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SOCIETAL HEALTH NOTEBOOKS

Mental health and well-being

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OPENING REMARKS

Mental health and well-being in perspective

Francisco G. Nunes, Elsa Pegado

The second volume of Cadernos de Saúde Societal, under the theme of mental health and well-being, brings together the plural views of very diverse actors. The first part gives voice to a set of five individuals who, through the form of interviews, shared their perspectives on the subject. The second part gathers contributions from twelve authors who wrote six articles on the same topic.

Even though the interviewees were not asked to rely on a guiding thread, it is possible to observe the emergence of a holistic, multifaceted, societal view of mental health and well-being as a common denominator. Seeds of this global and socially situated view of human health can be traced back, for example, to the year 700 AD in the region of Hacienda Agua Salada, in the Nasca province, in present-day Peru. Examination of the mummy who came to be known as Nasca boy revealed that he suffered from tuberculosis spondylitis (Pott's disease), which he came to die from at the age of 8-10. This being a disease that clearly debilitates the daily functioning of those who contract it: "he would have felt progressively weaker, becoming, from an early age, the typical 'sick child'. If the onset of Pott's disease happened in childhood, as it appears to be the case, the demands of living with its systemic symptoms – fever, chills, anorexia, weight loss, exhaustion, and reduced immunity – would most likely lead to delays in motor development, which in turn would affect cognitive, emotional, and social development" (Tilley & Nystrom, 2019, p. 76[1]).

[1] Tilley, L. e Nystrom, K. (2019). A ´cold case´ of care: Looking at old data from a new perspective in mummy research. *International Journal of Paleopathology*, 25, 72-81.

The archaeological evidence suggests that the Nasca boy received during his lifetime, and as preparation for his afterlife, various kinds of care aimed at optimizing his general well-being. His increasing inability to keep up with the activities typical of children in that culture, such as playing, exploring, or experimenting, but also to contribute to the community's economy through his work, will have been made up for by additional care. Besides the administration of medicinal plants for pain relief, an adapted stool was built to keep him upright and enable his transportation, thus revealing concerns with the individual's social integration. Moreover, the adoption of less physically demanding activities, such as playing an instrument, would have also been part of the panoply of care measures directed at the individual as a whole. A flute was even included in the assortment of funerary artifacts, which reveals symbolic, emotional, and practical concerns from those who placed it there, at the time.

Keeping with the ancestral and holistic healthcare, well-illustrated by the Nasca boy case, to be sure, the contributions gathered in this volume reveal a remarkable evolution of thinking in the mental health and well-being phenomenon, which signals a civilizational movement, hopefully leading up to a more advanced stage in the pursuit of health and well-being for all.

In his interview, Miguel Xavier emphasizes the need to view mental health as a set of one's capabilities to enjoy life, contradicting the usual perspective, which is exclusively associated with mental illness. Drawing on the social determinants of mental health, he believes that mental health problems cannot be tackled exclusively on the basis of a biomedical model. In this sense, he advocates that policies for the prevention and promotion of mental health cannot only be based on health factors, but also, in a more comprehensive way, on social inequality factors, such as educational or labor policies.

The importance of developing activities focused on mental health prevention, rather than the usual strategies aimed at treating mental illness, is what stands out the most from Telma Almeida's interview. In a world constantly changing and in which new technologies tend to be incorporated into the daily lives of an increasing number of citizens, having tools to promote mental health and well-being, which can be available both in the workplace and at home, can be a decisive factor. In this context, social economy organizations, such as AlertaMente, may have a relevant role to play.

Although Joaquina Castelão's testimony points to several latitudes, we highlight a vision of mental health service provision anchored in the

communities, in order to maximize access to those who need it. As this care is mainly provided within families, where there is usually a designated caregiver, but also within other entities and projects that exist at the national level, including FamiliarMente, coordinating different agents will be essential to guaranteeing the continuity of services, which is central to ensure care quality.

Stressing the importance of regarding mental health as a continuum, Francisco Miranda Rodrigues warns about the need to ensure the population's timely access, under equitable conditions, to outreach psychological services, particularly in health centers, which becomes even more pressing during the pandemic and implies strengthening these services. There is also an urgent need to focus on prevention, which requires interventions at the school level, but also in organizations, by intervening on psychosocial risk factors and introducing changes in management approaches to minimize these factors.

Finally, it is worth mentioning António Reis Marques' interview, for whom it is essential to anchor strategies for the prevention and promotion of mental health and well-being in a global understanding of people, by mobilizing several fields of knowledge, such as Sociology, Psychology, and Rehabilitation, to name a few. Faced with this prerequisite to overcome differences, only professionals capable of acting, at the same time, autonomously and interdependently – a contradiction that requires both the evolution of professional identities and the exercise of integrative leadership – will be able to implement effective strategies for the prevention and promotion of mental health and well-being.

In the first article of the second part, Carla Moleiro presents a comprehensive and critical reflection on the meaning of psychopathology, suggesting that the promotion of mental health and well-being can only be achieved when this phenomenon is understood in its interdependence with the social, cultural, political, and historical contexts that shape its meaning. This proposition is illustrated by the author's use of empirical studies carried out with distinct populations, such as LGBTQI+ people, migrants, and refugees, whose mental health and well-being are often threatened.

The second article, written by Maria Antónia Pires de Almeida, reminds us that mental health is especially tested during pandemics, a sensitive topic given the period we are going through at the time of this volume's publication. The historical analysis of the generalist press during the pandemic periods of the 19th and early 20th centuries shows how fear influenced the population's behavior and how the media played a pivotal role in reducing

uncertainty about the nature of various epidemics, in disseminating appropriate ways to combat them, and even in raising the necessary funds to help the most vulnerable groups deal with the different needs brought on by the diseases. The parallels with the current pandemic situation are inevitable.

The article written by Fátima Suleman and Diana Carvalho refers to the experience of young people recently graduated from higher education and their entry to the job market during the COVID-19 pandemic. Analysis of the young participants' testimonies, as reported in newspapers and on television, reveals that the pandemic has exacerbated the precariousness that already characterized youth employment, especially when it comes to access difficulties. Its consequences on the mental health and well-being of young people are evident and are expressed through feelings of insecurity and frustration, but also symptoms such as stress, anxiety, and depression.

Marcelo Moriconi and Cátia Miriam Costa proceed from the observation that today's society is faced with four fundamental crises – sports, employment, the resignation of new generations, and immigration. In particular, they explain how physical exercise has immediate and long-term effects on the health and well-being of individuals and, furthermore, how the practice of sports provides a fruitful context for the development of a wide range of skills – personal, relational, cognitive, and contextualizing – which are fundamental for entering the job market and fostering entrepreneurship.

How to promote adapted sports as an activity to improve the health and well-being of individuals with disabilities is the central focus of the work carried out by Ana Brochado, Pedro Dionísio and Carmo Leal. Based on group interviews with key members in this field, the authors show the nature of the reasons that drive individuals to practice adapted sports and the factors that lead to its abandonment. Based on this knowledge, they present practical proposals for categories like accessibility and transportation, protocols and support, networking, optional sports in schools, associations and clubs, and events and experimentation, in order to promote the health and well-being of individuals with disabilities through sports.

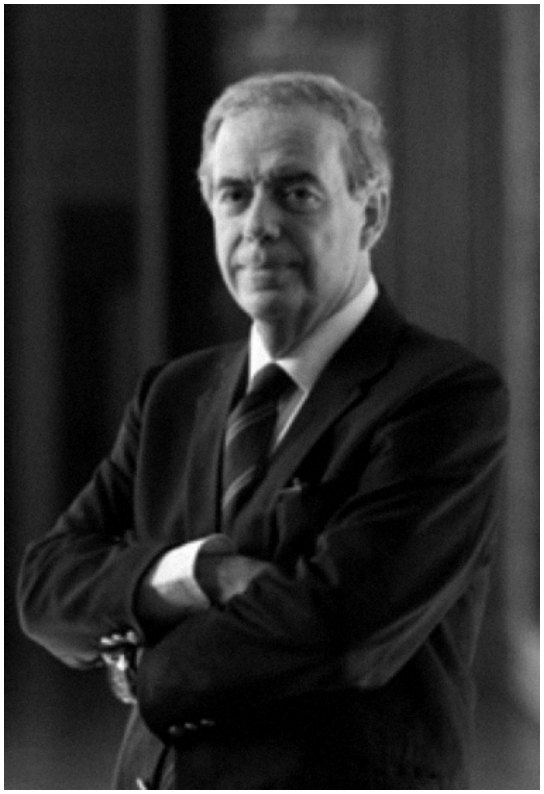
Space is a determining element of all human activity and, as such, strongly influences people's health and well-being. In this context, Susana Azevedo, Daniel Aelenei and Vasco Rato report the results of a study that analyzes the architectural characteristics of a sample of buildings used for preschool education, with emphasis on the available ventilation options. Since air circulation is a determining factor to create healthy indoor environments, these authors use their observations as a foundation to provide recommendations on the architectural design of the spaces, particularly on

the window characteristics that favor ventilation of the rooms, and, consequently, improve the health and well-being of the children.

As a whole, the interviews and articles celebrate the diversity of a theme that is as complex as it is appealing to all of those who, treading different paths, are fighting for a better world. Healthier, in this case.

PART 1

Mental health and well-being: diverse views, shared concerns



Miguel Xavier
Full Professor of Mental Health
at NOVA Medical School,
NOVA University Lisbon

Interview with the Director of National Plan for Mental Health

Interviewer: Luísa Lima, Coordinator of Iscte-Saúde and Full Professor of Social Psychology, Iscte

Mental health had immense visibility with the pandemic, and we talked more about mental health than mental illness. How do you see this transition from disease to mental health, and what are the main aspects of mental health?

Mental illness and mental health were something that we have been pressing for at least two decades. However, this takes time, has to follow its course. In my daily job, I have been trying to pass the message that mental illness is what comes to mind when we talk about mental health, and it was not supposed to because mental health is much more than that. Mental health is a skill set that we have to make life flow. And, in this sense, to restrain mental health issues to mental illness has been happening until now, a lot due to stigma, but I consider it reductive. Thus, I believe that the pandemic has contributed to the perception that these two things are different and, more than that, illness is contained on the mental health continuum. I defend the perspective that there is a continuum encompassing four dimensions with no categoric limits. And these dimensions are positive mental health, which is related to psychological well-being; psychological problems that are not yet categorised as illness, most of those that appeared during the pandemic; then psychiatric disturbances, and finally, the dimension that is on the other side of the spectrum, the incapacities. And I think we have to distinguish these four dimensions. We, as humans, wobble between these four stages, particularly between psychological well-being and having psychological problems, since none of us can escape from issues related to loss, grief, anxiety related to work, family conflicts, etc. A smaller group can evolve into a

psychiatric illness, and among those, an even smaller group develops to incapacity situations. Up until now, the problem is primarily due to stigma and because mental illnesses have been hidden from society for ages; people associate mental health with mental illness and mental illness to incapacity. This is the common association in social communication, movies, etc. And we build our concepts about health and mental health with biases.

The pandemic came to show that one can suffer psychologically without necessarily having a mental illness. And this time, that has been hard for society. On the other hand, it brought us a significant gain on social capital terms. Because I don't see these things on a strictly biomedical model, far from it. The pandemic had horrible aspects, in general terms and on mental health. However, it brought some incredible things in this area, like the sudden increase of sensibility in this dimension of our lives. We realised that we were all vulnerable during the pandemic (this is an important message). Some are more resilient, others are less, but we are all vulnerable. And if not us, our families, or our children. And why do I say the children? Because this was studied and has been proved that the age group that most suffered during the pandemic was the teenagers.

Do you think that there was a decrease in stigma? That we have a diminishing of stigma?

Because many people had suffered psychologically, this helped decrease stigma and allowed people to realise that this is a problem that moves them; that is a significant social problem. And this is why I think that our social capital has increased for all our sakes.

I don't know if there are indicators about the increase of mental health problems associated with the pandemic... increase in the suffering, of course we know.

We were able to verify that most people had psychological symptoms in the whole world, at least where there are reports, investigation studies with scientific validation. Depression, anxiety, insomnia, etc. But this doesn't necessarily mean that a person has a mental illness. We can say that this person has an adjustment disturbance. Once the psychosocial determinant decreases or disappears, the situation stabilises. And we watched this clearly because when both confinement periods ended, the indicators for ango-depressive symptoms tended to normal. This shows our essence: We are people with defence mechanisms and resilience. Sometimes we feel symptoms in situations beyond our capacity to adapt, and we tend to get better when the determinant disappears. Besides, there is a

smaller group, who already had a previous vulnerability, and in those could appear anxiety disturbance, post-traumatic stress disturbance. Still, I think we will only have quantitative evidence from this phenomenon in several months. Only then will we be able to distinguish between adjustment disturbance and severe prolonged cases, in other words, if there was a change not only in prevalence but also in incidence.

Or if cases already diagnosed have gotten worse, you mean...

And we, preventing that this would impact people, as it had, concentrated our efforts to make sure that care was available to those with more serious mental health problems. On those people, there are higher risks of psychotic decompensation and suicide.

Therefore these people's families were also suffering; it was not just the people...

In Portugal, things worked better than in most European countries because we were one of the few countries to increase the number of contacts from psychiatric services during 2020. If you look for consults in other areas, and unfortunately important areas like oncology, the same didn't happen…

And how did you achieve that?

Because we worked with decentralised network coordination, this encompasses the national coordination, the regional coordination, the ARS, primary care and local services for mental health. The efforts were concentrated on severe mental illness not to leave these people without evaluation and follow-ups, in any circumstance, even with all the difficulties found.

It was not yet the community teams, or was it?

No. In 2020/21, ten were created that were already previewed. Ten more are expected next year, ten more, and then, even more, ten on the following year. The first ten, already working, have been very useful during the pandemic.

And they guaranteed...

Not only, but also. All the services worked quite well and attended to those with severe mental illnesses. We do not have evidence of higher cases of

decompensations on the urgent assistance, although it is still early to evaluate this correctly.

Probably because of this proximity contact that you made. And talking about the problems, not the illnesses, but the issues. Some groups were more vulnerable. You mention the teenagers, but there were others, right? Probably the poorer, like in any mental health circumstance.

We expected a more significant impact on the elderly due to being separated from their families. However, the effect was more influential on teenagers, women, and the unemployed. And here there is an important message that I was trying to pass long before covid: most determinants for common mental illnesses, such as anxiety and depression, are mainly social determinants, in opposition to what happens with the severe mental conditions, where the genetic predisposition assumes a substantially more prominent part, even if not entirely known in pathogenic. Financial problems, for example, have a considerable role: all crises impact, more or less immediate, mental health and psychological suffering. Think about the escalation of the mental health situation in Portugal during Troika. People got worse primarily due to their critical financial difficulties. During the pandemic, it was not only the economic situation. How can it be expected that a person could keep good mental health in a terrible crisis of general fear and panic related to covid, aggravated by unemployment? It is not easy.

Or even for those with less-skilled jobs that had to keep working while others were doing home office.

Of course, it is also this. Like people on the hospital's front line knew they could not go away, even if they wanted to. All of these are vulnerability factors from the outside to the inside. They aren't genetic predispositions; they are social determinants with the potential of epigenetic activation. And a population's mental health (now I am talking about public health) cannot be explained exclusively by the biomedical model. It depends on the work done in terms of social determinants. This here is the critical argument. Because if someone thinks they will improve people's mental health by multiplying mental health services, they can stop fulling themselves. People's problems are solved primarily based on individual and community resources, with a good work organisation and job stability.

And prevention

And everything that leads to social inequality. Therefore, personally, I consider that inequality has a brutal driving force. Even though there is no conclusive data on this, social inequality is probably one of the most important factors to explain why mental illnesses in Portugal are significantly higher than in socially and culturally similar countries, like Spain, Italy, and even Greece. Our social inequality is closer to those existing in Anglo-Saxon countries (the United States, Australia, the United Kingdom, etc.;) that are large economies but with terrible social inequality and alarming mental health indicators.

This is why the professor defends public politics and prevention as the two paths to approach mental health issues in Portugal...

I think the basic policies aren't only just health politics. They are clear labour politics, politics on an educational level to improve mental health literacy in kids and teenagers. It doesn't seem right that a young student learns how the kidneys work but doesn't know about psychological well-being, mental health, bullying, dependency risks, suicide, etc. These decisions have to be taken outside the health area to change this. They are interministerial decisions, and we should follow the OMS recommendation "mental health in all politics". I don't see the advantage of systematically repeating studies of psychosocial risk evaluation from Portuguese workers when there is enough evidence to know what impacts the lousy quality of life for Portuguese workers: journeys to and from work, small salaries, strict policies related to flexible hours, lack of daycares, among others.

This context justifies the urgent need to bet on transversal politics that will cover all the ministries and government areas. I honestly don't believe that a country with 2/3 of its young adults in a precarious work situation could have good mental health. It is impossible.

Therefore we are at a critical moment related to mental health politics in Portugal, right? We had this increase in visibility, and we had much more money than we used to for mental health.

Much more is typically zero. As we know, mental health costs are destined to regulate services. However, over the last decades, there was no investment to hire new teams, create new programmes, and change the offer of care, which is still too focused on medicine. And there was no investment because the previous governments were not sensitive to this issue. An essential part of our job is political

pressure, in a good way, to show that the repercussions of bad mental health impact all sectors of society.

And do you think that the responses that we have are enough for our current needs?

We have the answers that other countries that made a mental health reform in Western Europe had 30 years ago. These other countries started this at the end of the eighties. They began to turn themselves to the community, de-hospitalize care, and invest more money into promotion and prevention programmes. If Portugal doesn't go in this direction, it will not go well. We are behind in many areas. And what others did in 20 years we will try to do in 5 or 6. I think now we have good conditions to move forward, learning from the experience of those before us.

