**Youth in Mental Health Care:**

**Needs, Usage Patterns, and Development of Tailored Responses**

**A Literature Review**

**Background**: Transition to adulthood is frequently characterized by changes, confusion, and the need to make decisions in multiple life areas such as education, employment, and family. Therefore, mental distress sometimes accompanies this stage. Most mental disorders manifest before the age of 25. Many young people experience mental distress that does not meet the criteria for a psychiatric diagnosis, yet impairs their functionality and quality of life. Few of these young people contact mental health services.

**Purpose of the article:** To review the patterns of utilization of public mental health services by young people experiencing mental distress, in Israel and internationally; to detail the barriers they face; and to explore the necessity of developing services tailored to their needs.

**Findings:** The review reveals various barriers to seeking treatment, such as stigma, the perception that it is possible and perhaps preferable to deal with one’s problems alone, and distrust of treatment services. Youth who do seek treatment tend to attend few sessions. Accessibility, discretion, a youthful communication style, and a focus on relevant content areas characterize interventions for youth, modeled on the Australian HeadSpace program. This program aims to provide access to mental health care for young people. It operates nationally and has branches around the world, including in Israel, to meet local needs.

**Policy implications:** This article focuses on a population of young people displaying multiple symptoms of mental distress. It presents common barriers to seeking help, and describes their patterns of accessing and utilizing treatment services. This review highlights the distinctive needs of young people and demonstrates, via a description of the HeadSpace program, the possibility of answering these needs. Establishment of the HeadSpace program in Israel, subsidized by the National Insurance Institute, reflects a growing recognition of the importance of meeting the distinctive mental health care needs of the country’s youth.

**Keywords**: young adulthood, youth, mental health care services, mental distress

**Background**

Mental distress often develops during adolescence and young adulthood. Even if distress does not meet the threshold for psychiatric diagnosis of a disorder, it can cause a decline in functioning in various life areas and impair quality of life. However, it is rare for people in these age groups to seek treatment. Those who do seek treatment often discontinue it after a minimal number of sessions. In light of the growing awareness of the need for treatment interventions tailored to this population, a number of specialized short-term care services for young people have been launched in recent years. Their goals are to improve patterns of seeking help and to make early, pre-diagnostic interventions available. One model at the forefront of this change is the Australian-based HeadSpace program. In the past decade, it has established a broad infrastructure of centers across Australia and expanded to other countries, including Israel. The goals of the current article are: to review the professional literature about the mental health challenges faced by young people in Israel and around the world; to explore young people’s patterns of utilizing mental health services; and to describe programs being implemented in various countries as a distinct response to this population, with a focus on the Australian HeadSpace model as it is being implemented in Israel.

**Literature Review**

**Mental Health During the Transition to Adulthood**

Adolescence and young adulthood are characterized by physiological, emotional, and psychological changes. The primary sexual maturation that takes place at this developmental stage is associated with considerable emotional lability and behaviors that may either promote or endanger one’s health. In addition to the physiological changes, adolescents and young adults are actively formulating their self-identity in general and their sexual and gender identity in particular. This complex process may lead to mental distress (Sawyer et al., 2012). Recently, it has been recognized that the stage of adolescence has become extended and a new phase has been defined – emerging adulthood. This stage presents distinct challenges such as confusion and uncertainty about the future, and the perception of social expectations to make decisions regarding developmental tasks such as acquiring higher education, starting a family, and finding employment (Arnett, 2007).

The rapidly changing social roles associated with this developmental stage may cause stress and mental distress. People between the ages of 12 and 25 show the highest prevalence of mental illness, which is the leading cause of disability for this age group (De Girolamo, Dagani, Purcell, Cocchi, & McGorry, 2012; Gore et al., 2011). At least 75% of mental disorders begin before the age of 25 (Kessler et al., 2005). This is no different in Israel, where it has been found that for about a quarter of the people coping with depression disorders or anxiety during their life, the disorder appeared by age 25, and often significantly earlier (Levinson, Silver, Lerner, Grinshpoon, & Levav, 2007).

