leadership practice in Europe in traditional and adaptive styles and to understand if adaptive leadership is more effective than traditional leadership in the promotion of child and youth mental health in Europe, a qualitative approach is suggested in **Table 1**.

To achieve the first aim of categorising leadership practice in Europe in traditional and adaptive styles, the option is a content analysis of the national mental health plan of each European country and interviews with the national contact points for mental health. To achieve the second aim of understanding if adaptive leadership is more effective than traditional leadership in the promotion of child and youth mental health in Europe the option is to conduct focus groups and observation in two countries categorised with the traditional leadership style and two countries categorised with the adaptive leadership style. **Table 2** presents the concepts, dimensions and key indicators for the focus groups, interviews, observation, and document reviews.

Table 1. Steps of a research approach to understand adaptive leadership in the promotion of youth mental health.

General aim	Activities
to categorise leadership practice in Europe in traditional and adaptive styles	to conduct a content analysis of the national mental health plan of each EU country
	to conduct an interview with the national contact points for mental health
to understand if adaptive leadership is more effective than traditional leadership in the promotion of child and youth mental health in Europe	to conduct focus groups with multiple informants and observation in two countries categorised with the traditional leadership style
	to conduct focus groups and observation in two countries categorised with the adaptive leadership style
	to conduct a qualitative analysis of further documents of these four countries concerning child and youth mental health might be of interest to complete this study

The qualitative analysis of further documents of these four countries concerning child and youth mental health is of interest to complete this approach. Document reviews are one of the most common techniques for data collection in qualitative methods. The documents to be reviewed can be mental health legislation, health policies/plans and relevant health programs. Data can be analysed using thematic content analysis. Content analysis refers to the coding strategies employed for analysing qualitative data. In this case it involves a rigorous process of reviewing documents line by line and assigning codes based on a priori and/or emergent topics [33, 34]. If it is based on a priori topics we called it a deductive process, if it is based on emergent topics we called it an inductive process. Both processes involve the creation of codes based on an a priori or emergent classification system respectively, construction of a codebook with a list of these units, and then the identification of themes through the use of text analysis software

Table 2. Concepts, dimensions, and key indicators for focus groups, interviews, observation and document reviews.

	Concepts	Dimensions	Key indicators
Definition	one concept can have more than one dimension	groups of meanings; one dimension can have more than one indicator	number, extent, amount of
Characteristic	highly abstract	more concrete than concept but less than indicator	concrete
Examples	1. concept of promotion of youth mental health 2. primary strategies of action towards promotion of youth mental 3. help-seeking behaviours towards promotion of youth mental health 4. access facilitators towards promotion of youth mental health 5. access barriers towards promotion of youth mental health 6. main contact persons practice towards promotion of youth mental health 7. stakeholders practice promotion of youth mental health 8. system competences towards promotion of youth mental health 9. professionals competences promotion of youth mental health 10. destigmatisation strategies practice towards promotion of youth mental health	1. positive meanings of youth mental health promotion 2. negative meanings of youth mental health promotion 3. positive characteristics of mental health promotion 4. negative characteristics of mental health promotion 5. positive behaviours within mental health promotion 6. negative behaviours within mental health promotion 7. challenges within mental health promotion 8. needs among mental health promotion 9. positive experiences in mental health promotion 10. negative experiences in mental health promotion	1. number of leadership roles 2. amount of leadership skills formally gained 3. amount of leadership skills formally gained 4. extent of engaging others 5. amount of shared purpose 6. extent of impact of leadership role 7. amount of future goals 8. extent of accountability to others in leadership role 9. amount of collaborations with others 10. extent of formal or informal peers feedback within leadership role 11. extent of formal or informal supervisor feedback within leadership role 12. extent of formal or informal users feedback within leadership role

or manually. After this we can then construct a conceptual framework or theory by using a methodology called grounded theory [35] in which both a priori and emergent topics are coded.

Focus groups can be conducted with multiple informants with daily contact with mental health as patients of different ages, family members, health professionals, education professionals, and managers of small, medium, and large related organizations. These focus groups can be analysed in terms of content [36] by Mayring reduction method [37] with all ethical rigour and anonymity guarantee in accordance with international standards [38, 39] and national standards [40]. **Table 3** presents key questions to be used in the conduction of focus groups and interviews.

Conclusion

The aim of this paper was to discuss if adaptive leadership, by mobilizing people to cope with difficult challenges and to progress, can be a driver of cultural change in the promotion of youth mental health. Adolescence and young adulthood are critical times for mental illness and focus of primary prevention, requiring a different leadership from authority, power, and influence that can be practiced by anyone independently from function, status, or position for an effective early detection and prevention of mental illness.

The potential practical implications for this leadership approach are significant, considering the increasing mental health issues worldwide. This approach, if used in different cultures, including immigrants, may be also useful to compare profiles between home country and host country, e.g. psychosocial situation: mental health indicators, worries, cognitive conditions, and physical health data. One might also think about the creation of a Specialisation on Adaptive Leadership in the Promotion of Youth Mental Health as it is a determinant of well-being, with benefits for education, work, health and human development and is influenced by gender, ethnicity, religious background, immigration history, marital status, employment situation, geographical proximity, socio-economical factors, and health. The creation of a new figure or department in organisations of Adaptive Leadership in the Promotion of Youth Mental Health Experts who are proficient in human development knowledge, effective communication, compromise partnership, interdisciplinary knowledge integration, adequate assessment tools, and reflection with care of bringing generations together for mutual benefit could also help in researching and intervening in the area of youth mental health.

Finally, we can add this Adaptive Leadership Approach to the needed use of mobile-based interventions and the increased use of internet-based interventions to prevent mental illness [41]. Internet-based interventions to prevent mental illness have been primarily used in adult populations and for specific mental illnesses, like eating disorders, general anxiety, and depression rather than with young people in the general population [42] for assessment, outcome monitoring, and interventions that supersede any time or location limitations.

Table 3. Key questions for focus groups and interviews.

Key question	Example
1. Concept of Promotion of Youth Mental Health	What does it mean Promotion of Youth Mental Health?
2. Primary Strategies of Action towards Promotion of Youth Mental Health	What do you do towards Promotion of Youth Mental Health?
3. Help-seeking behaviours towards Promotion of Youth Mental Health	What does youth do when feeling very down?
4. Access Facilitators towards Promotion of Youth Mental Health	How do you think does family, peers group, primary care givers, teachers and people from the community such as priest or cultural association leader help youth access mental health care?
5. Access Barriers towards Promotion of Youth Mental Health	How do you think does family, peers group, primary care givers, teachers and people from the community such as priest or cultural association leader difficult youth access mental health care?
6. Main Contact Persons Practice towards Promotion of Youth Mental Health	Who is the first contact point in questions of Youth Mental Health and why?
7. Stakeholders Practice Promotion of Youth Mental Health	Who are parts with interest and intervention in strategy and management in the Promotion of Youth Mental Health and why?
8. System Competences towards Promotion of Youth Mental Health	Which are the things to have in attention in the system towards improving the Promotion of Youth Mental Health?
9. Professionals Competences Promotion of Youth Mental Health	Which are the things professionals shall have in attention in towards improving the Promotion of Youth Mental Health?
10. Destigmatisation Strategies Practice towards Promotion of Youth Mental Health	What is being adopt to decrease the stigma related to Youth mental Health?

Competing interests

The author declares no conflict of interest.

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