From other countries, yes.

I will give you an example: people psychologically suffering due to the pandemic needed (and still need) care that was supposed to be provided by primary health care where it should be available non-pharmacological intervention, avoiding the immediate prescription of pharmaceuticals. The problem is that we don't have enough trained staff in these health centres. We should have on CSP a set of trained psychologists to manage anxiety and depression, much more extensive than we do.

We could also talk about prevention, right?

Prevention should always come first. We shouldn't be thinking about prevention only on health terms. Of course, early detection of psychological problems in primary healthcare will contribute to some not developing a disease. However, at the prevention level, from a public and community health perspective, that should act first and have to do with the conditions and circumstances necessary for a person to have any perception of well-being and inner happiness, which is related directly to mental health. Think about the following situation: a single mother of two, with a distant and precarious job, without family support, how could she have good mental health? It is unlikely. And she can't depend on a psychiatric service that will only treat her when she already has a case of severe depression. This kind of situation is widespread in a country with more than 2 million poor, and it has to be prevented. This is why using a strictly biomedical model to treat globally mental health problems is a fallacy. And to me, this is obvious.

The professor mentioned the importance of the school, the importance of work, and also the importance of family in preventing this situation. But all of this implies literacy on mental health, right?

This is the essential part of prevention at a school level. Kids can't study how the human body works and know nothing about this area directly related to their life experiences. What they will feel when they become teenagers, drug issues, bullying, anxiety, and whether it is normal to be depressed or not; are all problems that the school doesn't approach with some honourable exceptions. Some teachers talk about these issues in their spare time or inside a discipline, which benefits these kids development.

Yes, I think that at this point of the pandemic, also adults, but kids should have had training in identifying their emotions, right? Learning to know themselves better.

Exactly. We have all this work done for all of the school year. Because it is different to teach this to a fourth-grader, to a none-grader to a kid in high school. The material is prepared. Now we need a decision from the Educational Ministry. Even the decision in which discipline we will add the mental health content is political and symbolic. Should this go to biology? Some of it should, but not all of it. Should this go to citizenship? Some of it should also go, naturally. For this to happen, the citizenship discipline in our country should have the importance and the role it deserves.

Well, this is all I had to ask the professor. I don't know if you still want to add something related to mental health...

We reached a point that some conditions presented themselves, and we can see a possible change. What are they? There are three. First, there is a social sensibility on the subject. Second, the mental health agents, that for years lost time in ideological conflicts, now are more aligned with the path chosen by the National Mental Health plan, despite some inevitable different perspectives in several points. Third, for the first time in years, there is money. And I believe that all of us, independent of political circles, should try to maintain this path. We can't change it every year. It will be a shame if Portugal loses this opportunity.

Telma Almeida

AlertaMente Executive Council Director

Interview with the AlertaMente Executive Council Director

Interviewer: Cristina Camilo, Iscte-Saúde,
Invited Assistant Professor at the Department of Social and Organizational Psychology
(ECSH, Iscte)

You are focused on mental health and not on mental illness, and this is key in your intervention

Yes, our goal is to prevent. We know that mental illness is a tendency in Europe, giving all the determinants to which we are subjected, meaning our population is old. I can tell you that one among two people has dementia amongst the elderly. It is not my audience, but I know about it. Our objective is not to act on those people, since they are already a consequence, but to work on those active, meaning what happened to these people to develop a mental illness when they reached old age. This is why we talk about *active ageing* here and all over Europe. Our prevention goal is to inform and bring awareness to private sector leaders and CEOs that mental health tools can help management. AlertaMente has programmes and tools that can help control.

You started in 2018. Were there any responses that you needed to create specifically at this time due to the pandemic?

We started at a difficult time, to engage in Portugal and to show AlertaMente competencies, to put into context and realise Portuguese political position, since the new national director had just taken place.

Therefore the professor Miguel Xavier started when we formalised our Association. The position to take was given to us by the Mental Health

National Programme since, in the beginning, things were not so clear for us. What matters for us to take our mission forward is that 80% promised by the European Union will be invested. We have had a strategic agreement with the national programme for mental health since 2018, as we have with the European Union, where we are part of the Health Policy Network, also since 2018.

Amazingly, during the pandemic, we saw an increase in our workflow since we worked together with the public and the private sector. From a management point of view or a start-up entering its growing phase, it was a great start. Last year, for example, we had many programmes with PNSM like the 1º Mental Health Forum. This year we already had the second one. We also adjudicate private companies and other entities from the social sector where we are acting on mitigating possible psychosocial problems, helping in management and formation.

Several companies also come to us regarding home office, its work, and the impact. As a response, we launched an assistance plan to collaborators – PAC, wholly aligned with the World Health Organization and the EU, keeping, of course, our organisational culture and the reality of Portuguese companies. Many big companies have already joined this programme. It was interesting because we didn't pursue them it was a direct consequence of our work at all levels – *Policy-Making, Awareness, and Capacity Building.*

There were several issues related to, for example, younger people, children's mental health. There were reports of anxiety among teenagers, and that had to do with the fact that they didn't coexist with other teenagers during the pandemic. Social inequality also grew during this time. Did you respond to these issues?

We continued what was already our project. Regarding inequality, we are constantly working at this level, which is intrinsic. Now, what level of inequality are we talking about? We can see many people asking for help because they lost their job or because they were able to handle this or that. We saw people with a mental health condition enter continue care units where the interaction with the patient himself was not easy. It was mediated (between the continued care units and the families), and it also came to us. Some families came to us, and since they are our associates (we would never say no), we did the work voluntarily with pleasure.

We had other responses; for example, we gave mental health consults for free, most of them on the internet at the beginning of the pandemic, before the *Ordem dos Psicólogos* started. This happened to us and our colleagues and an almost daily propagational work to see all those responses done, even when they were not from our field. A very cool network ended up being spontaneous between the solidarity economic organisations.

Therefore you ended up creating partnerships. I know that the Ordem dos Psicólogos created a programme to support the families that didn't have access to mental health care, but in the perspective of the disease, not in health promotion, there is more your perspective.

During the pandemic, something inquisitive happened. All the symptoms of mental disturbance, I wouldn't say illnesses, manifested. And because people were in a condition that they could be more aware of them, since we were all locked in our homes, and that either we wanted or not, we were paying more attention to ourselves. This is isolation. And I think this "boom" ended up being good for mental health promotion. I think people noticed that "this is not only related to others but it is also related to all of us".

And there will be consequences that will be resolved in the short-medium term and others that will take a while to be handled. What are those that you think will last?

What is impressive about these problems we are seeing nowadays like anxiety, sleeping disturbances, stress, and panic attacks. WHO and ONU say all these problems have solutions; they possibly will not evolve into an illness; it is crucial to invest in promotion. Suppose we invest in literacy, passing on the tools, and adding them to the work environment like any other management tool necessary to productivity. In that case, we may avoid illnesses and stay only with disturbances…

And what are the main problems and the most significant gaps in mental health promotion, and what are the needs you can give a response to?

The biggest problem is that we still don't have a budget; we don't have it for mental health on a national level, meaning that several structural

issues need to be solved and end up conditioning promotion. In other words, it has to be solved quickly because if perturbances are increasing, together with the illnesses and we are sending everything to SNS, this doesn't make sense…On the other hand, we have to start working in a visible and structured way to understand these mental health determinants by learning how to manage their mental space. This has to be structured throughout all our lives, for example, if when I go to work, there is not a good environment, how my work is organised makes the execution difficult, there is a divergence between directors and other departments, ultimately there are factors that don't promote my professional development, they have to be mitigated, or my performance will not be excellent. As a consequence, national productivity will decrease.

Also, we need to bring together the Finance ministry, the Economy, and even the Modernisation ministry; all the decision-making stakeholders there aren't directly involved with mental health, but perhaps the Portuguese business sector can pay attention to them much better than listening to me or PNSM. We need a group with several people that would have almost the role of *opinion makers* and would be able to show the transversal amplitude of mental health in our society. Even more, we need to realise that every law, every law decree, every norm, every rule launched in our country has an impact on citizens mental health and when they are made, mental health can be seen as a determinant. Their execution could mitigate any possible effects on people; this is how we could build a well-being society.

But now, there is a plan for mental health. In your perspective, does it fulfil the objectives proposed?

Yes, there is a Plan and a National Programme that is decapitalised, that has no guaranteed budget, and this is how we have been living on the last two years, and since Troika. The National Programme for Mental Health, or National Plan for Mental Health, is the most effective, and it is excellent and has the solutions. The problem here is that if you ask an associate leader if they think the programme makes sense, yes, it makes sense. Now, does it make more sense if it has a budget if it has an executive guideline…because even for us associate leaders, it is tough to work like this…Most of my colleagues, or even me, work with the National Programme for Mental Health. If the budget we have is sufficient? Of course not. Or the programmes at our disposal? Also no. Is this the

fault of PNSM? Not at all; PNSM does fantastic work in the field and making the government aware of the funds. I can also add that they do this incredible job with very few human resources and without sufficient funds. *"The frustration is to know we have a Ferrari and lots of Bugattis, and they don't let us in the freeway…"*[1]

In the north of Europe models, there are interventions where there is significant community involvement. There are community groups dedicated to mental health promotion in different areas. But these are models that don't arrive in the south of Europe. Do you think those models would work in the south and Portugal, or are they related so culturally rooted that they wouldn't work in other contexts?

I think it is about losing the prejudice. I was abroad for 17 years, and I was in contact with what you are saying, the so-called third sector. In England, at this moment, if I needed a mental health centre due to a panic attack, or stress, I would have it at my disposal. And usually, it is close to the hospital, or belongs to the hospital, or belongs to a charity that does this kind of work, but the society respects that. And here is the problem. If people from the third sector provide this service with a mental health centre, like my colleagues from IPSS, it will be seen as a mental illness centre. It wouldn't be seen as proactive by society. It wouldn't be seen as a place a person can go to resolve a problem, as a disturbance, to gain the tools for it not to happen again. This is not seen this way. And here I think the problem is us as a society. Our society doesn't look for this solution; it is related to the promotion once again.

I know you have an interdisciplinary approach. How is this relevant?

Yes, in the executive council, I come from the Sciences and communication field, with a marketing specialisation, one of my colleagues is a strategist, another one is from social economics and the other from human motricity; in the capacity building, we have psychologists, psychiatrists,

[1] Free translation.

just like artists from the theatre, movies, and music, layers, people from finance…We are, in fact, interdisciplinary, which is excellent.

What is the importance of having this team with different skills to work on so many levels?

First is the organisation's sustainability because if it had only a medical area, we wouldn't have sustainability. Second, it is strategic since it is easy to work in any health area. It depends on who will lead my team because all the skills are there, which is terrific. Depending on the meeting we are having, a leader always emerges. Now we are trying to involve more people since we are growing, and we cannot do all the work.

To sum up, AlertaMente is managed with the same criteria and accuracy as a company, and our profit is the Social Benefit Created. The idea is not to look 80% of how it survives, but it develops 80% of the time. One thing I notice in Portugal is how associations are managed. It is all voluntary; it is not professionalised. AlertaMente has a professionalised structure. There are positions here; there are salaries. There is an accountant sector; there is a commitment with the state; there is a commitment with the private sector, meaning this is for real; it can't run in a voluntary scheme. It is a serious organisation with a track record.

And you think this is a model that works? Should this model work in mental health promotion beyond de communities inside the society?

We cannot only talk about communities; we need to talk about Silicon Valleys. We have to bring scientific development and reach the community and the companies, right? It irritates me to say the community in Portugal because the illness is usually next to the community. And there are always actions regarding diseases; even the ludic activities are directed to these conditions. AlertaMente is not that; we are the opposite. AlertaMente is health and its promotion.

We need a completely different approach; we need something fresh. We need a space where people like to come and talk about well-being and mental health. We need to detach from the hospitals. We need to see that mental health is a good thing. I like to think that if we give them mental health gadgets, for example, something similar to the measures watches are doing now, smartwatches? High technology can attract people my age and

young people to mental health and well-being. Not all craziness is healthy, but we also need some craziness to try something new, which will allow changing the paradigm for mental health. We need to bring the good side of mental health, which AlertaMente does every day.

Joaquina Castelão
FamiliarMente President

Interview with the FamiliarMente President

Interviewer: Diana Mendes, Iscte-Saúde, Associate Professor of Department of Quantitative Methods for Management and Economics (IBS, Iscte)

We are living in challenging times due to covid. Do you think the pandemic affected the Portuguese population's mental health?

Everyone that was already being accompanied in terms of psychiatry or mental health in hospitals or the responses from the health community was affected. All of us had to stay in our homes for a long time. Social isolation and confinement, sometimes followed by unemployment, create more significant problems for those who have already suffered from an illness. It also made new issues for those that haven't yet manifested any mental health issues. The pandemic and how we were forced to live together with the uncertainty, fear from the pandemic itself that ended up taking many lives, increased mental illnesses, primarily depressions. This increase was seen in adults, children, and teenagers since all the schools were closed for weeks/months and kids were not following their routine, were not coexisting with other kids, and started to have classes through a computer. This 24/7 routine with families living in small spaces without better living conditions caused disturbances that are still seen today.

Patients could not go to doctor's appointments, and the contact was made most of the time through the phone. We have to be aware that most hospitals are not well equipped for digital to make teleconsultations. Therefore the consults were over the phone or telegraphic. Observation and conversation between the patient and professionals in mental health are critical, and it was compromised with teleconsultations. Things are

slowly going back to normal, but unfortunately, people will have to wait for proper care until it is all normal again.

What difficulties can be identified in terms of access to care and mental health in general?

Inequality, unfortunately, still exists. The national service distribution is still asymmetric. We usually respond to treatment, stabilisation, and rehabilitation in major cities like Lisbon, Porto, and Coimbra. It doesn't mean that there is nothing in other regions, but they are insufficient to respond to every need and aren't adequate to the population's needs. We know that we can't have an organised structure with all mental health responses on our doorsteps. However, it is essential to have equal distribution through all the territory or give conditions to those that cannot access them to reach it when necessary. This is one of the FamiliarMente fights to implement and develop services for mental health so everyone can have equal access.

Mental health has always been considered the "poor relative" in health. It is a shame that not all the areas, including mental health, are not contemplated with adequate funds to allow access and treatment to people. On the other hand, an acronical mental patient doesn't have 100% co-participation in medicine regarding pharmacological treatment. Even though a bill has passed in June to provide oral and injectable antipsychotics, for this measure to work, it depends on each hospital administration, and there is an incredible difference between patient treatments in several national hospitals. Therefore we have equity problems and inequality in access to treatment.

What is the role of the family and patient associations in mental health promotion? What is the work done, and how can it be better?

In every family, there is always the one who assumes the responsibility of caring, without knowing what they are taking upon themselves and without adequate and specialised support. Taking care of a person with a mental health condition is entirely different from taking care of someone with an organic illness. Because they usually have routines that allow the caregiver to have some moments to decompress. In mental diseases, we know that behaviours and attitudes are related to each condition, and

even when they have the proper treatment, they can have a crisis. It's not always possible for the caregiver to control a mental patient's every move. And this alone creates anxiety and difficulties in caring. Therefore promoting mental health inside the family first is fundamental.

Only for this to happen, families need adequate responses from local mental health services. They have to be included in the patient treatment process. They have to be heard, partners, and not only resources to engage in therapy. I am family. I am not a psychiatrist; I am not a mental health nurse; I am not an occupational therapist; I am not a social worker; nor a psychologist. I need to have the community team support in mental health that the national health plan has been contemplating since 2008. These teams are relevant because they are formed by five or six professionals, each one from their field, that complement each other and support the patient and their families. It is a responsibility of the State, through SNS and of the national mental health programmes, from the pre-natal phase until death. And this has not been done. They are measures implicating costs and hiring human resources, which are used in campaigns.

It would be necessary a well-defined plan, with continuity...

We have to change our population's mentality because the stigma regarding mental illnesses is significant and generates self-stigma. People with a mental health condition and their families are aware that when they announce a person with a mental health condition in the family, they are treated differently. Nowadays, no one has a problem saying they are recovering from cancer, have a substance dependency, and have HIV; however, in mental illness, it is something transcendent. Everyone is inhibited to talk about it. Regarding mental health, we are talking about a diagnosis, treatment, and rehabilitation. While this doesn't change, we will not evolve in mental health promotion and prevention.

In effect, mental health programmes that already exist are specific activities without continuity and direction. At a school level, it was supposed to be included not only psychological support at school orientation services but also individual and collective interventions that would respond to the situations seen at school, from kindergarten until high school, involving families, patients, and society in general. Since in reality, the response has to come from society. It would be relevant to articulate this without wasting resources and monetising them. We can see this at a municipal level. There is the youth, health, education, the elderly.

It is only natural that this is all compartmentalised to allocate responsibility to the executive, although we need to understand a connection between all. More efforts should be made to implement comprehensive plans and not fragmented. This is the main problem that I feel today as a family member.

At a college level, it is the same. When they finish high school and go to college, some young people have integration problems. There is a competition for grades, the number of courses at their disposal is massive, but it cannot correspond to their expectations or is not suitable for the job market. All of this creates problems for young people at the beginning of their professional careers and can reflect on their mental health and to those around them. We need to explain to those young people, men and women of tomorrow, multidiscipline, career changes, and career adaptations crucial for mental health and productivity. If we don't have a satisfied workforce integrated, it's evident that productivity and PIB will not increase. These are all significant problems in our society, affecting our mental health.