Mental distress may become chronic if no response, or an inappropriate response, is given. This may negatively impact the person’s mental health, well-being, and quality of life (De Girolamo et al., 2012). Poor mental health at an early age has been linked to emotional problems and psychiatric disorders later in life (Patel, Flisher, Hetrick, & McGorry, 2007). Mental distress among young people impairs intra-personal and inter-personal interactions, and may manifest as symptoms of depression and anxiety, difficulty in decision-making, and conflict within the family (Kessler et al., 2009). At the functional level, mental distress may lead to difficulties in integrating at school, unstable employment, and poor social functioning (Hamilton, Naismith, Scott, Purcell, & Hickie, 2011). Extreme cases of mental distress may drive a person to suicide, which is the second-leading cause of death for this age group (World Health Organization, 2017).

Young people often present a multi-symptomatic picture that does not meet the definitional criteria for a diagnosis of any single disorder. Further, comorbidities are associated with the use of addictive substances (McGorry, 2013). Females have higher rates of manifesting symptoms of mental distress in comparison to males. An ongoing poor socio-economic situation negatively impacts mental health (Landstedt, Coffey, & Nygren, 2016). Engaging in questions of sexual and gender identity has also been associated with mental distress (Fergusson, Horwood, & Beautrais, 1999). The functional consequences of mental distress and the risk of chronic morbidity may become a financial burden on society, as has been reported in the United Kingdom (Fineberg et al., 2013) and Israel (Aviram & Azary-Viesel, 2015).

**The Prevalence of Mental Distress among Youth in Israel**

In accordance with the global trend mentioned above, awareness in Israel is increasing regarding the distinct characteristics and multiple challenges of the period of emerging adulthood. However, the current epidemiological data available in Israel follows the traditional differentiation between youth (ages 12-18) and adults (18 and older). According to Israel’s Central Bureau of Statistics (2017), it may be estimated that as of the end of 2014, youth in transition to adulthood (ages 12-25) represented approximately 18% of the population. An extensive survey of the general population of Israel finds that 11.8% of individuals aged 14-17 exhibit symptoms of mental disorders that cause distress and impair functioning (Farbstein et al., 2010); this is similar to much of the rest of the world. The most common mental disorders include: depression (3.3%), deficiencies in attention and concentration (3%), specific phobias (2.5%), behavioral disorders (1.8%), general anxiety disorder (1.4%), and obsessive-compulsive disorder (1.2%). Many more symptoms of mental disorders have been identified among Jews, children of single-parent families, and children with learning disabilities or sensory disabilities.

In a social survey conducted in Israel in 2013, people aged 20-24 were asked whether they had experienced various emotional difficulties (such as stress and depression) in the previous year; 14% reported experiencing two or more emotional difficulties, and 7% reported that they required psychological treatment (Kahan-Stravchinsky, Amiel & Constantinov, 2016). Among those 21 or older, 28% reported that in the year prior to the survey they experienced mental distress with which they had difficulty coping alone, and 26% said that at some time in their life they had experienced mental distress. About 55% of those reporting mental distress said they experience difficulties in daily functioning (Brammli-Greenberg & Medina-Artom, 2015; Elroy, Rosen, Elmkase, & Samuel, 2017). People in these age groups are at higher risk for attempting suicide: in 2014, about half of the females and about 41% of the males who attempted suicide were between the ages of 10 and 24 (Israel Ministry of Health, 2016).

**Patterns of Use and Barriers to Using Mental Health Services among Young People**

Interventions in the early stages of the onset of mental distress among young people may improve their mental health, well-being, productiveness, and self-fulfillment (McGorry, Goldstone, Parker, Rickwood, & Hickie, 2014). However, there is a considerable gap between the number of people in need of mental health care and the number of those receiving it (Andrade et al., 2014). An extensive national survey in the United States found that up to 80% of youth do not attempt to address their mental and emotional difficulties (Costello, He, Sampson, Kessler, & Merikangas, 2014). Utilization of mental health services by young adults is similarly low in Australia, Ireland, and the United Kingdom (McGorry, Bates, & Birchwood, 2013).