Due to Portugal's economic conditions, a significant part of the population doesn't have the requirements to have professional caregivers for patients and for mental health problems they have in their families. Most caregivers are informal workers. Does FamiliarMente or patient associations promote any formation? What kind of support is given to these families?

FamiliarMente has a national meeting that happens every year dedicated to all the families, that covers broad topics. For example, the last one was dedicated to access and equity to treatment in mental illnesses since we felt this difficulty. Caregivers and families organised panels, round tables, and testimonials to understand the issues and demand responses. We have to bring awareness to the responsible politicians for the problems faced in mental illnesses, particularly for the caregivers.

There is already a support measure for informal caregivers. It is not the informal caregiver statute approved in 2019 but measures to support informal caregivers. However, these measures are so restrictive that to regulate the primary informal caregiver, it is necessary for the patient also to have a third person, which is not adequate for a mentally ill patient. If our family members don't have other comorbidities besides mental

illness, they are not allowed to have a third person, which is discrimination. On the other hand, support measures were only implemented in 2020/2021 to restrict caregivers, only in some regions considered a pilot experience. And this is going to be evaluated, after the pilot experience, to be improved. However, our hopes to include caregivers related to mentally ill patients will probably not pass since it would need a significant investment from the State. The funds allocated to the caregivers' support measures were restrained in 2020, 2021 and their application was way shorter than what was in the budget. There is a fallacy that the state invests X in mental health or support of caregivers, and the number is always below the budget. They pass the image of support, but they don't. And in mental health, people are penalised, not only the caregivers but also 25% of the population that needs care and doesn't have access to it.

They are going back to what FamiliarMente our associates develop formative projects to support caregivers. The key is to support the families according to their needs through adequate modules. However, it is difficult for FamiliarMente to do this since we are 14 associations, and to reach everyone is not easy. It is also hard to mobilise informal caregivers; they are millions and are not connected to any association, it is difficult. FamiliarMente's head office is in Lisbon, and our associates are members from the respective councils to which they are integrated. There are also associated groups for the elderly and children at a local level. The projects tend to be destined to specific groups to develop articulated programmes.

Families need to continue support and not only the formation programme, for when they have a problem, they still have help. If your family member doesn't have an assigned therapist with whom will they dialogue? Will they call the hospital? Will they reach the health centre? And with whom they talk to? We can't speak with our family doctors or directly with specialists. They tell us to make an appointment that can take months, and sometimes we have a problem that the support or solution is urgent. Therefore it is not easy. Even with all the initiatives made by the community, through FamiliarMente, through our associates, or through caretakers associations, what we need is continuous support.

How is the support from occupational, health, and other services?

Continue care responds to certain situations for a determined period. If we are talking about severe mental illnesses when patients no longer

have the support of their families, there is no access to continue care since there is no structure for it. On the national network for continued care related to mental health, there will be a little more than 1000 spots at a national level where the socio-occupational units and the residences of maximum support are concentrated. At these units, there are 48 spots: 24 in Porto, 24 in Lisbon, and these spots are occupied for those referenced when the residences were created, 10, 12 years ago. There are also few residences for autonomy training. There are half a dozen in Portugal, and they have six or eight patients that are also the same since the beginning.

We cannot say that all things are bad. For example, in the current direction of the mental health national programme, there has been a significant increase and an effort to implement the measures that are missing and are already part of the programme. Although, in effect, the financial resources of the country prevent development. We have also noticed an effort from our health minister, and we have to thank her. However, even with all these efforts, things are moving slow. With the PRR, 300 more spots are supposed to be created to give assistance and care to patients with severe mental illnesses. Of course, it is impossible to attend to everyone; even the most advanced country wouldn't be able to. But we have to invest more. It also reminds our politicians about these necessities so that more people can be contemplated.

What is the importance of prevention in mental health? What measures are ongoing in this area, and which others should be implemented?

Prevention is essential. Despite promotion. Because if we do a good advertisement, maybe it wouldn't be necessary to invest so much in prevention. Like promotion, prevention should start at preschool and daycares, since a person is born until she dies. And it is fundamental to have this promotion at the childhood level, teenagers and adult life. Measures are being adopted similar to those in advertising at the national programmes for mental health, but these measures don't have continuity. There are also prevention projects usually financed by community funds in civil society. However, when there is no more money, there is no more project. Last year FamiliarMente was involved in a campaign with LisbonPH; we did small videos and interviews to combat stigma since the biggest problem in prevention is the stigma that mental illnesses have. People are afraid to

talk about it, are ashamed, get inhibited, and don't seek help. If we talk more about prevention, we will eventually make people understand the necessity for self-care and look for help.

Several factors can help us to keep our well-being. However, for this to happen, we need tools to help us. In this sense, the campaigns should involve more people, not only the idols they usually use. After all, if this person, a soap opera actor, a film producer, related to the arts can assume that they have a problem, why can't I? It is not only to acknowledge the illness. It is also about prevention. And for me to prevent, I have to obtain knowledge and have tools that would help me.

Francisco Miranda Rodrigues

President (“Bastonário”) of Portuguese Psychological Association (“Ordem dos Psicólogos Portugueses”)

Interview with the President ("Bastonário") of Portuguese Psychological Association ("Ordem dos Psicólogos Portugueses")

Interviewer: Elsa Pegado, Iscte-Saúde,
Researcher at Centre for Research and Studies in Sociology (CIES-Iscte)
and Assistant Professor in the Department of Sociology (ESPP, Iscte)

One of the main aspects that emerged during the pandemic was mental health; even we talked more about mental health than mental illness. The focus was on mental health...

The pandemic brought visibility to a new set of issues related to mental health and amplified voices that already existed, that now and then talked about it, on the media, on politics, but this has gained a different dimension. We were living in a pandemic caused by a virus, and together with the physical impact (epidemiological of the virus), we started to talk about the effects on mental health. And because the results were generalised, it was not affecting only a group; it affected the most vulnerable. It was affecting them and all the others. In this sense, and only here, we can say it was democratic, but it had different impacts according to each circumstance. Having a simultaneous effect worldwide made mental health problems more common. If everyone was not dealing with disturbances, there was something besides mental disorders. Before, when someone used the term mental health, it was to design mental illness. And this was the reason that the Psychological Association *("Ordem dos Psicólogos")* even before the pandemic started to use the term psychological health and not mental health. Mental health was so attached to mental illness that it was almost impossible to send a message on health promotion and prevention associated with the term mental health.

The pandemic gave us the chance to explain that we are talking about a continuum when we talk about mental health and well-being. Before, no one

was interested in apprehending this message. And this was possible early on in the pandemic. I noticed a significant interest amongst journalists to understand this better. We have data showing this evolution on communicational impact and visibility on psychology themes and mental health before and after the pandemic. And it is massive, even though it was already mentioned in social communication before. The possibility to talk about mental health as a continuum and not only about lack or presence of illness allows an entirely different approach. People were also looking for practical tools that would immediately respond to their feelings. I believe that it was the first contact, recognition, and acceptance of what they were fishing for some people.

It also changed the initial depreciation of mental health problems caused by the pandemic constantly criticised at the order. In the early stage, we had data from other countries suggesting the opposite. We had a lack of response to those already in need of support. Later, an answer still working today was created: the psychological counselling from SNS24, which was very important.

And it is going to continue, right?

It has been integrated on SNS24 responses; this means that it will continue for the next three years. This line was a quick and assertive response opposite what usually happens. It was also intelligent in its methodology. The structures and technology from the ministry were used, and we organised the technical-scientific part. We had a fast response capacity, and it was possible to get it running within 15 days. Now how it is possible to create a structure like this so fast that has already replied to 120 thousand support requests and at the same time, the basics can't be resolved? It is possible because we surpass many intermediate structures of a particular tradition and are associated with some professions that do not facilitate implementing new intervention models that do not follow the dominant biomedical model. We could have action based on different models reaching higher population numbers than usual. The line has allowed people from all over the country to find a psychologist, no matter where they were, any time of the day, any day of the week. This is a massive change, from one day to the other.

I also have been insisting on the idea of the stigma associated with mental health. I think the stigma is not as significant as it appears to be. I think it is like a "stigmatic dust" and not cement. And when we enable people to access these services provided by these professionals, and this is easy, there is no longer a stigma. I am not saying it doesn't exist; I'm saying that we overestimate it. We are attached to the idea, "this is boring, it is a shame if only

people had a different mentality…" no, the problem is in the context, on the barriers surrounding this issue than on people's minds. Of course, prejudice exists, and it is established, and it was used to justify the lack of investment in the area.

Is the line support sufficient for the type of support necessary? Where do we need to invest?

It is not sufficient at all. The line was built only to give short answers to situations essentially related to anxiety. In an emergency, the line can forward the patient directly to INEM, and a psychologist always accompanies this person until they arrive at INEM. What were we not able to do? There is no connection between the line and the health services to the health centre. There is only an indication for people to make an appointment with their family doctor.

Yes, but then the health centres have no response...

Yes, they don't have, and this is a problem. It could only be solved if the government decided to take action, which it didn't, on exceptional measures, to eliminate all the bureaucracies involving hiring psychologists to the health centres.

So this can be one of the biggest problems at the moment?

Yes, this is is the main problem when the majority of the population doesn't have the means to resort to continuous support when they need it from a psychologist unless this support is public and for free. We could discuss politically and ideologically if this solution is private or public. Still, these are the facts; the Portuguese population has the social and economic reality. This is not a corporation issue. It is common sense. People need psychological help, thus psychological intervention. Who are the professionals that make this kind of intervention? The psychologists. Soon, because it will take a while to change, Portugal will need more psychologists in the health centres. There are 250, a little more, 2 or 3 dozens with "covid contracts" of four months, renewable up to 3 years.

Another problem is the lack of response from schools. It has nothing to do with the number of psychologists at schools; this was increased. Five years ago, we had 750 psychologists at schools; today, we are close to 1800. I wish we had this kind of progression in other areas. The problem is that psychologists

at the schools are doing the job they were hired to do and doing clinical work that was supposed to be done in health centres. School is not the appropriate context to do clinic intervention; school is to do interventions regarding the development of competencies for emotional situations that are protective, that will increase resilience, that will make sure that we later have healthier young adults more healthy and able to deal with the challenges that all of us have to face in life and that will be able to do it without so many specialised help.

Another topic that we should explore is prevention in mental health. What can be done in the promotion and prevention of mental health?

We have to find a different financial mechanism for prevention. This is something that is not only us psychologists that say, it is also health economists that say that the biggest problem in prevention is economical. When someone does the math to invest in prevention, the return can only be expected in 10, 20, 30 years. Health is even more problematic since the prevention that impacts health is not only done in the health budget. And there is another problem, the old drama of transversal public politics and how they should work. We must simplify processes and structures if we want more crossings between politics. And then we need a different culture inside public administration, it is like the resources we have come from other states, but it is the same state. Finally, there is the political issue, the political cycles. When I invest in prevention, I don't collect the results in the next election. And there is literacy; the more the population is literate, the more they will support investments in prevention. If people can identify what they are feeling and the signs for eventual psychological problems, they can prevent them from happening. And at this point, there was a positive development related to people's comprehension. Our model is far from the classical biomedical model, which is also changing. Fortunately, today we can see a more respectful attitude to the person who attends the service, autonomy, and a less paternalistic view. Our intervention is not much directive, and this means that many interventions help people understand why that health situation evolved and what is happening to them.

Let's suppose we don't change how we look at prevention and how we act on health promotion and prevention. In that case, I don't see how it would be possible for public systems, like health and social security, to have any sustainability in a few years, even demographically. In 30 years, 40% of the

Portuguese population will be over 60 years old. And I can't see how this will be sustained; what will be the wellness we will need to support a minimal equal society. Nowadays, most people still have access to the basics, not all of them; psychological health is not available to everyone.

This lack of access has consequences on mental health, right? There is a fraction of the population that is at a disadvantage...

Yes, colossal disadvantage. And the numbers show us that now there are more people not only due to the pandemic impact but also because of the awareness that we have today that allows us to identify more situations. It doesn't mean that now we all suffer more because there was a change in the way we live in a society that makes us suffer more. I wouldn't jump to the general conclusion that our lifestyle makes us suffer more. Now we can see a reality that we could not see before.

And it is a vicious circle. We have to associate this with poverty and the impact of not attending the most vulnerable ones. The effect that this has on their socio-economic condition. Psychological problems are a risk factor added to these situations, inequality, and poverty because they limit people's capacity. I usually say it is a psychological phenomenon, a scarcity mental state. It is like we restrict all our horizons to a scarcity mental state. There are several studies with populations that live with seasonal income that have massive changes between a period of scarcity and a period of abundance. And this has direct implications on how people make decisions; rational mechanisms for problem solutions are affected, diminished, make more mistakes, and cost money. It is the same vicious circle.

And here, we can understand why other social phenomena are fed, like populism, etc., because these people are more biased since they are more vulnerable. Therefore, even for social cohesion on a political level, fighting extremism, building more bridges, finding common ground, more joint solutions, and more cooperation. For that, people's well-being and psychological health are essential. So it is fundamental to invest more in promotion and prevention. Until now, it has only been the State, and it is only 1% of the health budget that goes to prevention.

Would you like to add any other aspect that you find meaningful and that we haven't talked about?

Yes, there is a fundamental issue that I did not approach, workplaces. We need to address this (and we are trying hard to put this on the agenda), we need to

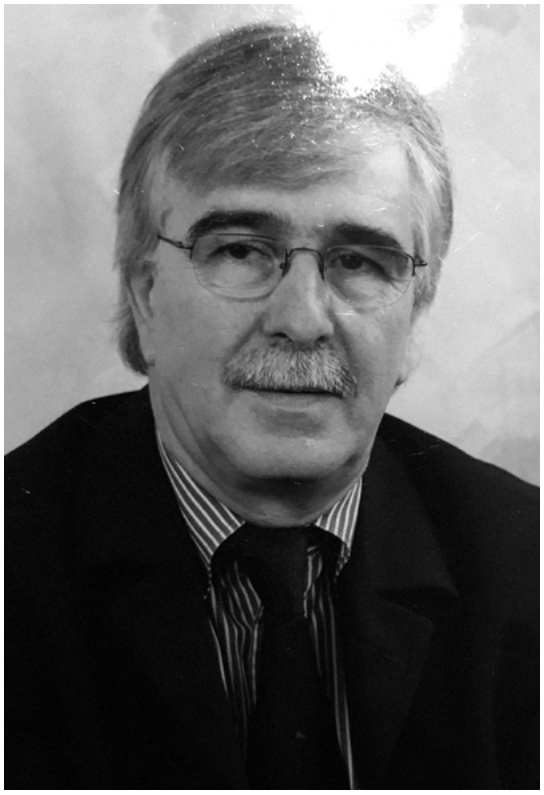
work harder with management practices and leadership to get them up to speed to what we know today about the impacts of these management practices and leadership on people's health and well-being. And how this impacts these organisations' productivity, competitiveness, and even sustainability. What has more impact on workers' health and well-being are the decisions made by those in charge. So the most important is for us to work with the leadership, and we have to work on management practices.

We did the math and saw only private companies, not the financial ones, in Portugal in 2019 lost 3,2 million euros related to stress and other psychological problems in the workplaces. These are the 3 Vasco da Gama bridges. Managers voluntarily or not have to change this. However, usually, management tends to blame the workers; it would be best to teach people how to manage their stress better. It doesn't make sense to the point that the only problem is that people cannot handle stress because if there are psychosocial risk factors that determine levels of stress, there will be people that no matter what competencies they have to manage stress, they will not be able to handle the situation. And others can take it for a while and then stop dealing with it due to intensity and the duration that became unsustainable. Therefore both things are essential. We need people to be more resilient, but we also need prevention from the organisations. Psychosocial risks prevention cannot be surpassed. It is a public health issue. But it doesn't have the attention it was supposed to because it is not an issue that can be seen, like a broken leg. We need to make explicit psychosocial evaluation risks that are already mandatory, but it is not clear as it was supposed to be, and prevention programmes should be required. Among all the schedules for organisations, it would be great to include those that encourage evaluation and prevention programmes. This would be a great measure to stimulate organisations to take the step; once they do, they will realise that these measures are not an additional cost. What costs are doing nothing?

Finally, it is essential to remember that services in mental health are not services for mental illness; they are only a part of it. PRR has 80 million destined for mental illness. We have been waiting more than 15 years for those initiatives to begin. This is positive. But it is also substantial that those responsible in the field and politics understand that these resources are only for mental illnesses. There is no prevention; there is nothing for people with psychological problems without disturbances. Nothing.

We need to simplify the circuits to access what we need. Fewer structures, simplification, reach people faster, mechanisms for general management, multidisciplinary work (respecting who has the competencies to do

each process). This is how we can deliver the best service to people. Therefore it is accountability, effectiveness on interventions, and monitoring results, besides the processes. Today all we have are processes results. It is how many acts were practised, and even, so they are not all accounted for. What about the results with the population? This is far from being done. We need to acknowledge the effectiveness of intervention since this is the path we have to take.



António Reis Marques
President of College of Psychiatry of the Portuguese Medical Association ("Ordem dos Médicos")

Interview with the President of College of Psychiatry of the Portuguese Medical Association ("Ordem dos Médicos")

Interviewer: Francisco Nunes, Assistant Professor at the Department of Human Resources and Organizational Behavior (IBS, Iscte)

How do you see mental health and well-being phenomena?