As with older adults, the reasons that prevent young adults from using mental health services are many and varied, including: stigma associated with receiving mental health care, lack of understanding the severity of the situation, fear of exposure, a perception of being able to resolve the situation alone, difficulties with transportation, lack of time, pessimism about the effectiveness of mental health care, distrust of treatment systems, and incompatibility of services with young people’s needs (Ben-David, Cole, Spencer, Jaccard, & Munson, 2017; Pottick, Bilder, Vander Stoep, Warner, & Alvarez, 2008). A meta-analysis of research on this subject identified stigma, lack of discretion, and distrust as the most common barriers (Gulliver, Griffiths, & Christensen, 2010). Examination of the sources of help to which young people in mental distress are most likely to turn indicates that they are unlikely to approach health care systems for consultation on emotional or mental health issues. Most often, they first turn to their parents. While parents play an important role in helping their children receive mental health care, they too have barriers to contacting mental health services: their level of knowledge about mental disorders and ability to recognize the severity of the symptoms; shame and fear of stigma associated with mental illness; and objective, logistical barriers associated with parental resources, such as the times needed to wait for referral and treatment and the cost of care (Reardon et al., 2017).

The pattern of not seeking or utilizing treatment services among this population is a cause for concern. There are not yet published data from Israel on these specific ages, because of the traditional division in terms of both practical services and epidemiologic research. Therefore, data on youth are presented separately from data on the general adult population, although this makes it difficult to draw conclusions about emerging adults (ages18-25).

The latest Israeli national survey on the subject reveals that professional assistance is sought by only 34% of adolescents diagnosed with symptoms of a mental disorder and by only 40% of mothers of adolescents suffering from mental disorders (Mansbach-Kleinfeld et al., 2010). School counselors and teachers were found to be the most common authorities to whom mothers turn. Only a small percentage (4%) of the mothers of these youth contacted a pediatrician. Mothers of adolescents who displaying extrinsic symptoms, such as ADHD and behavioral difficulties, are more likely to seek professional help than are mothers of adolescents with intrinsic symptoms such as depression. The same survey found that the majority of the mental health care needs of Israeli youth remained unanswered (60%) (ibid.). Among adults in Israel, only 36% of those who have experienced mental distress in the previous year sought professional treatment from a psychiatrist, psychologist, or family physician (Elroy et al., 2017).

Barriers to accessing mental health services in Israel are similar to those noted in the international literature. The main barriers identified among Israeli youth are the stigma of receiving mental health care, fear of exposure, essential distrust of mental health services, and doubts regarding the quality of the services (Kaim & Romi, 2015; Sterne & Porter, 2013). Additionally, the multitude of agencies and organizations offering services to youth creates uncertainty about the correct one to contact for assistance (Mansbach-Kleinfeld et al., 2010).

The World Health Organization (WHO) conducted a survey of adults (18 and older) who had been diagnosed with mental disorders according to DSM-IV-criteria in 24 countries including Israel (Andrade et al., 2014). It found that in Israel, personal attitudes are more common barriers to seeking help than are structural and logistical barriers (such as waiting time, accessibility, location) regardless of the severity of symptoms. The main barrier to accessing mental health services is the perception of not needing help (ibid.). This was validated in a recent survey, which found that among adults experiencing mental distress but not seeking help, the desire to deal with the problem themselves was the most common reason (cited by 49%) for not making contact with a professional (Elroy et al., 2017). Other common barriers reported were disbelief in the effectiveness of treatment, lack of information, financial cost, unavailability of services, and stigma. In other words, among youth and young adults in Israel, mental health care resources are underutilized due to a combination of personal attitudes and logistical factors.

**Youth-oriented Mental Health Services: Characteristics and Needs**

Knowledge of the fact that mental illness often first manifests during adolescence or young adulthood, awareness of the importance of early intervention, and understanding the barriers to utilizing services can guide the allocation of resources to develop interventions tailored to these age groups. However, most services still follow the traditional division between children (under 18) and adults (18 and over). They are not specifically targeted for this developmental stage, which has distinctive clinical characteristics and requires an integrative approach to emotional, familial, or behavioral issues (Kelley, de Andrade Kelley, De Andrade, Sheffer, & Bickman, 2010).

A comprehensive and current meta-analysis of a wide variety of traditional evidence-based psychological approaches and treatments concludes that psychological therapy for youth has only a moderate effect (Weisz et al., 2017). This finding is probably influenced by the paucity of studies examining the multiple syndromes affecting young people, and the difficulty of assessing the results of this clinical picture. Given this, it is not surprising that only a few countries (14 out of 191 surveyed) have a clearly-articulated policy regarding mental health services for youth and emerging adults (Shatkin & Belfer, 2004).

In response to this trend, the WHO (2012) established guidelines for health care services overall and youth-oriented services in particular. They conducted studies in several countries (beginning with Australia) to identify the mental health care needs of young people such as: discretion and the utmost concern for privacy, addressing challenges such as career development and planning for the future, reducing stigma, and improving accessibility and availability (convenient transportation, immediacy, and more). The issue of immediacy is essential, because a prolonged wait reduces the chances of beginning treatment (Westin, Barksdale, & Stephan, 2014).

It is vital to involve young people in their own care: this means respecting their desire to take care of themselves, promoting self-management skills, and engaging them at all levels and activities of the services (Malla et al., 2016; Muir, Powell, & McDermott, 2012). The general frame of reference for mental health care services for youth should focus on preventative care, optimism, and attempting to offer a positive experience. This encourages the initial appeal for help as well as persistence in treatment. Negative experiences during an initial encounter with a service (advertising materials, location, response to a phone call) inhibit young people from taking further steps to request help (Schrank, Brownell, Tylee, & Slade, 2014).

In 2015, a reform was implemented in Israel that transferred responsibility for mental health care services to the national health care clinics. The reform sought to reduce the rates of psychiatric hospitalizations and to consolidate mental health services with other health services, as a means to reduce the stigma against people facing mental illnesses (Rosen, Waitzberg, & Markur, 2015). However, despite the data on the disturbingly-high prevalence of mental illness and distress in the population, less than 5% of the health care budget is allocated to mental health, compared with about 10% of the budgets in other OECD countries. Furthermore, the distribution of mental health care clinics around the country is incomplete (Aviram & Azary-Viesel, 2015). In addition, there is currently no clear mental health care policy in Israel, and no guidelines for treatment of young people (Reuben & Turgeman, 2015). In fact, except for the pilot program, described in detail below, there are no public health services dedicated to the distinct difficulties of emerging adulthood. While there are public agencies such as social services and nonprofit organizations dedicated to at-risk youth, providing mental health care is not their primary purpose. Further, some agencies provide services to youth only up to the age of 18, while those who are 18 and over receive treatment through services for adults. Thus, services for adolescents and emerging adults are fragmented among different agencies.

Moreover, as part of the reform, receiving mental health care depends on having a diagnosis and adhering to conventional medical diagnostics. This may perpetuate associated stigmas and create a significant barrier to making initial contact. Given the current division of services, adolescents and young adults have two options: services intended for the adult population, which sometimes presents an image of chronic mental illness, or services designed for children (Sterne & Porter, 2013); neither of these is appropriate.

**Responses of Youth to Treatment**

In order to adapt mental health care to young people, the ways in which they utilize treatment services must be understood. In addition to the inherent difficulty in encouraging young people to seek help, there is a challenge in promoting their persistence in receiving treatment. Research estimates that 40% - 60% of young people discontinue treatment before completion. Among other reasons, this is often because they do not perceive the treatment as helpful (Garcia & Weisz, 2002; Miller, Southam, Gerow, & Allin, 2008). A study of youth who sought treatment at a community mental health care clinic found the average number of sessions attended was eight, and that less than one-third completed even this many (Miller et al., 2008). Since young people do not persist in long-term treatment, it is necessary to develop short-term treatments for them (Schleider & Weisz, 2017).

It is difficult to determine the characteristics predicting dropout or persistence in treatment among adolescents, and researchers are divided on this issue. For example, a study on the number of treatments required to achieve results finds that the differentiation between a minor disorder (adjustment disorders) and other disorders (depression, anxiety, etc.) is related to participation in fewer treatments, whereas exposure to stress is associated with participation in more treatments. However, the specified traits failed to predict most cases of dropout from treatment (75%) (Miller et al., 2008). This may be related to the definition of ‘dropout’. For the most part, completing the full number of sessions offered by the service is considered a desirable outcome. Discontinuation of treatment prior to reaching that number is considered dropout, a failure of the process, and non-compliance with the treatment plan (Roe & Davidson, 2017). These concepts reflect the perspective of the therapist, who sees dropout from treatment as an unsuccessful or disappointing outcome. When working with young people, there is a need to change and challenge perceptions regarding the duration of treatment and when it should end.