Any version that sees mental health as a pure discipline from medicine or psychology is restrictive. This is a concept that the school (the Medical Psychiatric Order) and the Mental Health Programme that will be implemented does not have. We relate mental health with several other social areas. On the other hand, our mental health is related to our expectations, frustrations, ambitions, and how we live. When we look into mental health, we need to have an open mind and see that it goes beyond depression and ezquizofrenia. To comprehend mental health, we need a global human vision. Therefore there is no successful mental health policy without apprehending and introducing other essential areas of knowledge, like sociology, psychology, and rehabilitation. People suffering from a crisis or with inadequate mental health can be periodically or permanently helped in these areas. Who should coordinate the team to support someone with mental health problems should be a psychiatrist. They are the ones that have psychological and medical knowledge and that should be open to embodying dynamics that come from other areas of expertise.

Therefore the intervention on mental health should embody a broad, holistic view. How do you see the current policies in this field?

Until not so long ago, there was a distorted perception of psychiatry. It was an ostracised area of medicine at a caring and social level. There is a social stigma. For example, the support hospitals for this kind of patient were hidden, and out of the city, so no one could see them. In Lisbon as well, psychiatric hospitals had no connections with the others at the centre. This changed only 20 years ago when psychiatry was incorporated into hospitals and general health dimensions. However, the problem was not solved, and there is still a difficulty, not concerning other areas of medicine, but related to cultural aspects regarding psychiatry. When I say cultural elements, I'm referring to how people with mental disturbances seem strange, different, and, consequently, ostracised. If it is not ostensive, it is disguised. For example, in a job search, these people are relegated to the background. This is related to a deficit in mental health education and a general knowledge that these alterations will never catch us. We know that they are often related to genetic aspects and life dynamics, such as unpleasant events, ambition, frustration, unsatisfied expectations, and difficult situations. This clarification was never done correctly.

Families and patient associations have an important role here?

Until now, the social dynamics connected to mental health where families were involved almost didn't exist. Families themselves stigmatised their members that had mental illnesses. Nothing on a social level brought together all the actors involved. In the last years, a national mental health programme was made, encompassing all these aspects. At its core, this programme reveals a different and integrative vision when mental health can only be achieved with the contribution from all the agents working in general health (doctors, nurses, and psychologists). They can contribute to the person's homeostatic equilibrium, making this person emotionally balanced and feeling good about their life.

At the national level, there is a lack of investment from the authorities. Today we know there is money to invest in the area, 90 million euros that come from Europe, which will allow us to start with structure.

It is necessary to incorporate several professionals to create support, and fundamentally it is required to change behaviours in the community. A substantial change needs an intervention close to people who know their difficulties and concerns, and helps them to resolve their problems, and allow them easy access to a doctor or a psychologist. It needs professional recovery and politics that will integrate ills that don't separate them from their social dynamics and their families. If it becomes history, separation can bring difficulties that are hard to surpass. Think about the pandemic and how we saw ourselves destitute from one or more aspects of our daily routines, especially socialising with others. This had negative impacts even on healthy people. All of this directly influences how we feel and how we live.

You mentioned the impact of the pandemic on mental health and well-being. Did the pandemic affect some more than others, or did all of us feel its effects?

It affected all of us; however, the less favoured and with less capacity to defend themselves were the ones that suffered more since they didn't have the conditions to create a healthy environment and didn't have good homes. Most of the time, the home office was good, but it also created some problematic situations. I followed some patients that found themselves with only one living room for the whole family to do home office. Family conflicts emerged because there was no space and no time for relaxation. The pandemic caught this group fundamentally and created enormous difficulties, even though everyone suffered. It is noticeable that the consequences to the majority of the population were the changes in each experience. Of course, the symptoms got worse on those who were already ill. In my professional experience, I saw that it was only when the pandemic started to get better globally that people began to seek medical help because there was a time when there was no perception of the consequences of the pandemic. Now that the measures have gotten weaker, people could breathe and find support for their suffering. Unfortunately, all can go back due to the global evolution.

What political elements would you highlight?

Every policy should bear in mind the community's needs, calling upon primary healthcare structures, multidisciplinary professionals (that have to be recruited fast), and the correct organisation and leadership. Deficits should be corrected; difficulties have to be surpassed to allow quick access to care, guaranteeing minimal well-being conditions to all.

The health sector has to be reorganised. At this moment, there is a lack of leadership that could make all the actors work in harmony without cleavage, an agile flow between primary care, hospitals, social dynamics, all those resources available to the ill and those in need. It is not only about mental health. It is all over because sometimes there is no intervention capacity since the connections were not made yet. We have excellent technicians, a logistic and technological capability that measure what we see abroad; we miss organisation. Without financial aid, we can't recruit the people we need, such as socio-professional recovery (we need structures). Social work is key to this type of intervention alongside people and the community. Now there is a will, and we have someone leading this process that I find competent, able to teach and introduce something new in our country. That knows the professional aspects and perceives the difficulties of this organisational superstructure. Besides, it is intelligent enough to congregate people and diminish resistance. We have to show those responsible that modifications need to be made. Otherwise, we risk being even further behind than the rest of Europe regarding support to those people. When we talk about mental health, it is common to associate it with "a crazy person" when we say "the person has a serious illness" with other diseases. Nowadays, international studies show that 50-60% of the population that goes to a general clinic or the health centre has emotional disturbances and poor mental health. All these patients can make primary care difficult since they need help from other technicians, not necessarily doctors, and could be assisted outside the health centres. These technicians should be part of the team that works in the communities and do multidisciplinary work.

Another aspect is the access difficulty. Due to this difficulty, people go to the emergency. All the reality we talked about is wrong. We need money and organisation, but leadership is the most important. An administration that can introduce modifications will lead to professionals working with pleasure, well paid, and that can easily approach the

population. These leaderships cannot be on *Terreiro do Paço; they* are locals, they are the people from the community capable of bringing all the actors together.

We can say that there are two main elements in this leadership. An administration focused on mobilising professionals; on the other side, an oversight that promotes different actors working together.

It is noticeable an unjustified corporativism, where every professional class wants to show their importance. But our significance is measured by the contribution we give to those in need. We cannot stay closed in ourselves; we must have a global vision accepting that we all have a role. The leadership in support and care must come from doctors since it has an organic component, a psychopharmacological therapeutic aptitude, and more. At this moment, we are committed to improving psychiatrists' training, giving them these perceptions and forming them correctly in psychotherapy and social dynamics so they can lead.

Does this mean that other professions should change their role?

Precisely, in a harmonic and adjusted interaction. If we go to Sweden, Denmark, Germany, and even France, we know people don't measure the importance of a profession by their title, but on what they can give to society. I think that in the nearest future we have to change some things.

There is no alternative in the current state of things that can change our present situation. We do not only have bad things. We could create good things quickly; we have been a democracy for 40 years. Change in posture and conceptual change cannot be introduced soon in a society or by decree; this requires a certain amount of time for things to settle in, for reflection, and for people to realise what is at stake. We have a tradition that doctors were almost someone with magical and mystical powers. Still, little by little, people and doctors are changing this cultural aspect and realising that they can't solve everything by themselves. I am from a time when doctors were professionals who only existed in the councils and tried to resolve everything themselves, without any help.

When needed, they would dislocate themselves to the villages to patients' houses or receive the patients at their offices. Fortunately, this has changed, and today we have very advanced ways of intervention. I think what is missing is the interaction between all the intervention fields.

What is the importance of prevention in mental health? What needs to be done?

Prevention is essential in all areas of health and mental health as well. When I talk about work in the community, a lot of it is prevention (for example, in schools and ATL creating a harmonic development for children). Without the community dynamic, there are no ways to prevent without the community dynamic because you will find the difficulties where people live and have problems. We also have to improve our aptitudes and capacities, so things are surpassed healthily. Teach children to resolve their issues harmonically and healthily without letting the way out be delinquency or social misery.

We have to focus our attention on those in need, fundamentally to those with vulnerable health and socially helpless. At least we can intervene to give conditions to children so they can develop their maturity almost at the same pace as others. There will always be differences. We don't have this experience here in Coimbra, but in the Lisbon periphery, a part of the population resorts to delinquency since they have no other alternative. It is the perfect storm.

To conclude, there is no good mental health without prevention, just like there is no health in general without the prevention aspects. However, there is work to be done in mental health, which is urgent. Suppose we do not have a central power capable of acknowledging this and has social concerns. In that case, that is not only imbued with excessively liberal theories where each develops according to their capacity and condition; we will not go further. This is a way for some to create, but most people cannot be left to the less favourable aspects of life. I am in favour of a social state. I think the State should look at all of us as equals and with the same rights. Only with central policies, this can change. I am convinced that there is a possibility and will to start this path. I don't know if the same conditions are created and if there is a conflict of interest to implement this type of concessions. I am an optimist. I accept that people are sovereigns, but they must realise what is at stake; this must

move forward and create new dynamics that can improve people's lives. And therefore generate education and health conditions for us to have more evolved citizens, with more autonomy, healthy, and well-being.

PART 2

Mental health and well-being: plural contributions from the scientific community

1.

Psychopathology, Culture, and Current Societal Challenges: A critical turn to mental health

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ABSTRACT

In making sense of the concept of psychopathology and borrowing from critical health psychology, in this chapter we will argue that striving for the psychological well-being *of all* in contemporary societies requires to expand from an individual to a social focus, and an understanding of mental health and illness in wider social, cultural, political, and historical contexts. Concerns with social justice and mental health care disparities will be illustrated by studies with different groups and populations, including LGBTQI+ persons, migrants, and refugees. Finally, we will examine our work on trans and gender diverse individuals, gender identities, and self-determination. Consequences for training in a diversity of health professionals will be discussed.

Keywords: mental health; critical health psychology; culture; minority health; clinical diversity training

ON THE CONCEPT OF MENTAL HEALTH AND THE ROLE OF CULTURE

Diverse conceptions of mental health and mental illness have been offered over the years, having evolved alongside our understanding of psychopathology and experiences of well-being. Historically, the definition of mental illness was marked by the notion of psychological phenomena that were abnormal, atypical, and/or deviant from a norm, either from a perspective of its frequency or from a social convention. While simple and appealing from a layperson's perspective, this approach presents several challenges. Problems include its subjectivity (e.g. how different should a phenomenon be from a norm to be pathological) and the fact that is based on values, beliefs, and practices that are ever-changing and context-dependent, rather than scientifically defined (Maddux, Gosselin & Winstead, 2016). Atypically may reveal extraordinary competence or genius; and, at times, going against norms or accepted conventions may constitute a healthy response. Furthermore, this approach has greatly contributed to the stigmatization of mental illness, which has been carried to the present day (Rössler, 2016). Currently, views on mental health have mainly focused on the role of subjective distress, dysfunction, and impairment. In other words, the presence of clinically significant subjective distress that is experienced by the person, and the experience of impairment to one or more of his/hers/their areas of functioning (i.e., social, occupational, or educational) are core elements for conceptualizing psychopathology (American Psychiatric Association; APA, 2013).

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Advances have been made in several domains which have helped further our comprehension of psychopathology, and our efforts in prevention and intervention toward the promotion of mental health. Developmental psychopathology has addressed human development to look into mechanisms and processes involved in psychopathological trajectories and manifestations in childhood and adolescence and throughout the life cycle (Rutter, 2013). Neurobiological foundations of psychopathology have been explored, with insights from genetics (e.g. human genome) to brain functioning (e.g. through neuroimaging), into the vulnerability to certain disorders, sensitivity, and reactivity to stimuli substracts of personality, and their variability (Nikolas, Markon & Tranel, 2016). At present, it is recognized that understanding mental health and illness solely from one level of analysis is not

fruitful, in that multiple dimensions and variables operate and dynamically influence each other. This includes the social and cultural milieu.

Social context and culture shape every aspect of our experiences. As such, they also shape experiences of health and illness, in particular those that have to do with emotional, psychological, and social well-being. In recent years, cultural issues have moved to the fore in the study of psychopathology since the seminal works of Kleinman (1980, 1988) to Kirmayer (2006). As recognized by the U.S. Department of Health and Human Services, "the cultures from which people hail affect all aspects of mental health and illness, including the types of stresses they confront, whether they seek help, what types of help they seek, what symptoms and concerns they bring to clinical attention, and what types of coping styles and social supports they possess." (U.S. Department of Health and Human Services, 2001, p. ii).

ON THE CONTRIBUTIONS OF CRITICAL HEALTH PSYCHOLOGY TO MENTAL HEALTH ISSUES

Another relevant contribution to our view of mental health results from critical psychology (Fox, Prilleltensky & Austin, 2009), specifically from its impacts on the development of critical health psychology (Horrocks & Johnson, 2012). In its focus on the study of health and well-being of individuals, communities, and societies, critical health psychology embraced the exploration of the relationships between health and the broader social, cultural, and global contexts, ultimately aiming at improving health and well-being outcomes. Importantly, its applied concern is to contribute to transforming an unhealthy world (Morison, Lyons & Chamberlain, 2019). This critical perspective in health psychology encompasses being "part of a moral project of individual and social transformation, rather than accepting (or reinforcing) the *status quo*, which requires radically different approaches, new agendas, theories and methods" (Hepworth, 2006, p. 332). In this endeavour, critical health psychologists have recognised their dissatisfaction with the positivist assumptions of conventional approaches in psychology and with the lack of engagement with broader social and political issues. Some (see Morison, Lyons & Chamberlain, 2019) have argued that the biopsychosocial framework, taking contextual factors into account, does not go far enough (by placing an individual focus on health behaviors, such as in social cognitive models and health behavior models), without recognizing power issues, institutions, political economy, media, etc, that impact diverse dimensions of health in multiple,

complex and sometimes contradictory ways. Thus, critical health psychology has defended increased interest in theories and approaches such as feminism and social-constructionism; the use of more qualitative, participatory, and collaborative research, including community-led projects, ethnography, and discourse and narrative inquiries; a focus on the awareness of social, political and cultural dimensions of health, such as poverty, racism, sexism and other discriminations; and an active commitment to improving the well-being of socially marginalized groups (Morison, Lyons & Chamberlain, 2019).

A CRITICAL TURN TO MENTAL HEALTH

Borrowing from critical health psychology, we argue that striving for the psychological well-being *of all* requires expanding from an individual to a social focus, and an understanding of mental health and illness in these wider social, cultural, political, and historical contexts. This perspective entails several consequences to the study of psychopathology and its main aetiological models (e.g. biomedical, psychodynamic, cognitive-behavioral). Firstly, in line with a social constructionist perspective, it is proposed that conceptions of mental illness are also socially construed, both by professional consensus and its recognized power and by lay people's representations of human suffering and search for meaning (Maddux, Gosselin & Winstead, 2016). It also recognizes that the ways of displaying distress and (dys)functionality are dynamic, and situated in a historical and cultural context. Recent proposals of continuum or spectrum disorders, rather than discrete categories, reflect this understanding, as do the revisions of classification systems over time (APA, 2013). Secondly, in mental health research and practice, a need for deepening social analysis is also recognized in promoting social justice purposes. Multicultural counseling (Ratts & Pedersen, 2014; Sue & Sue, 2008) and affirmative psychotherapies (Ritter & Terndrup, 2002) are examples of clinical approaches that have already embraced this principle and call for action. Counsellors and psychotherapists can contribute to social justice issues through active involvement in advocacy, community outreach, and public policymaking, while also being aware that power and its asymmetrical distribution can contribute to systemic, institutionalised discrimination and minority stress (Goodman & Gorski, 2015), with undeniable impacts on mental health.

Borrowing from critical health psychology, we argue that striving for the psychological well-being of all *requires expanding from an individual to a social focus*

ON SOCIAL JUSTICE CONCERNS IN MENTAL HEALTH AND SOCIALLY MARGINALIZED GROUPS

Concerns with social justice and mental health disparities have been the basis for several studies with different socially marginalized or stigmatized groups and populations, including ethnic minorities, migrants and refugees, and LGBTQI+ persons. Minority stress (Meyer, 2003) and acculturative and other post-displacement stressors (Bhugra et al, 2011) have been shown to increase vulnerability to diverse psychological conditions, given stigmatized groups may be exposed to a higher number of risk factors (e.g., related to legal status, perceived discrimination, social exclusion, and victimization). For instance, among refugees, a diverse set of both pre-and post-displacement stressors have been linked to a multitude of adverse mental health and social consequences (Hynie, 2018; Siriwardhana, Ali, Roberts & Stewart, 2014). The relationship between migration and mental health has also been explored (Bhugra, 2004), having varied effects in different groups (e.g. such as women, children, and youth, older adults) and distinct phases of the migration process (Bhugra et al, 2011). Moreover, lesbian, gay, and bisexual populations have been found to present an increased risk for mood and anxiety disorders, including traumatic stress reactions and suicide risk, among others (e.g., King at al, 2008). Our work has also explored the experiences of refugee minors (Moleiro & Roberto, 2021) and their stakeholders (Roberto, Moleiro & Lemos, 2020); resilience among migrants (Roberto & Moleiro, 2016); the mental health care needs of migrants (Moleiro, Freire & Tomsic, 2013) and LGB populations (Moleiro & Pinto, 2012); promotion of equity of care in mental health among diverse individuals (Moleiro et al., 2018); and intersectional positions among queer migrants (Solntseva, 2019).