A recent study of the HeadSpace youth-oriented mental health care setting in Australia found that gender, symptom severity, and level of functionality predict the number of appointments made for treatment sessions, and the number of sessions attended. Males tend to make more appointments for therapeutic sessions, and those manifesting more severe symptoms attend a greater number of sessions. In contrast, among females, level of function has a stronger influence on the number of treatments than does severity of symptoms: the greater the extent of impairment to functionality, the greater the number of sessions females attend. Regarding functionality, about half of the patients exhibiting mild to moderate symptoms attended six treatments or less (Cross, Hermens, Scott, Salvador-Carulla, & Hickie, 2017).

A study conducted in Israel at the Abarbanel Medical Center’s clinic for adults found that half the patients attended five or fewer treatments, and thus did not complete treatment according to the therapist’s definition. Close to 80% of the patients stopped treatment on their own decision, for a variety of reasons including exhaustion, a sense of satisfactory improvement, or a feeling that the treatment wasn’t helping (Shamir, Szor, & Melamed, 2010). Because young people attend few treatments, it is important to assess and identify therapeutic goals in a timely manner that is best-adapted to their needs. Therefore, in recent decades, several countries have begun to dedicate clinical resources and research efforts to developing early and short-term interventions for young people.

**Attempts to Develop Age-appropriate Interventions for Young People**

Approximately a decade ago, after realizing that addressing the needs of young people is a weak point in mental health services, Australia began developing a program to provide mental health care to youth and their families, and to increase young people’s utilization of these services (De Girolamo et al., 2012). This program is based on a clinical staging model, according to which diagnosis is made along a spectrum. At one end, the person “at risk” displays only minor symptoms of distress and at the other end of the spectrum the person is suffering from a chronic mental illness (Hickie et al., 2013). This approach is highly relevant for young people because the diagnostic spectrum allows for reference to early stages of mental distress.

The HeadSpace program directs resources towards a therapeutic model that develops specialized professional expertise in youth and young-adult mental health care. HeadSpace emphasizes the involvement of young people and their families in the therapeutic process, and working with community organizations (Howe, Batchelor, Coates, & Cashman, 2014). The program is partially funded by the Australian government. This national flagship program is part of an official policy to care for the mental health of young people (McGorry et al., 2013). The centers serve young people suffering from various levels of mental distress as well as their families. They create friendly, pleasant, and accessible spaces, aimed at reducing barriers to seeking help. The centers offer interventions in the areas of mental health, alcohol and drug use, physical health, and employment services. The model is based on creating partnerships and community relations, community engagement activities, specialized clinical care, a youth-friendly environment, coordinated care, structured assessment, and participation and feedback from the young people and their families. Following these principles, the HeadSpace program strives to improve community awareness, education, training for professionals, and increasing the involvement of young people in managing their own mental health (Muir et al., 2009; Rickwood, Telford, Parker, Tanti, & McGorry, 2014).

This pioneering program has led to increased interest in and recognition of the distinctive mental health care needs of young people. Subsequently, other models for early therapeutic interventions for youth have been established. For example, in Ireland, a model called Jigsaw promotes broad community activity to raise awareness about the mental health of young people, and offers relevant treatments. In the United Kingdom, resources are being dedicated to young people, and Youthspace, a center with similar goals, was established (McGorry et al., 2013). Under the framework of a reform process underway in Canada, a multi-disciplinary team of experts and a network of government offices has been established to operate 12 centers across the country, following a model called ACCESS. Its purpose is to improve young people’s access to services, reduce stigma, encourage pre-diagnosis treatment and improve the transition between services aimed at children and youth and those offering mental health care for adults (Malla et al., 2016). The Australian HeadSpace model has been implemented in other countries, including Denmark and Israel.