Our work has also explored the experiences of refugee minors

An important contribution to the very notion of mental illness and a critical reflection on its paradigm shifts can come from the work on the well-being and affirmative care of Transgender and Gender Diverse (TGGD) persons (see Moleiro & Pinto, 2015). Significant changes and advances have been made in our understanding of gender identity and its alignment (or inconsistency) with the sex assigned at birth since it was first identified in the main diagnostic systems. This recent paradigm shift (Drescher, 2009, 2013) reflects, on the one hand, our understanding of sex and gender as non-binary constructs, moving from binary assumptions underlying the initial notions of "transsexualism". On the other hand, the shift refers to a change of focus from the identity of the individual (perceived as "disordered" in "Gender Identity

Disorder") to a condition of subjective distress that he/she/they may or may not experience for a period of their lives, in a fluid and dynamic process, as a result of the inconsistency between the assigned sex at birth and the way one identifies in terms of gender (termed as "Gender Dysphoria" in DSM-5, APA, 2013). It is now recognized that gender identity is defined as a person's deeply felt, inherent sense of being a woman, a man, a blend of male or female, or an alternative gender (American Psychological Association, APA, 2015). In addition, it is acknowledged that TGGD individuals are a heterogeneous population in terms of gender, sexual orientation, ethnicity, migration status, and other characteristics (Pinto & Moleiro, 2015); and that they face stigma and are one of the most targeted groups in terms of discrimination (see Moleiro & Pinto, 2015). Unsurprisingly, transgender people have been identified as being at a greater risk for developing a variety of psychological conditions, including anxiety disorders and depression (Mustanski, Garofalo, & Emerson, 2010). Importantly, suicide ideation and suicidal attempts among this population are greater than in the LGB population and cisgender peers (Maguen & Shipherd, 2010). In particular, adolescence has been identified as a period of increased risk regarding the mental health of TGGD (Dean et al., 2000).

gender identity is defined as a person's deeply felt, inherent sense of being a woman, a man, a blend of male or female, or an alternative gender

Trans-affirmative health care and self-determination (ApA, 2015; Lev, 2004) have been defended as a way to prevent and/or reduce gender dysphoria. In Portugal, our work (Moleiro & Pinto, 2020) evidenced how the change in the legal framework for gender identity recognition had a positive impact on satisfaction with life, psychological and social well-being of the participants and paved the way toward self-determination in the law. Consistently, among children and adolescents, Russell, Pollitt, Li, and Grossman (2018) demonstrated that chosen name use (e.g. the ability of the youth to be referred to by the pronoun and name of their choice) in multiple contexts was associated with lower depression, suicidal ideation, and suicidal behavior. These works illustrate social, political, and cultural dimensions of mental health, pushing its margins, as well as an active commitment to improving the well-being of marginalized groups.

ON THE FUTURE OF TRAINING, RESEARCH, AND PRACTICE

A critical perspective on mental health is not complete unless it also addresses the need to train clinicians in diversity, on the one hand, and a call for action in ways to reconnect research methods, theory, and practice in promoting social justice, on the other.

On training, cultural competence (Kirmayer, 2012) has been proposed as a strategy to respond to diversity in contemporary societies and make mental health care services more accessible, sensitive, and effective for diverse communities – including age, sex and gender, sexual orientation, gender identity, ethnicity, migration, religion, social class, language, and ability status. Recent debates address related concepts like cultural safety, cultural sensitivity, cultural responsiveness, and cultural humility (Kirmayer, 2012), while all agree with a process aligned with person-centered care in responding to health care disparities. Most are consistent with a three-dimensional model, referring to (i) self- and other-awareness and attitudes in the clinical encounter; (ii) specific knowledge (e.g. acculturative stress, minority stress, identity development models, mental health inequities); and (iii) clinical skills and organizational practices (Moleiro, 2018). Delgadillo (2018) argues for better integration of the literature on social inequalities, power imbalance, and cultural competence into clinical training programmes.

A critical perspective on mental health is not complete unless it also addresses the need to train clinicians in diversity

Additionally, a call for action pushes the boundary beyond *critique* (Morison, Lyons, & Chamberlain, 2019). It argues for the need to change our research and clinical practices, and also bridge the academic and non-academic divide. Addressing this gap and mainstreaming cultural competence are key developments in promoting mental health *for all*.

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2.

Fear in epidemic crisis: a historic approach

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ABSTRACT

Mental health in epidemic periods is a recurrent theme, as well as epidemics themselves. Based on an investigation of news and advertisements published in the generalist press, we became aware of the importance of disseminating scientific knowledge to a wide audience and of the themes addressed in these periods of health crises, which affected the economy, society, and politics. This article addresses the effect that new diseases had on the more intimate behaviour of affected populations. From the ancestral fear of hospitals, places associated with certain death, to the fear of the unknown, in the face of diseases whose causes and their treatments had not yet been identified by science. The sanitary measures applied by the authorities have always aroused antagonistic reactions due to the deprivations to which each affected populations were subject. From the mid-nineteenth century onwards, daily newspapers were fundamental vehicles in the transmission of scientific knowledge, health advice, and standards, and the discussions that these novelties have raised.

Keywords: newspapers, epidemics, fear, guilt, punishment

This research on epidemics and pandemic periods in the nineteenth and early twentieth centuries was based on news and advertisements published in the generalist press. It revealed the concerns of health authorities and their efforts to disclose the knowledge of the time about diseases, their prevention, and known treatments, sanitary and hygienic advice. Newspaper editors played a fundamental role in the publication of this information, never failing to clearly express their opinions on the containment measures adopted by governments. In times of huge shortages in public assistance to patients, the newspapers themselves took initiatives to organize fundraising to improve the lives of groups most affected by situations of need caused by diseases and by the consequences of sanitary measures and military sieges on cities. Among the topics covered, fear assumes an importance that is reflected in the news about the diseases, especially due to the novelty and lack of knowledge about the new epidemics that swept Europe, taking doctors by surprise and without great possibilities for diagnosis or treatment.

Faced with a population weakened by poor hygiene and food conditions, combined with endemic diseases that kept population growth and life expectancy at very low levels, the first cholera pandemic reached Europe and the United States in the 1930s and shook the moral and cultural structures of the Western world. The succession of epidemic waves of this disease, whose transmission was only scientifically established decades later, led to discussions in International Health Conferences that brought together the best experts of the time from all countries involved, in an attempt to establish common rules for controlling the spread and to minimize "the delays and inconveniences that subjected international trade" (Garnel, 2009). In an already globalized world, where the circulation of raw materials and manufactured products assumed growing importance, the interdiction of ports during these sanitary crises caused constraints that put food supply at risk, especially in countries like Portugal, where there was never self-sufficiency. The same applied to sanitary cords, which prevented the movement of people and goods, directly leading to situations of generalized shortages and hunger.

In times of huge shortages in public assistance to patients, the newspapers themselves took initiatives to organize fundraising

Therefore, fear of the disease was associated with fear of the consequences of sanitary measures to contain epidemics and the resulting economic paralysis.

Several fears plagued the population and were expressed in the news throughout the nineteenth century. Starting with the fear associated with the concepts of guilt and sin. In a Catholic country with a strong Church influence, even in revolutionary periods when anticlericalism prevailed, the issue

of behaviour affected the way people related to their bodies. If something bad happened, the reason was more easily attributed to divine causes, especially in the absence of scientific explanations and effective treatments. With the spread of cholera throughout all social classes, regardless of good or bad actions, this structure of thought was called into question, which certainly contributed to the malaise of a society that did not yet have the scientific capacity to solve the problem.

Thus, and to counter the trend of the authorities towards sanitary cords and drastic measures prohibiting freedom of movement and trade, since the mid-nineteenth century we have found news that not only deny the epidemic but attribute it to deviant behaviour, increasing personal responsibility on the transmission of the disease and creating even more fear and also terror.

If something bad happened, the reason was more easily attributed to divine causes, especially in the absence of scientific explanations and effective treatments

"This is the time of year we fear the most. It's the time for cucumbers, prunes, poorly seasoned fruits, which our peasants, not through hunger but out of vice and reprehensible abuse, will not stop eating" (*O Século*, 14 Aug 1855).

The quotation above shows the arguments used to deny the cholera morbus epidemic of 1855 in Portugal: the poor were sick on their behalf because they had reprehensible vices and behaviours. Therefore, all the sanitary measures issued by the authorities, particularly in Porto, where quarantine to ships and transit and the prohibition of markets were imposed, were regarded as unnecessary. Most importantly: There was a need to re-establish trade freedom (Almeida, 2013b). Newspapers in Porto were particularly active in this campaign to end the sanitary cord, protesting "inept measures, which greatly harm the public, and especially the commercial class" (*O Comércio*, 16 May 1855). Advice on hygiene multiplied: cholera "is easily avoided. It's necessary not to be afraid, and to observe hygienic advice..." (*O Século*, 13 May 1855). These were the isolation of the sick and cleaning of houses and clothes, stressing the importance of opening windows and airing houses to get rid of "putrid miasmas", considered the main source of contamination.

"The best way to purify the air in a room currently occupied by a sick person is to renew it by opening the doors and windows (...) Those who live in country houses or farms, in addition to cleaning and ventilating the rooms, must not consent manure houses with stagnant waters nearby, because they produce exhalations that can cause putrid fevers, especially during the heat of summer..." (*O Comércio*, 6 Jun 1855).

When markets were prohibited in June 1855, the press reacted in defence of local commerce, small producers, and consumers: "We have already

demonstrated, and still no one has convinced us otherwise, that the suspension of large markets is an evil and a desperate resource, which, without a recognized advantage over the invasion of cholera, is the origin of serious disturbances for commerce (...) which visibly damages all industries..." (*O Comércio*, 26 Jul 1855). "If, as is generally believed, hunger is one of the causes that has contributed the most to the disease, the ban on markets will increase it" (*O Comércio*, 30 Jul 1855). "Banning markets is a greater calamity than the transmission of evil, because the resulting evil is much greater, increasing misery..." (*O Comércio*, 1 Aug 1855). To make matters worse, some doctors abandoned villagers to their fate, as well as the authorities: "We know, for sure, that the authorities of Caminha, military, judicial and fiscal, fled that village in fear of cholera!!!" (*O Século*, 04 Nov 1855). No wonder that, in addition to fear of divine punishment, people found themselves helpless, which, according to newspapers at the time, further increased the symptoms of cholera: "terror is one of the powerful causes for the onset of the disease... ."; "there is nothing more fatal than the fear of the epidemic when it exists" (*O Comércio*, 27 Aug 1855 and 28 Sep 1855), causing death "perhaps more from terror than from disease" (*O Comércio*, 20 Sep 1854) . Even scientific experiments were carried out in this regard:

Some doctors abandoned villagers to their fate, as well as the authorities

"Lately, wrote the *Journal of Frankfurt*, a doctor from Vienna, Dr. F…, carried out an interesting experiment to find out what influence the fear of cholera could exert on an individual in perfect health. After obtaining the consent of the competent authority, Dr. F.. promised a convict, robust and healthy, that the sentence would be commuted if he consented to get into bed with a man who had just died from cholera. (…) After a few hours, all symptoms manifested themselves, and a formal cholera attack was observed. All the treatments were done to him, and thanks to his strong constitution he was saved. But what was the surprise of the assistants when Dr. F.. declared that the one with whom the condemned man had fallen into bed had not died of cholera! Dr. F … had made him believe this to observe the effect of imagination and fear on the organism" (*O Comércio*, 31 Oct 1855).

As a treatment against this powerful psychological factor, peace of mind and good humour were advised: "The first physician of the King of Saxony, Norbeck, gives the following advice as a preservative against cholera influences. Take 20 shots of warmth, 5 shots of cleansing, 12 shots of morality, 1 shot of activity, 2 shots of good sleep, 10 shots of fresh air, and 50 shots of peace of mind. These 100 parts put together form an excellent anti-choleric. This prescription contains serious advice in joking form. The reader will note that it is the tranquillity of mind that is represented by the highest dose (...)

it is now well established that fear is the only cause of a good half of the accidents attributed to the scourge. As for the other half, imprudence is enough to explain most of them. If the populations wanted to observe the simple hygienic prescriptions that have been indicated to them and keep some cold blood, cholera would lose, with its prestige, the sad privilege of making more victims than other diseases" (*O Comércio*, 13 Sep 1854).

As a treatment against this powerful psychological factor, peace of mind and good humour were advised

The same was observed during the bubonic plague epidemic that hit Porto in 1899, when Ricardo Jorge, municipal doctor, and director of public disinfection facilities, put in place hygiene measures considered violent by the "filthiest classes" (Jorge, 1899). For the cleaning of individuals and their houses, doctors made inspections on the poorest neighbourhoods, with cleaning brigades paid by the municipality and accompanied by the police (*O Comércio do Porto*, 29 Sep 1899), burning clothes and mattresses, sometimes the houses themselves, and forcing people to bathe. Ricardo Jorge ordered public bathhouses to be built and took precautions against the rats that infested the city, not only distributing poison but also taking care of the waters where the poison and dead rats were found. People in poor neighbourhoods did not accept such actions peacefully and responded with civil unrest. There was a lack of understanding regarding sanitary measures and fear of the disease and its treatments. All of this exited the population, who demonstrated against the representatives of the health authority, against doctors in general, and against Ricardo Jorge in particular. Several doctors were stoned, and bombs exploded on the streets and in some houses.

"If any exaltation reigns in Porto, it is against the exaggerations of sanitary measures, especially against the inconsistency of some orders. At night, around 10, Maria Oliveira Pinho, widow of a man who died at the Misericórdia hospital, jumped from the 3rd floor of the house on Rua Escura, when clinicians classified the case as bubonic plague. For this reason, many people gathered in Rua Escura to accompany the injured woman to the Misericórdia hospital. During the journey, there were hostile demonstrations against the municipal doctor" (*Diário de Notícias*, 20 Aug 1899). The news referred to Ricardo Jorge, who at the end of September resigned and moved to Lisbon, where he was appointed General Inspector of the Health Services of the Kingdom and professor of Hygiene at the Medical and Surgical School of Lisbon.

The Church also contributed to the dissemination of hygienic measures, emphasizing the spiritual issues associated with the disease: awareness and peace of mind to prevent it and fear as a dissemination factor, repeating what was observed in the cholera epidemic four decades earlier. "Pastoral

of the Cardinal Patriarch (...) with the following prophylactic instructions: '1st Cleansing of the soul, through a well-made confession, with the firm intention to change one's life (...) A good conscience produces certain well-being of spirit and body that generates trust in God (...) thus lessens the terror of death, the main driver of the plague, after it has been declared; 2nd Cleaning of the body and housing, and therefore the use of disinfectants, such as vases with lime chloride in homes...'" (*Diário de Notícias*, 04 Sep 1899).

The year 1918 was particularly dramatic in terms of health. If the First World War caused the death of nine million soldiers, plus thirteen million civilians (Keegan, 1993), the pneumonic flu, which the movements of the armies spread around the world, proved to be "one of the worst epidemic scourges of human history", killing 50 to 100 million people (Killingray, 2009). The Portuguese Expeditionary Corps mobilized around 55,000 soldiers, of which 7,000 died (Marques, 2008). The official report on the flu in Portugal pointed to 59,000 deaths between 1918 and 1919, with a mortality rate of 9.8 per thousand. Later studies point to 135,257, which was considered a "true hecatomb" with "dramatic human contours" (Sobral, Sousa, Lima, Castro, 2009).

The pneumonic flu, which the movements of the armies spread around the world, proved to be "one of the worst epidemic scourges of human history", killing 50 to 100 million people

In Porto the flu found a population already extremely debilitated by multiple endemic diseases, among which tuberculosis stands out, aggravated by sanitary conditions that had not yet been subject to significant improvements, and by an epidemic of exanthematic typhus that preceded it (Almeida, 2013a).

One of the most important pieces of advice in epidemic periods was the hospitalization of patients, which confronted the fear these institutions provoked: they were considered places where people went to die. These assistance establishments conveyed an image of squalor and misery and were traditionally associated with poverty and groups that were unable to receive medical treatment at home (Almeida, 2008). For almost all illnesses the implicit rule was that people stayed at home, were cared for by their family and neighbours, and died in their bed. Slowly, the introduction of medicine into private life changed mentalities, but the effects on hospital attendance only became visible in the second half of the 20th century.

In February 1918 the exanthematic typhus epidemic caused a mortality rate that reached 10 percent in hospitals, and higher at home. "Despite the prophylactic measures and the efforts employed by the health delegation of this city, the epidemic of exanthematic typhus has increased in recent days. From Saturday to Sunday, around 60 people were admitted to the

Joaquim Urbano Hospital with typhus attacks (...) That hospital is completely full of patients, making accommodation difficult in the different wards..." (*O Comércio do Porto*, 12 Feb 1918). People who did not comply with periods of isolation and mandatory sanitary inspections were considered "offenders of sanitary regulations" (*O Comércio do Porto*, 07 Jun 1918). They could be fine or even arrested, which did not prevent some patients from fleeing these dens of disease and death and from doing everything they could to avoid hospitalizations: "Alfredo Caldeira was arrested and sent to Bonfim Hospital. He had escaped from that hospital on the 9th of the month, where he was being treated for typhus" (*Diário de Notícias*, 14 Feb 1918); "A waiter at the Hotel Nacional, Miguel Rodrigues, born in Pontevedra, having been attacked with typhus, was ordered to go to the typhus hospital. However, the waiter was so frightened that he locked himself in his room and shot himself in the head with a revolver, dying instantly. The corpse was removed to the graveyard" (*Diário de Notícias*, 20 Feb 1918).

People who did not comply with periods of isolation and mandatory sanitary inspections were considered "offenders of sanitary regulations"

With the arrival of the pneumonic flu, President Sidónio Pais made a point of following the matter personally, not neglecting assistance to healed patients and victims' families, contributing from his own pocket to help fight the disease, even though the 1911 Constitution already declared the right to public assistance. Also, the National Assistance Fund and the General Health Services had already been created. In addition to the train trip he made to the north to visit flu patients and distribute food, medicine, and clothing (*Diário de Notícias*, 24 Sep 1918), the president paid for the "hospitalization of poor patients" and authorized "all expenses incurred as a result of the disease..." (*O Comércio do Porto*, 26 Sep 1918). And he promoted a measure that may have contributed to alleviating the fear of hospitals: "The President of the Republic, given the misery of sick people in hospitals, according to information from the government's general commissioner, ordered that each discharged patient, alone or with family, should receive 1$000, and 2$000 should be given to each family of those who died in hospitals" (*O Comércio do Porto*, 16 Oct 1918). Civil society responded actively, and newspapers were agents to activate and rally the efforts of the benefactors and collect money.