**Outcomes of the Australian HeadSpace Program**

A study conducted on HeadSpace program activities in Australia in 2013-2014 found that applicants to the centers’ services exhibited a high level of psychological distress. A larger percentage of contacts were from females (62.8%) than males. The most common reasons for contacting HeadSpace (cited by about two-thirds) were symptoms of depression or anxiety. Concerns regarding sexual health and employment were among the least prevalent. Young females (ages 12 – 15) exhibited higher levels of mental distress and attended more treatments than males of the same age range.

Almost half of HeadSpace applicants exhibited a decrease in their level of psychological distress at the end of treatment, one-third showed no change, and about one-fifth showed an increased level of distress. Most of the young people who exhibited no change attended only two or three treatments. The majority of those who attended seven or more sessions showed improvement by the end of treatment (Hilferty et al., 2015). In keeping with the literature on change resulting from psychotherapy, a high level of mental distress and low psychosocial functioning predicted improvement in mental distress at the end of treatment (Cross, Hermens, & Hickie, 2016). In a program evaluation study, 93% of participants reported satisfaction with the care they received at HeadSpace centers and said the treatment helped them find strategies to manage their mental state. Moreover, their families reported satisfaction and noted that the center offered a place where they could address their concerns (Muir et al., 2009).

**HeadSpace in Israel**

The HeadSpace model was recently introduced to Israel to promote interventions for youth facing mental distress that impairs their functioning yet does not meet the threshold requirements for receiving a psychiatric diagnosis. This was done in response to this population’s pattern of low utilization of Israel’s mental health services. Program implementation is a collaboration between several agencies: the nonprofit organization “Enosh” (The Israeli Mental Health Association), the National Insurance Institute, the Schneider Children’s Medical Center in Israel, the Israel Ministry of Health, and the Municipality of Bat Yam. A HeadSpace center began operating in Bat Yam (a coastal city near Tel Aviv) in December, 2014 as a pilot program.

The HeadSpace program in Israel is geared towards young people in early stages of mental distress. It offers short-term targeted interventions of up to 15 sessions, usually held weekly. In an attempt to overcome common barriers, the center is located in an anonymous downtown office building; intake is scheduled with no waiting period; the physical space has a youth-friendly design; all team members are specially trained to work with youth; communication is egalitarian and with strict avoidance of professional jargon or intimidating language; and information is made easily accessible. The case management component of therapists’ work is based on encouraging collaboration among all relevant parties, while mediating the young people’s difficulties and challenges in adapting to their environment.

The center receives about 300 patients a year. The center has a team of psychologists, clinical social workers, and psychiatrists, all of whom are specialized in providing care to youth between the ages of 12 and 25. They offer individual or group therapy sessions, and workshops for parents. The methods used include cognitive behavioral therapy, mentalization-based treatment, and a psycho-educational approach. Therapists listen to patients’ goals for the treatment, and together they determine the preferred intervention. A young person who requires more intensive treatment than is offered at HeadSpace, but who has not contacted the appropriate agency because of the stigma, may be accepted for “preparation for treatment”; this involves working to overcome the barriers preventing the person from seeking more appropriate treatment.

Another core element of the center’s perspective and activities is the community connection. Community engagement and strengthening young people’s relationships with community resources (such as school counseling, informal education, social services) and with their peer group, can help improve awareness of mental health.

Given the large number of referrals (over 500) in the first year of operation of the HeadSpace center in Israel, it seems that such a resource is indeed necessary. Research supported by the National Insurance Institute’s fund for demonstration projects conducted an evaluation of the implementation of the model in Israel (Roe, Gerber-Epstein, Mashiach-Eizenberg, & Hoter-Yishai, 2015). Preliminary findings provide a profile of applicants. A similar percentage of males (52%) and females (48%) contact the center. Approximately 60% are between the ages of 12-15, while only 19% are 18 or older. Just over half (52%) of the applicants previously received treatment for mental distress. Applicants’ primary reasons for contacting HeadSpace include: emotional distress (46%), difficulties at school or work (20%), other reasons (20%), and arriving out of necessity (10%). Most come from families in which the parents are married (61%). For the majority (79%) their average monthly income is below the national average (as of 2015). These figures give a general picture of a new, young population seeking treatment. These young people exhibit emotional difficulties leading to a high level of distress, similar to what is seen at HeadSpace in Australia. The conclusions of the study clarify the contribution of this kind of treatment, who it can assist, and how.