A common factor in all the above-mentioned epidemics is fear, an "overwhelming presence" (Santos, 2006) that is rooted in anxiety, a feature of contemporary society (Snowden, 1995). As well as the moral issue of the disease and the behavioural factor: epidemics as punishment for unruly behaviour, which included eating raw fruits and vegetables, or even sexual excesses,

referred to in the eighth "prophylactic instruction on bubonic plague" in 1899 (*Diário de Notícias*, 10 Sep 1899). These concepts of merit, sin and punishment are a religious heritage that science has absorbed and still does not deny, as it has incorporated it into its discourse. Lack of hygiene and socially reprehensible behaviour are always associated with disease and the guilt factor is still there (Crespo, 1990).

These concepts of merit, sin and punishment are a religious heritage that science has absorbed and still does not deny, as it has incorporated it into its discourse

These prejudices were strongly manifested in the AIDS epidemic in the 1980s. Those who caught the disease were viewed as having deviant behaviour, which resulted, in those days, in the lack of stronger measures to fight it. And it continues to be the case with cancer or obesity, and currently with individual accountability for the spread of the covid-19 pandemic, ignoring that there are situations, such as public transportation, in which responsibility rests with their managers.

The effects on mental health resulting from sanitary measures imposed since March 2020, and their repeated disclosure by the media, are still to be measured, but some cases of suicide, the increase in divorces, and other factors are symptoms of the problems that society shall have to face. The fear that has been inflicted on populations will be difficult to overcome, especially on people with previous anxiety problems and mental illnesses that were heightened in this period.

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3.

Entering the labour market during the pandemic: Emotional responses of recent graduates

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ABSTRACT

Young graduates from higher education are striving to enter the labour market during the COVID-19 outbreak, since the government has imposed lockdowns and remote work, and restricted internal and external mobility. This study explores news articles with statements from young soon-to-be and recent graduates to ascertain their emotional responses and mental health symptoms during the pandemic. Most of the graduates became unemployed due to cancellation of job offer or internship, and loss of part-time or recently started jobs. The findings show different emotional responses and highlight a negative perception of the current labour market. It seems that the pandemic has left graduates in "*limbo*", created a sense of insecurity, and raised concern and frustration. Some reported mental health symptoms, notably stress, anxiety, and depression. The study showed the crucial role of

family financial support and protection during the pandemic and the lack of employment opportunities and state support.

Keywords: young graduates; transition into the labour market; pandemic; emotional responses; mental health.

INTRODUCTION

The COVID-19 pandemic had and is still having a massive impact on economic activity, notably on labour markets, since the government has imposed lockdowns and remote work, and has restricted internal and external mobility. The various categories of workers were affected very differently by these constraints, but some remained almost outside of the main public debate. This is especially the case of young graduates from higher education striving to enter the labour market during lockdown periods. Fortunately, soon-to-be and recent graduates were given a voice in some of the media, thus documenting the major problems they faced and how the pandemic-driven economic crisis affected their transition into the labour market.

There is several empirical evidence that suggests that new graduates entering the labour market during an economic recession suffer large, negative, and persistent consequences, notably high unemployment rates, earning losses, and lower expectations of career progression (e.g. Kahn, 2010; Oreopoulos, von Wachter, & Heisz, 2012). However, the recession associated with the pandemic involved greater challenges, namely due to the lockdowns which made it more difficult for the graduates, labeled as class 2020, to transition into the labour market. This context has affected their professional and personal lives and raised the following question: What were the emotional responses of young people graduating during the pandemic?

New graduates entering the labour market during an economic recession suffer large, negative, and persistent consequences

Despite the concerns expressed by researchers and experts about the unprecedented consequences of the pandemic for young people, these have gone largely unheard. The UN Inter-Agency Network on Youth Development has called for action that sheds light on the pandemic's specific impacts on young people's lives and has demanded responses that guarantee their human rights and needs (UN IANYD, 2020). Our study explores 55 news articles with statements from young soon-to-be and recent graduates (n= 140).

The goal is to ascertain young graduates' various emotional responses and mental health symptoms during the COVID-19 outbreak. The graduates in the sample are mostly under the age of 25 and have obtained bachelor's or master's degrees in hard or soft fields of education.

These articles were collected from newspapers and TV broadcast transcripts in 2020, in the early stage of the pandemic. We opted for these media due to the scarcity of statistics and because they represent a relevant platform for breaking news and help audiences remain up to date on a set of topics (Thorsen & Jackson, 2018). Furthermore, the selection criteria, i.e., the articles that include graduates' statements, gave them a voice and made it possible to record their feelings in this unique context.

The rest of the paper is structured as follows. The next section provides a summary of the literature describing the impacts of economic recessions on labour market entries and examines their link with mental health problems. After presenting the data and methodology in Section 3, section 4 focuses on the empirical findings on labour market outcomes and the emotional responses of a sample of graduates worldwide. Concluding remarks and some recommendations are set out in the final section.

YOUNG PEOPLE AND ECONOMIC RECESSION

It is well documented in the literature that youth employment is more sensitive to economic cycles (Ghoshray, Ordóñez & Sala, 2016) and that graduating during a recession has non-negligible impacts on the labour outcomes and trajectories of graduates. Studies have consistently shown that economic recessions have a large, negative, persistent, and scarring effect on young graduates' careers, particularly on spells of unemployment and earnings losses (Kahn, 2010; Oreopoulos, von Wachter, & Heisz, 2012).

Another strand of the literature focuses on the effects of economic crises on mental health, notably anxiety, depression, and suicide (Chang et al., 2013). For example, Selenko (2019) noted that unemployment in adolescence, especially among the low-educated, impacts well-being in several ways. It reduces the chance of meeting people and enlarging the circle beyond family, hinders status recognition and feedback, and makes them less equipped and confident to deal with unemployment.

In what regards recent graduates, Dekker et al. (2014) underlined the considerable resilience of young Dutch graduates in coping with unemployment and their engagement in job search during the economic crisis. Ersoy-Kart and Erdost (2008) found differences across hard and soft fields

of education among Turkish graduates, with social science graduates being more apprehensive about accessing a job than science graduates.

More recently, Ribeiro (2020) confirmed the negative impacts of the pandemic on mental health and suicidal behaviours worldwide. The author reports several public initiatives to prevent or mitigate mental health disorders, notably the prevention of suicide; and the mechanisms to cope with anxiety and isolation. Other studies have shown how young people are particularly vulnerable to the pandemic's negative impact on their emotional and psychological well-being (O'Connor et al., 2021; Every-Palmer et al., 2020). Although the available studies are of interest, the specific emotional responses of young higher education graduates to the hostile labour market during the outbreak of COVID-19 deserve greater scrutiny. Young people expect serious problems and must adopt appropriate strategies to address them. While some respond confidently, others might be unable to handle the situation.

Young people expect serious problems and must adopt appropriate strategies to address them. While some respond confidently, others might be unable to handle the situation

GRADUATES IN THE NEWS ARTICLES

The search of online news articles was conducted from March to September 2020 and was based on certain keywords, notably 'young graduates', 'COVID-19', and 'labour market'. Following an initial look at the news, we realised that a significant number of news items included interviews with soon-to-be graduates and therefore we included the keyword 'soon-to-be graduates'. The focus on soon-to-be graduates at the beginning of the pandemic is explained by the fact that initiatives were introduced to support the transition into the labour market towards the end of the academic year. The articles often include the name of the interviewees (few were anonymous) and this helped us avoid possible duplicate cases, i.e., the same graduates inquired by different news outlets.

The articles cover European (Czech Republic, Finland, France, Germany, Ireland, Spain, and the UK, and non-European countries (Canada, China, India, Sri Lanka, and the US). Although we searched for news in different languages (English, French, Spanish, and Portuguese) to access information from different labour markets worldwide, most of the articles examined are in English. While the collection of data is not exhaustive, it is clear this topic has gone viral in the US. The graduates' statements were

transposed to MaxQda, in which the unit of analysis was the graduate as opposed to the news article and was subject to qualitative content analysis. We collected data on 140 graduates from 55 news articles.

Table 1 summarises the socio-demographic characteristics of graduates interviewed by the media. Most of the graduates are young, women, and undergraduates from soft fields of education.

Table 1. The class 2020 interviewed by the media: Sociodemographic characteristics

Variable	Category	N	%
Gender	Feminine	93	66.91
Age group	Up to 21	9	17.31
	22-24	34	65.38
	25 or +	9	17.31
Degree	Undergraduate	75	87.21
Field of education	Soft	64	75.29
N (total of graduates)		140	

LABOUR MARKET DIFFICULTIES AND MENTAL HEALTH SYMPTOMS

The labour market outcomes of class 2020

Most of the graduates allude to unemployment as the major labour market outcome during the pandemic and report different factors that led them to this outcome. Some had their job or internship offer cancelled, that is they had been engaged in or completed the hiring process, but their employers withdrew the job or internship offer at the last minute. Others' first employment experience was interrupted by the pandemic and they were left unemployed. Some graduates doing part-time or casual

jobs while studying or who had been employed very recently lost their job. In sum, job offer cancellation or job loss threw young people out of work.

A sizeable number of graduates were actively searching for a job, they were classified as unemployed, though not all of them reported the withdrawal of the offer or loss of the job. Many of them reported either no response or refusals to their multiple job applications. Ultimately, the unemployed graduates were dismissed before or after a job experience; lost their job; or their job or internship offer was cancelled or postponed, destroying their opportunity to transit into the labour market.

Young graduates respond to this hostile labour market differently and some reveal mental health symptoms that deserve due attention.

A small number of graduates secured a job during the pandemic, but the employers postponed the start of the employment relationship. Even though the job offer was maintained, there are signs that it may suddenly be withdrawn, and these graduates will join the group of dismissed. Finally, a very small number of graduates successfully started work, but are either working remotely or had to accept a wage cut.

Young graduates respond to this hostile labour market differently and some reveal mental health symptoms that deserve due attention.

Mental health complaints

The news articles reported a set of emotional responses to the graduates' labour situations and the impact of the pandemic, these included health problems. Figure 1 illustrates these responses and clearly shows the different emotional responses among graduates and highlights their negative perception of the current labour market.

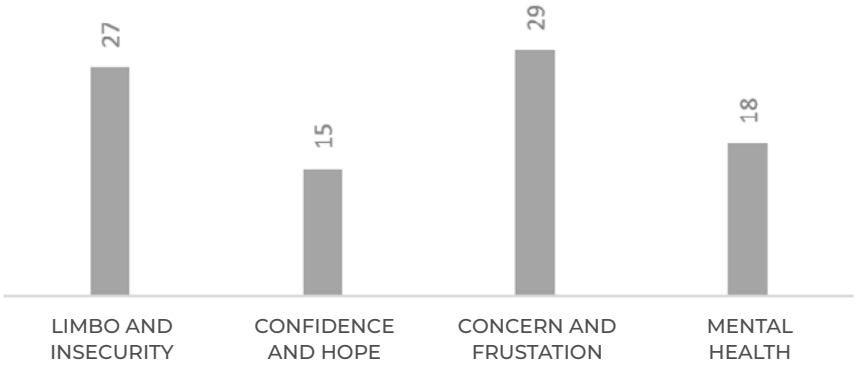

Figure 1. Graduates' emotional responses (frequencies)

The pandemic has left many graduates in "*limbo*" and created a sense of insecurity, raised concern and frustration, but some are still confident and hopeful. More specifically, their statements[1] illustrate that they "*have no idea what is going to happen*" and this raises fear and apprehension about the future. Graduates persistently underline that their "*life has been put on hold*", without any improvements in their situation and life perspective. These feelings may be captured in the complex expression: "*life in limbo*". The sense of insecurity is heightened by the news reporting companies that dismiss workers and suspend hiring. One graduate expresses his feelings as follows: *"so it is really disheartening when you hear things like that while you are looking for a job* " (Female, Aerospace Engineering).

There are reports of concerns and frustration since graduates expect their investments in higher education to bring benefits. Some are demoralised and feel their "*diplomas are worthless*". Moreover, they expect to face "*fierce competition*" among graduates since the stock of job seekers is increasing due to lockdowns and a saturated labour market: "*It is unlucky for our generation that we were born a year after the … financial crisis … and are now facing the gloomy prospect of unemployment*" (Male, Tourism).

Some are demoralised and feel their "diplomas are worthless"

As can be noted from Figure 1, 18 graduates referred explicitly to mental health symptoms, describing a general decline in mental health and

[1] The statements included in this paper are all from undergraduates.

emotional well-being due to stress, anxiety, and depression. Their statements often refer to different contexts in which they feel the impact in different aspects of their well-being; job search or lack of job opportunities and perspectives stand out. Overall, graduates describe this process as stressful and frustrating, and they feel emotionally exhausted by the accumulated stress of job applications and the insecurity brought by the worsening of the health and economic environment. It is usual for graduates to feel anxious during the transition into the labour market, but some insisted that the pandemic had "*amplified our anxieties*" (Female, Commercial Law); "*That has always been a big source of my anxiety, but now it's 10 times worse*" (Female, 21, Cosmetology); and "*it brings back all those memories and feelings of anxiety of going through job interviews, job hunting, receiving all those rejections*" (Male, Computer Science). In other words, mental health is linked to the extreme uncertainly and insecurity amplified by the pandemic.

The pandemic led to a delay in their transition to independent life and, therefore, their autonomy

Similarly, others refer to demotivation and lack of structure linked to the above-mentioned state of "*limbo*": *"I am feeling under pressure and depressed, but I can't do anything except wait for the government to bring the pandemic under control so we can resume our [new] normal life" (*Male, Tourism). Other graduates associate their psychological symptoms to more direct impacts of COVID-19 and its restrictions, mentioning, for example, struggles due to the infection or death of family members; or dealing with a difficult financial situation in the family caused by the pandemic.

The pandemic led to a delay in their transition to independent life and, therefore, their autonomy. These are additional reasons for anxiety and stress. The stress is also associated with financial constraints that may force some graduates to return to their family home (Female, 21, Theatre); to take out a loan or rely on parents' financial support (Male, Environmental Studies and Economics); or struggle to pay off the loans to complete higher education (Male, Media Studies): "*I was very stressed, I didn't know what to do. I'm back living with the parents again for the first time in four years*" (Female, Tourism, and Hospitality).

Others are not only anxious about the effects of the pandemic but also about racial discrimination: "*A lot of Black and Brown students have had to deal with not only the global pandemic but also deal with racism*" (Female). So, the hostile labour market may exacerbate the difficulties felt by certain groups that usually benefit less from their investment in education.

Some of the sampled graduates are confident about going into the labour market during the pandemic. Their coping strategies include acquiring new skills; working as volunteers; or accepting jobs outside their field of education. However, they go to great efforts to get a job and make dozens or hundreds of applications with no or negligible responses.

CONCLUDING REMARKS

Our study shows some of the difficulties experienced by a set of graduates in European and non-European countries during the first stage of the pandemic. We explored news articles due to the scarcity of data and because the media is a platform for breaking news that helps audiences remain up to date on a set of topics and gives a voice to those who go unheard.

The graduates expressed feelings of anxiety, stress, depression in a tough labour market that is aggravated by the pandemic context

The news articles highlighted how young graduates are experiencing and dealing with the consequences of COVID-19 in their transition into the labour market. They raised awareness among researchers and policymakers of the specific problems facing youngsters because of the pandemic while also unveiling cyclical and structural youth labour market outcomes. The media showed how graduates struggle to find a job and often worry about the lack of job offers and fear competition.

The graduates expressed feelings of anxiety, stress, depression in a tough labour market that is aggravated by the pandemic context. Their lives have been put in *limbo* by the pandemic, which has also hindered their ability to become financially and economically independent. If policymakers ignore this effect of the pandemic, it could lead to greater mental health problems. Previous crises have contributed to severe mental health disorders and policy initiatives are required to avoid such problems. Furthermore, governments must develop policies and strategies to avoid losing this generation of highly skilled youngsters.

An appropriate answer involves a combination of policies that facilitate the transition into the labour market, using and improving young people's skills, providing financial support, and working to reduce mental health problems. Policymakers should understand that mental health symptoms are intrinsically related to labour market outcomes. Joblessness increases anxiety, stress, and feelings of depression among young people, notably graduates. Furthermore, the worsening inequalities and transition

of minorities is an additional source of stress reported by graduates. Governments should take action to mitigate mental health problems caused by economic recessions and tackle inequalities.

Finally, governments must collect specific microdata on coping strategies and health problems to examine whether they are transitory or persistent; whether they appeared during the pandemic or had already existed; to identify the most affected categories of young people, and the remedial strategies to cope with them. Our study showed the crucial role of family financial support and protection during the pandemic and the lack of employment opportunities and state support.

ACKNOWLEDGMENTS

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RUS

4.

Sport as a vehicle for skills development, integration, and well-being

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ABSTRACT

This work synthesizes the links between sport and health, evidenced during the fieldwork of Sport as a vehicle for developing skills for the labor market and promoting employability and entrepreneurship (S4MED), funded by the European Commission through the Erasmus program + Sport. The project aims to promote education and the development of skills in and through sport, through the proposal of activities aimed at the creation of educational resources open to the public, dedicated to the transfer of skills acquired with sports activity to the labor market. In parallel, the project serves to combat four crucial crises in today's society: the sports crisis, the employment crisis, the crisis of resignation of new generations, and the immigration crisis. In this text, we demonstrate how the results of this initiative and the fight against these outbreaks of conflict have direct implications for the health of the societal groups involved.