**Directions for the Future**

This literature review indicates a need for a change in perception, implementation, and clinical care. In the therapeutic model described, work with youth includes activities in three primary areas: improving awareness, providing services, and training. Further, technological platforms for youth-oriented services in these areas should be developed, since this is how young people spend much of their time, and they may feel more comfortable applying for help in this way (Zukerman & Kaim, 2011).

In the area of promoting awareness of mental health, reducing stigma, and increasing appeals for help, youth-oriented mental health services should strive to help bring about a societal change in perceptions of mental health. Mental health should be viewed as a continuum rather than a binary category. It should be emphasized that psychological treatment may be helpful at various stages of mental distress. Awareness can be raised through the creation of relevant content distributed through social media channels such as Facebook, Instagram and Snapchat (Burns, Davenport, Durkin, Luscombe, & Hickie, 2010).

In terms of services, it must be recognized that technology is central to the world of young people today, and therefore should be integrated into treatment. Technology can broaden opportunities for self-help and psychoeducation, help in monitoring patients’ functioning and their emotional and cognitive state, and help maintain contact outside of in-person meetings. Use of online systems addresses young people’s need for accessibility and availability. Further, technologies may be helpful individually and in terms of systemic efficiency. Youth culture is familiar with tools such as virtual reality. When treating anxiety, for example, technological platforms may offer an alternative to actually exposing patients to anxiety-producing situations. This is especially valuable since the latter requires time and resources that can complicate treatment. Using these tools increases cooperation among some types of patients, such as young people who have a low level of communication and expression (Smokowsky & Hartung, 2003).

At the systemic level, an online service that facilitates making initial contact and receiving a response may enlarge the number of young people seeking help. Various projects around the world show high rates of online referrals. The Australian online service (eheadspace) allows for access to populations who are unlikely to use physical services, thus encouraging contact at earlier stages of mental distress (Rickwood, Webb, Kennedy, & Telford, 2016).

This review indicates that all professionals who work with young people (family physicians, pediatricians, teachers, counselors in cultural centers, etc.) should be encouraged to receive training in mental health. Such professionals are important early sources of support and referral to therapy. Developing their ability to identify mental distress among young people, promoting mental health awareness, and combatting stigma can lead to a significant change in the likelihood that people will contact agencies offering therapeutic services. A national training unit could be developed, which would improve access to information, create a shared discourse, and coordinate referrals among the various agencies offering services to youth. Moving towards youth-oriented work represents a substantial change in therapists’ work and the nature of the therapist-patient relationship. It requires flexibility, creativity, and integrative clinical work. Finally, it is important to emphasize the need for research that will contribute to a body of knowledge that can help tailor interventions to the specific needs of young people. At the systemic level, such knowledge can assist in building and formulating broad, evidence-based policies as part of early intervention and promotion of mental health for this age group.

In summary: This review examines the challenging issue of mental health for youth at global and local levels. In the last decade there has been notable increase in allocation of resources to young people from different walks of life. This review highlights the importance of focusing on their mental health, with emphasis on the early stages of onset of distress and developing targeted and appropriate treatments for them. The HeadSpace program is an example of a youth-oriented service. There is clearly room for development of a wide range of interventions, which depend on research for establishing the necessary knowledge.

**Key Points**

* Mental distress often emerges during transition to adulthood, but few people of this age group seek treatment, and when they do, they tend to attend few therapeutic sessions.
* Young people often present a multi-symptomatic picture that does not meet the necessary criteria for diagnosis, but nevertheless requires attention.
* Israel does not have a cohesive policy or principles for services dedicated to the mental health of its youth population.
* A youth-oriented program should promote and maintain a positive atmosphere, egalitarian discourse, immediacy, accessibility, respect, and confidentiality. It should encourage involvement of the young people, and offer short-term interventions.
* Around the world, individualized treatment programs for youth are being developed, which promote community awareness and targeted youth-oriented training, taking into account this group’s distinctive characteristics. Israel has established such a program based on the Australian HeadSpace project.

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