Keywords: Sport, employment, labor market, health, skills.

INTRODUCTION

The COVID-19 pandemic demonstrated the importance of sport and physical exercise for both physical and mental health (Chen et. al 2020; Dwyer et. al 2020). When confinement measures were presented around the world, government officials and opinion leaders recommended that the entire population exercise in their homes. Exercise, in this context, was understood as a way to combat stress, anxiety, and promote channels of resilience[2].

Later, sporting activities were one of the first things that were allowed: going out and running, cycling, surfing. In Portugal, spending on gyms was included in the list of tax-deductible invoices. However, according to the Eurobarometer, Portugal continues to be one of the countries where the least sport is practiced, lacking a clear program of public sports policy, where there is still a lot of work to be done for society to understand the social, economic and political impact that sport has.

Portugal continues to be one of the countries where the least sport is practiced

In this context, Iscte has been developing several projects aimed at demonstrating the social impact of sport (Schulenkorf et. Al 2016) and promoting its social development[3]. In this sense, the project "Sport as a vehicle for the development of skills for the labor market and promotion of employability and entrepreneurship (SbS4Med)", financed by the European Commission through the Erasmus + Sport Programme, aims to promote education and develop skills in and through sport, through the proposal of activities aimed at the creation of educational resources open to the public, dedicated to transferring skills acquired with sporting activity to the labor market.

The 3-year-project was launched in January 2020. It is a collaborative partnership among Portuguese institutions (Iscte and Coaches Portugal); Italy (Università Cattolica del Sacro Cuore and Okkam srl); Qatar/England (International Center for Sport Security and Save the dream), Croatia (HAŠK Mladost), Greece (The International Olympic Truce Centre), Spain (Universitat de les Illes Balears), and Cyprus (Cyprus Sports Organization).

[2] https://es.unesco.org/news/deporte-es-clave-revertir-crisis

[3] Among them T-PREG (http://www.tpreg-training.eu/); AMATT (https://www.amatt.eu/); BITEFIX (https://www.bitefix.eu/)

WORKING PLAN

Sport is a vehicle for developing skills for the labor market and for promoting employability and entrepreneurship. Through its practice, it can also foster social transformation (Spaaij 2019). This project has a particular focus on the Mediterranean region, mirroring different socio-cultural backgrounds that include young people, people starting their careers, and immigrants. Its target groups are sports coaches and instructors, young people, and the unemployed who can find in sport an added value for (re) integration in the labor market.

As a starting point, we conformed working groups and we carried out interviews with coaches and sports instructors to know their opinion about the essential skills they developed and which they transmit to sports practitioners. To complete the table, perspectives of human resources experts and managers on the impact of sport on professional career development were also collected and analyzed.

Sport is a vehicle for developing skills for the labor market and for promoting employability and entrepreneurship

A qualitative methodology was chosen, which consisted of conducting semi-structured interviews with sports instructors and HR experts through focus groups. The results of in-depth analysis and comparison of these interviews made it possible to highlight commonalities and differences between them. All participants agreed that sport can be a fundamental tool for the development of employability skills, endorsing the existence of a strong link between the skills developed through sports and those helpful in entering the job market. The higher valued skills were

- communication skills;
- inter-personal (collaboration) and intra-personal (adaptation) skills;
- contextualization skills (management of complexity); and
- cognitive skills (decision making and creativity).

They further underlined the importance of professional practices and awareness-raising in the promotion of such skills and their transferability. Both sports coaches and HR experts recognize thus the importance of leadership in the development of behavioural skills and the need for its consolidation through educational programs. While all participants consider that subjectivity can play a role in acquiring and transferring specific skills depending on each person's internal dispositions, coaches mentioned

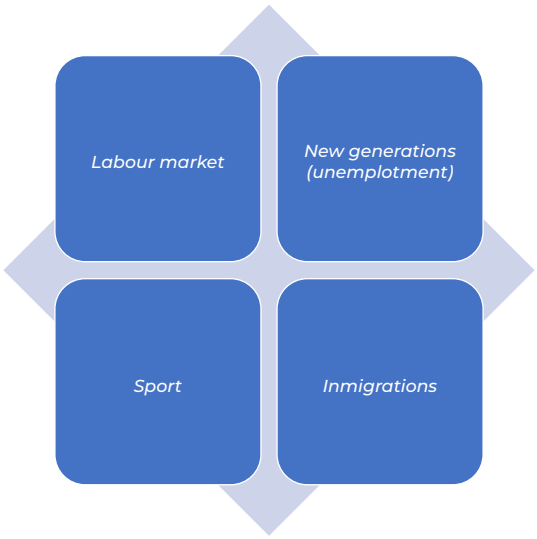
the importance of personality-related skills, whereas HR experts did not explicitly. As far as difficulties are concerned, three dimensions have been underlined.

1. First, the concrete mechanisms and processes of skills transferability seem to remain unclear for most participants, namely the ways and degree to which that transfer can be accomplished. Likewise, the participants struggle to explain the methods and practical actions to be implemented on the playing field to promote this awareness among athletes.
2. Second, participants in the sports world and the business world recognize a lack of familiarity regarding the other context, which suggests that a more direct and active communication exchange between sports and business contexts would be desirable in promoting employability and entrepreneurship through sport.
3. At a more societal level, all participants expressed significant concern regarding the effects of COVID-19's pandemic over their professional activity and the likeliness of skill development during the present time; they recognized the need for hard skills, such as technology to be integrated/developed, even at an elementary level, but never at the expense of behavioral skills.

Finally, in some cases, coaches expressed concern over the political lack of attention and visibility attributed to sports and to life-long sports' promotion and the inequality of financial and material resources between different modalities and clubs, all of which are considered aspects to improve.

FOUR CRISES, ONE PROPOSAL

The project aims to address four crises of contemporary society, all directly or indirectly related to physical or mental health issues.



The first one is the sports crisis. The health benefits of sporting activity are well known (Coalter 2005; Khan et al 2012)). However, Portugal remains one of the countries in the European Union where people practice less sport[4]. This situation has been getting worse due to the crisis that sport is going through in contemporary societies. This crisis is materialized in the loss of members in clubs, contraction in the number of practitioners of federated sports, and reduced use of sports facilities. Amid this crisis, two social practices appear that create the new sports ecosystem. On the one hand, new sports enthusiasts prefer outdoor and individual sports such as running, cycling, yoga, pilates, or surfing. At the same time, new generations have lost interest in traditional sport and have been seduced by electronic sports or eSport, a new industry that came to compete directly with the traditional sports industry (Pizzo et al 2018).

new generations have lost interest in traditional sport and have been seduced by electronic sports or eSport

Second, there is an employment crisis. Youth unemployment rates are higher than in the general population, reaching worrying values, such as 40% in some southern European countries (Tomic 2018; Karamessini et al 2019). Wages have also lost purchase levels in recent years. Paradoxically, Europe has the best

[4] https://www.dn.pt/vida-e-futuro/portugueses-sao-dos-que-menos-exercicio-praticam-na-europa-10735355.html

prepared new generations in its entire history, with levels of postgraduate studies never reached before. Therefore, we are faced with a mixture of robust curriculum and knowledge and limited employment with decent wages according to the worker's education and training. This situation creates discontent, anxiety, loss of confidence, and the conviction of an unfair world (Moriconi 2015; Ramos and Moriconi 2018). Holding master's and doctoral degrees, but having not proportional returns and recognition, psychic health, and stability become problematic.

The first two crises combine to create the third. The new generations are trained to achieve recognition and social impact that they rarely achieve. They are dynamic and formatted for a world of screens that can create a lack of concentration and resilience skills. They are individualistic and teamwork can be a problem for their development. This dynamism has generated a loss of interest in traditional sports, which materializes in a drop in television audiences, a loss of practitioners of traditional sports, and an increase in electronic sports. These are generations with many abilities and university degrees, but sometimes with few tools for emotional intelligence, which has led to record levels of stress, anxiety, and depression (González-Ramírez 2021).

While this situation exists on the North Coast of the Mediterranean, with the affirmation of the trend towards an aging population, as in other European countries, on the other coast of the Mediterranean, on the South Coast of this sea, Africa doubles its population every 20 years. The threat of disproportionate immigration increases (Idemudia and Boehnke 2020; Perkowski and Squire 2019; Mainwaring 2019). It is, therefore, urgent to integrate the southern coast of the Mediterranean into the perspectives of the development of European public policies.

The SbS4Med project seeks to reflect and study responses to these four crises, demonstrating the relevance of sport as an engine for integration, development, and education. The concrete demonstration of the social impact of sport allows us to re-evaluate its value and enhance its social recognition (Lyras and Peachey 2011; Moriconi 2020; Jackson 2013; Nygard and Gated 2013; Malm et al 2019; Moriconi and Almeida 2019), helping to overcome the crisis in which it currently finds itself.

In particular, SbS4Med demonstrates the potential of sport as a promoter of key skills to succeed in the labor market, which contributes to mitigating the second crisis, that of the labor market and unemployment.

sport can help to apprehend, to consolidate skills such as resilience, patience, teamwork, concentration

Concretely, sport can help to apprehend, to consolidate skills such as resilience, patience, teamwork,

concentration, all keys when it comes to overcoming critical contexts, and overcoming focuses of stress and anxiety. Sport, as a transmission of competencies, is a key tool to combat complex sources of public health problems and mental instability. This is what motivated opinion leaders around the world to recommend physical exercise during confinement.

Finally, SbS4Med proposes a comprehensive area of intervention and influence, reaching the North African coast, bringing together different entities in a partnership that encompasses the academic and social intervention areas, and incorporating associated partners in Egypt, Tunisia, and Algeria. The project also seeks to be a tool for the development of this region, by supporting the creation of more and better human resources that can boost local economies. The impact of sport, in addition to the benefits for health, is also cultural, social, and economic. The availability of tools in open access and digital format that the project proposes aims to raise awareness and train for this strong interconnection between sports, employability, entrepreneurship, healthy living, social integration, with the ultimate goal of providing the full experience of the individual in the community.

CONCLUSIONS

This article demonstrates the usefulness of sport as a factor for social development and the contribution that research on and through sport can have for the study and social intervention in the area of (physical and mental) health. Although its social and economic impact has been scientifically proven, the relevance of sport is sometimes called into question and the sector still struggles to get the place it deserves on the political and academic agenda. In this sense, the Erasmus + Sport program has become an efficient tool to respond to these needs. It has put academic, sports, and political institutions working together to revalue sport and turn it into a permanent source of social development. And Iscte, through SbS4Med and other projects, has been a relevant player in this process.

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5.

Strengthening the role of adaptive sport in well-being: recommendations

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ABSTRACT

This study analyses the role of sport in improving the mental and physical health of people with disabilities and identifies the main barriers to and facilitators of participation in adaptive sport. The discussion includes the factors associated with initial adherence to and abandonment of programmes. Content analysis was carried out of the data gathered from two focus groups, which included varied stakeholders' participation in adaptive sport. The results reveal that four internal motivations are the main factors determining adherence to adaptive sports programmes: health, social life, satisfaction, and inclusion. The primary determinants of decisions to drop out are cost and/or support, transport, and accessibility. Proposed interventions are presented that can help improve the well-being of people with disabilities through adaptive sport.

Keywords: adaptive sport; disability; motivation; barrier; well-being.

INTRODUCTION

Sport plays an important role in improving the mental and physical health of people with disabilities. Individuals with disabilities who engage in sport report better psychological well-being than non-participants do (Lundberg et al., 2010). Although the literature acknowledges the association between sport participation and practitioners' physical and mental health development, the marginalisation of people with disabilities has undermined their involvement in the dominant sport-related cultural patterns (Cassese and Raiola, 2017; Kiuppis, 2018; Christiaens and Brittain, 2021).

Participation in sport and physical activity by individuals with disabilities has often been seen as a function of physical or psychological therapy. However, sport can also be an effective social inclusion tool (Christiaens and Brittain, 2021). Kiuppis (2018) emphasises that this specific population's choice of sport should include not only separate activities for people with disabilities but also modified activities that target all sports participants and offer inclusive structures.

Participation in sport and physical activity by individuals with disabilities has often been seen as a function of physical or psychological therapy

Each individual's experience of sport is a feeling derived from their assessment of whether their sports activities satisfy one or more of their values and needs in terms of six aspects: availability, autonomy, challenge, mastery, involvement, and meaning (Evans et al., 2018). Adaptive sport offers opportunities to build social relationships, experience freedom and success, and make positive comparisons with other disabled athletes (Lundberg et al., 2011). Darcy et al.'s (2017) study revealed five factors that function as motivations or constraints for people considering doing adaptive sport: necessary equipment, economic conditions, intrapersonal and interpersonal issues, and problems with transport and facilities' location. The literature also underlines the role played by families of young individuals with disabilities either in experimentation with or loyalty to sports activities (Armila et al., 2017; Evans et al., 2018). Facilities' location and accessibility are also crucial for athletes with mobility difficulties (Gombás and Gál, 2016; Reklaitiene et al., 2016).

The Paralympic Games in the summer of 2021 once again stimulated public discussions about participation in sport by individuals with disabilities. According to the Federação Portuguesa de Desporto para Pessoas com Deficiência (Portuguese Federation of Sport for People with Disabilities [FPDD], 2021), only 0.135% of people with disabilities enrolled in formal sports programs in 2020. Saraiva et al. (2013) found that, in addition to a

low rate of involvement in adaptive sports activities, Portugal is characterised by an asymmetric geographical distribution of individuals with disabilities. Of the athletes with disabilities registered in clubs, 27% practiced futsal, basketball, or boccia; 20% athletics; 13% swimming, and 12% football.

In general, the Portuguese population has limited knowledge about adaptive sport. This chapter presents the results of an exploratory study focused on this topic. The main objective was to formulate recommendations for how best to promote sports activities for individuals with disabilities in Portugal.

ADAPTIVE SPORT IN PORTUGAL

Legal framework

The Republic of Portugal's Constitution states in Article 79, that all citizens have the right to enjoy physical cultural activities and sport. In addition, Article 1 of Law 30/2004 of 21 July – Basic Sports Law – assumes that sport is an indispensable component of an individual's and society's development. The specific points contained in Articles 5, 26, 32, 70, and 82 are related to sports activities for citizens with disabilities. Law 38/2004 of 18 August is the Basic Law for the Prevention of Marginalisation and the Rehabilitation and Integration of People with Disabilities, which refers to the importance of sport for citizens with disabilities. In particular, sport and recreational activities are listed as measures that promote habilitation and rehabilitation (i.e. Article 25). The technical standards to ensure the accessibility of sports facilities is defined in Decree-Law 163/2006 of 8 August. The option of offering sports activities in special schools is mentioned in Decree-Law 3/2008 of 7 January, which provides for specialised support to be provided in pre-school, basic, and secondary education programmes in the public, private and cooperative business sectors.

Adaptive sport participation

According to the 2011 census, approximately 9% of the Portuguese population (900,000 people) has one or more disabilities and/or functional limitations. The FPDD reports that, in 2020, only about 0.135% of individuals with disabilities (1,217 athletes) were enrolled in formal sports activities. The latter group are members of 98 clubs in 18 districts (see Table 1). Three out

of four adaptive sports athletes are men, and only a small percentage of these individuals fall within the young age range. In addition, the data show a decrease in indicators related to participation in the adaptive sport over the last five years. For example, the number of active clubs fell from 160 to 98 during this period.

Table 1. Status of sport for people with disabilities in Portugal, 2016–2020

	2016	2017	2018	2019	2020
Number of practitioners	1,450	1,609	1,362	1,368	1,217
Female participation rate (%)	26	23	24	24	25
Number of practitioners at youth levels (juniors)	103	76	70	61	74
Geographical location (number of districts)	19	18	19	20	18
Number of active clubs	160	110	11	155	98
Number of training activities	46	38	46	56	
Number of referees and judges	39	27	43	37	24
Number of coaches and/or technicians	133	123	135	154	122

Source: FPDD (2021)

In 2020, adaptive sport human resources comprised 41 managers, 59 assistant coaches, 38 competition partners, and 10 medical support personnel. In the same year, 94 athletes with disabilities were members of national teams and part of the high-performance programme subsystem (see Table 2).

Table 2. Individuals with disabilities on national teams and in high-performance programmes

	2016	2017	2018	2019	2020
Level A	72	47	108	86	75
Level B	0	5	8	0	3
Level C	16	9	2	1	16
Total	88	61	118	87	94

Source: FPDD (2021)

METHODOLOGY

In the present study, two group discussions (i.e. focus groups) were organised with 35 participants. The latter represented 30 organisations linked to adaptive sport, including clubs, gyms, associations linked to various types of disabilities, associations, federations, and people related to school sports activities. This wide set of organisational memberships facilitated the gathering of data reflecting both the adaptive sports offer and demand perspectives.

The focus group guide included questions about the definition of adaptive sport, events, and public policies, as well as factors affecting initial adherence and abandonment by people with disabilities. The meetings were conducted by two moderators and recorded with the participants' consent. Content analysis was conducted of the resulting transcripts. The fieldwork was carried out as part of the preparations for Lisbon's year as the European Capital of Sport in 2021.

RESULTS

An analysis of the focus group transcripts revealed that the term 'adaptive sport' is not commonly accepted. This expression is considered by experts from some sectors as inaccurate because it is thought to discriminate against a specific population and thus to be disappearing from common usage. Preferred alternatives are terms such as sport for all, sport for people with disabilities, and accessible sport. However, a consensus has not yet been reached on which of these options is the best.

The participants identified the five most important initial factors favouring adherence to sports programmes. Society and/or policies come first, followed by internal motivations; inclusion, integration, group and/or shared living spaces; accessibility; family and friends; and organisations. Other factors mentioned are health, competition, information and/or communication, timetables, security, technical skill, and previous contact with sports programmes.

Regarding internal motivations to join adaptive sports activities, one participant said, 'health, social life, and satisfaction are among the main reasons for engaging in sport due to the growing recognition of the benefits associated with doing sport in these areas.' Another focus group member emphasised that adherence was encouraged by 'inclusion, social interaction, [a need to] achieve physical and psychological goals in their daily lives and 'the desire to show their potential to their family and/or friends.

The participants also listed the factors causing people with disabilities to abandon sports activities, including, first and foremost, determinants related

to cost and/or support, followed by transport, accessibility, and internal motivations. Additional factors mentioned were a lack of support from family and friends; aspects related to society, policies, and/or organisations; and technical skills. Some group members referred to available locations and/or distance, communication and/or information, hours, and health and/or injuries.

The participants also listed the factors causing people with disabilities to abandon sports activities, including, first and foremost, determinants related to cost and/or support, followed by transport, accessibility, and internal motivations

While discussing costs, one participant asserted that 'they are a direct obstacle. The van and driver always entail fees.' In addition, 'urban transport is very inaccessible – inaccessible metro stations [and a] lack of bus lines at night or on weekends – when there are many sports activities.' Regarding accessibility, another group member shared, 'when we talk about participation in adaptive sport, we must always consider that the existence of architectural barriers and the lack of adapted equipment can constitute barriers to sport participation.' Table 3 presents an overview of the results.

Table 3. Intervention priorities

Importance rating	Initial adhesion factors	Abandonment factors
1	Internal motivations – 12	Costs – 12
2	Inclusion, integration, group and/or social factors – 12	Accessibility – 9
3	Accessibility – 7	Transport – 9
4	Family and friends – 7	Internal motivations – 6
5	Society, policies and/or organisations – 5	Family and friends – 5
6	Health – 5	Society, policies and/or organisations – 5
7	Competition – 2	Technical skill – 5
8	Information and/or communication – 2	Available locations and/or distance – 4
9	Time – 2	Information and/or communication – 2
10	Security – 1	Hours – 2
11	Technical skill – 1	Health and/or injuries – 2
12	Transport – 1	N/A
13	Contact with sport and/or known participants – 1	N/A

Note. Figures in the second and third columns are the number of participants who reported the factor in focus group sessions.

The focus panel members reported that spectators at events are often associated with the athletes' families and friends. Accessibility is a further key point to be taken into account when organising events.

Regarding sport policies in Portugal, the meetings' participants concluded that positive aspects have been developed and strengthened in the legislative framework addressing adaptive sports participants' real needs. However, the existing policies are tightly focused on the competition, and a chain of linked policies is missing. Official guidelines at the European level reveal insufficient reflection, producing flaws that result in weak operationalisation and excessive bureaucratisation.

RECOMMENDATIONS

The small percentage of people with disabilities who formally participate in sport means officials need to reinforce initiatives that attract and retain more individuals with disabilities in regular sports programmes. In addition, women and young athletes' greater participation should be systematically encouraged. Programmes must especially focus on promoting experimentation and loyalty in the latter two groups. The present results indicate the potential exists for improvement in various areas, namely, accessibility and transport; protocols and support; networks; optional sport in schools; associations, communities, and clubs; events; experimentation; and communication:

A. Accessibility and transport

1. Improve accessibility via public transport for those participating in adaptive sport, ensure accessibility to infrastructures such as swimming pools and pavilions and offer special rates for people with disabilities
2. Guarantee the best facilities for all those accompanying individuals who engage in adaptive sport (e.g. existing bathroom conditions)
3. Make sure spaces are available at peak times to avoid differentiating adaptive sports participants in negative ways

B. Protocols and support

4. Create accreditation for companies and/or organisations, such as equipment suppliers, sports facilities, and gyms, that encourages them to become the most welcoming and accessible facilities possible for individuals with disabilities (e.g. attribution of a Friend of Adaptive Sports certificate and/or seal)
5. Support innovation in sports equipment dedicated to people with disabilities

C. Networks

6. Develop a database of technical sports aids and share materials and equipment between users and entities so that equipment, spaces, and coaches, among other assets, can be used by various clubs, associations, and collectives and an information-sharing platform can be created to maximises possible synergies
7. Generate a realistic agenda for adaptive sport on a website that contains all the necessary information about the agenda

D. Optional sport in schools

8. Encourage optional adaptive sports activities in schools by conducting more demonstrations in educational institutions to show what forms adaptive sport can take
9. Develop initiatives to attract young people with disabilities who have the potential to practice adaptive sport, based on education programmes shared by schools, clubs, federations, and associations

E. Associations, communities, and clubs

10. Promote inclusion of all individuals with disabilities so that conditions can be created for participation in adaptive sport, offering reasonable solutions even if these activities and/or modes are not exactly what first-time visitors to clubs and/or collectives are seeking at the outset
11. Develop initiatives reflecting various aspects of what can be included within the scope of adaptive sport, such as high-level and local competitions, recreation and leisure activities, and enhancement of well-being and health

F. Events

12. Promote – with the help of the main organisers of sports events – the inclusion in competitions of awareness-raising initiatives to encourage participation in adaptive sport
13. Reinforce initiatives targeting the media in all adaptive sports events or those that have an adaptive sports activity component to raise their visibility and contribute to a more positive image
14. Develop strategies to attract spectators and increase events' exposure, taking advantage of other sports events with large numbers of spectators

G. Experimentation

15. Create a loyalty programme that offers incentives to participate in specific activities and that encourages athletes to continue
16. Encourage equitable participation in terms of gender, launching a campaign to promote physical activity and sport aimed at women with disabilities
17. Conduct a survey of adaptive sport covering the following questions:
    A. What is the potential user population?
    B. Which clubs, collectives, associations, and schools offer adaptive sport?
    C. What is done and who does what?
    D. Who and how many are already part of the existing system and how many more could participate, including reasons why they are not involved?
5. Implement initiatives that reinforce inclusion in sport and that can contribute to increasing spectators' variety and numbers beyond those associated with sports participants' families and friends

H. Communication

6. Generate public communication using well-known figures such as Paralympic athletes to facilitate the promotion and greater awareness of the adaptive sport
7. Strengthen the marketing of adaptive and/or Paralympic sport through engagement and/or bonding strategies targeting the public and/or mainstream, in particular focusing on the emotions generated by sports activities and all their components rather than just showing how athletes overcome difficulties
8. Promote the systematic dissemination of activities and/or events to enhance participation and/or attendance and stay focused on constant communication and/or disclosure
9. Reinforce the previously mentioned dissemination of information through social networks and the media and invite individuals linked to sport – with or without disabilities – such as famous coaches and politicians
10. Seek out sponsorships because adaptive sport produces no revenue and has almost no broadcasting rights, as well as creating a niche in the clothing and/or equipment market, which is a large part of how national-scale events related to the adaptive sport are financed, and focusing on persuading major brands of the importance of being recognised as promoters of adaptive sport causes

Following the above recommendations should generate the desired sustainable growth of the adaptive sport, in Portugal and elsewhere, in terms of both quantity and quality.

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6.

The impact of architectural design on children's health

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ABSTRACT

Recent studies indicate that enclosed spaces with poor ventilation are prone to higher concentrations of contaminants, causing a significant reduction in the quality of the indoor environment, affecting people's well-being with significant implications for their health. This scenario is evident in pre-school buildings, and a prevalence of respiratory diseases has been observed in pre-school children when they started attending children's daycare centres and kindergartens. This article presents in detail the methodology and the results, with particular focus on architectural features, of the research project Environment and Health in Children Day Care Centres (ENVIRH), carried out in pre-school buildings. The results show that the architectural design of the activity rooms influences the way we inhabit the space; on the other hand, the characteristics of the window frames, namely the typology of the windows, influences users' ventilation practices having an

impact on the quality of the indoor environment and the children's health and well-being.

Keywords: Architecture; Ventilation; Health; Well-Being; Children.

INTRODUCTION

The characteristics of architectural space, as well as indoor air quality, have a great impact on people's health and well-being, which has become evident in the current public health context. According to the World Health Organization, Health is a state of complete physical, mental, and social well-being and not merely the absence of disease (WHO, 1946). Recent studies indicate that enclosed spaces with poor ventilation are prone to higher concentrations of indoor pollutants, causing a significant reduction in the quality of the indoor environment, with an impact on people's health and well-being. This scenario is evident in pre-school buildings, with the prevalence of respiratory infections in children under 6 years of age when they start attending daycare centres (Hagerhed-Engman et al., 2006; Zuraimi et al., 2007). Several studies show that poor ventilation conditions are associated with high levels of carbon dioxide in schools (Cano et al., 2012; Dijken et al., 2012; Neuparth et al., 2013; Viegas et al., 2012). Carbon dioxide (CO_2) is a colourless and odourless gas. The CO_2 concentration in indoor air is used as an indicator of indoor environment quality, with the maximum reference limit being 1800mg/m^3 (1000ppm). CO_2 concentrations above the reference limit are an indicator of the presence of other pollutants also above the reference value in indoor air, such as microorganisms, particles and volatile organic compounds (Clements-Croome, 2008; Fanger, 2006; Godwin & Batterman, 2007; Griffiths & Eftekhari, 2008; Shendell et al., 2004; Simoni et al., 2010; Zuraimi et al., 2003). It has been observed that even at low indoor concentrations, these pollutants can have adverse health effects when the exposure is prolonged (Simoni et al., 2010). The quality of the indoor environment depends not only on ventilation rates but also on architectural characteristics and construction elements of the space that stimulate or condition ventilation practices and strategies (Azevedo et al., 2012). This article presents in detail the methodology and results, with particular focus on architectural features, of the research, carried out within the scope of the research project ENVIRH – Environment and Health in Children Day Care Centres (Araújo-Martins

The characteristics of architectural space, as well as indoor air quality, have a great impact on people's health and well-being

et al., 2014), conducted in preschool buildings by a multidisciplinary team, funded by the Foundation for Science and Technology (FCT).

METHODS

This study was developed between the months of October and December 2010. A total of 45 day-care centres were observed, 25 in Lisbon and 20 in Oporto. In each building, architectural descriptors and construction solutions that may influence the quality of the indoor environment and the health and well-being of children were registered, namely, the characteristics of the urban environment – location, footprint area, and typology; the characteristics of the functional organisation of space – relationship between indoors and outdoors; and the characteristics of the window frames – size and location of windows, as well as the type of moving leaf.

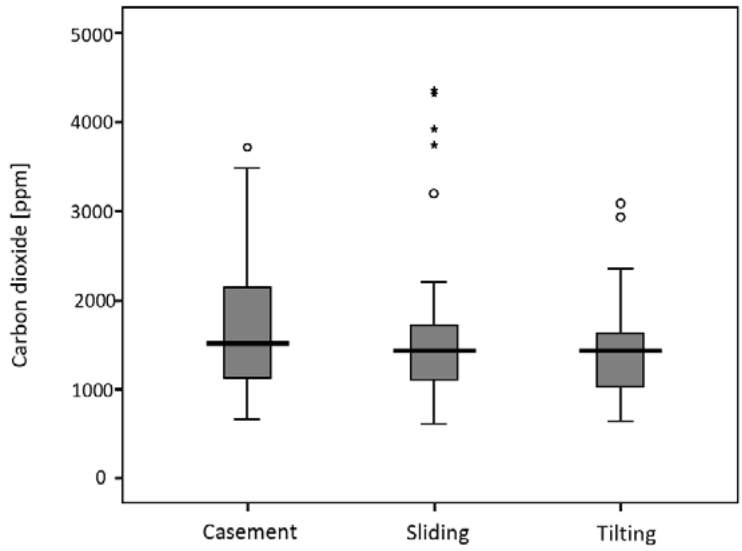
On average, three activity rooms were monitored in each school. In total, 143 activity rooms were studied (82 in Lisbon and 61 in Oporto). In each room, the following data were registered: area and height of the room, type of windows (casement, sliding or tilt/tilt-turn), the position of the windows (open or shut), number of children present, children group age, air temperature, and relative humidity, and CO_2 concentration inside and outside (sampling from 10 to 15 minutes corresponding to time necessary to obtain a stable reading in the equipment). For the measurement of air temperature and relative humidity outdoors and indoors, a digital Thermo hygrometer, model Oregon Scientific THGR328N, was used. The carbon dioxide concentration outside and inside was measured with a non-dispersive infra-red absorption detector, model Telaire 7001. Based on the collected data, an exploratory analysis of the variables was conducted considering room area [m^2], room volume [m^3], window framing characteristics, orientation, access, number of children, occupational density [m^{-2}], average outdoor temperature [ºC], indoor temperature [ºC], relative humidity [%], precipitation, wind speed [m/s], observed and declared ventilation practices, and CO_2 concentration [ppm] in the period of use. For quantitative variables, characteristics were presented as medians and inter-quartile range (25^{th} percentile: P_{25} – 75^{th} percentile: P_{75}), because of the existence of outliers, high variability, and skewed distributions. For categorical data, frequencies and/or percentages were calculated. Spearman correlation coefficient was used to evaluate the association between some of the quantitative variables, however, since no linear relationship was detected, the Locally Weighted Scatterplot Smoother (LOWESS) was used to identify the functional form of the association between those variables.

For the comparison of quantitative variables, the Mann-Whitney and Kruskal-Wallis tests were used, to study the hypothesis of differences of variables with two or more categories, respectively. When the Kruskal-Wallis test was applied, multiple comparisons were made, whenever necessary, to identify which groups were different. For the association study between categorical variables, the Chi-Squared test or Fisher's Exact Test was used, as required. Because CO_2 is a continuous variable, simple and multiple linear regression models were used. To obtain residuals with a Gaussian distribution, a logarithmic transformation of CO_2 values was done. Confidence intervals (95% CI) were calculated whenever appropriate. A level of significance $\alpha = 0.05$ was considered. Data analysis was performed using SPSS 15.0 (Statistical Package for the Social Sciences, Chicago, Illinois, USA) software.

RESULTS

The results of the evaluation campaign conducted between October and December 2010 in the 143 activity rooms show indoor CO_2 concentrations higher than 1000ppm (1800 mg/m^3) in 92% of daycare centres in Lisbon and 90% of daycare centres in Oporto. As expected, it was also found that the characteristics of the window frames, namely the type of moving leaf (casement, sliding, tilt/tilt-turn), condition the quality of room ventilation, as the highest CO_2 concentrations were recorded in the activity rooms with casement windows (median=1509; P_{25}:1119 – P_{75}:2138). In comparison, rooms with sliding windows (median=1433; P_{25}:1086 – P_{75}:1730) and tilt windows (median=1433; P_{25}:1000 – P_{75}:1627) –recorded slightly better values (see boxplot 1).

The characteristics of the window frames, namely the type of moving leaf (casement, sliding, tilt/tilt-turn), condition the quality of room ventilation



Boxplot 1 Association between CO2 concentration and window type of moving.

This relationship between the type of windows and CO_2 concentration is justified by the type of gaskets (plush) in the sliding windows (more permeable to the surrounding air) and the greater frequency of window opening with tilt-turn type of leaf during the occupation period. It was observed that 64.7% of the rooms with tilt or tilt-turn windows were open, and 13.2% of the rooms with casement windows were closed. On rainy days during the occupancy period, it was observed that 100% of the rooms with tilt or tilt-turn windows were open, and 95.2% of the rooms with casement windows were closed.

The tilt or tilt turn windows – figure 1, when opened in a tilting position, are not intrusive in the space, do not invade the area of activities intended for permanence and allow directing the air flow entering the space to the outside of the occupation zone – figure 2. They do not present any problems when open, with regard to rain entry – figure 3, nor problems in terms of children's safety, (possible falls of children to the outside, being unlikely to occur finger crushing, limb and head collisions on the edges of window leaves).

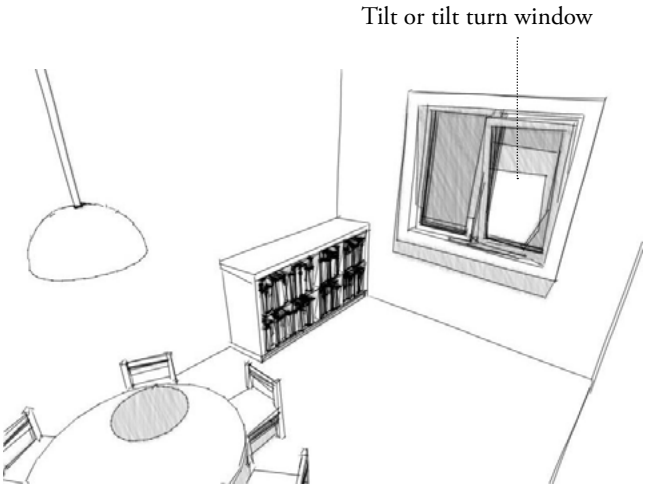


Figure 1 Illustrative drawing of activity room with tilt window (Azevedo, 2012).

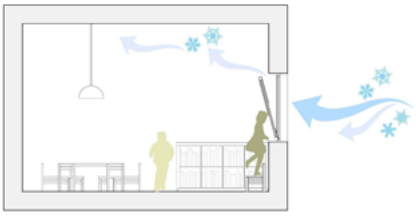


Figure 2 Illustrative drawing of ventilation impact on the occupation area – Tilt window (Azevedo, 2012).

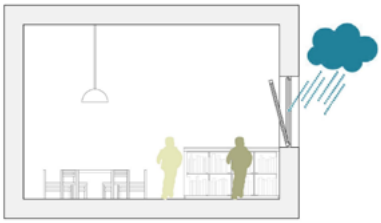
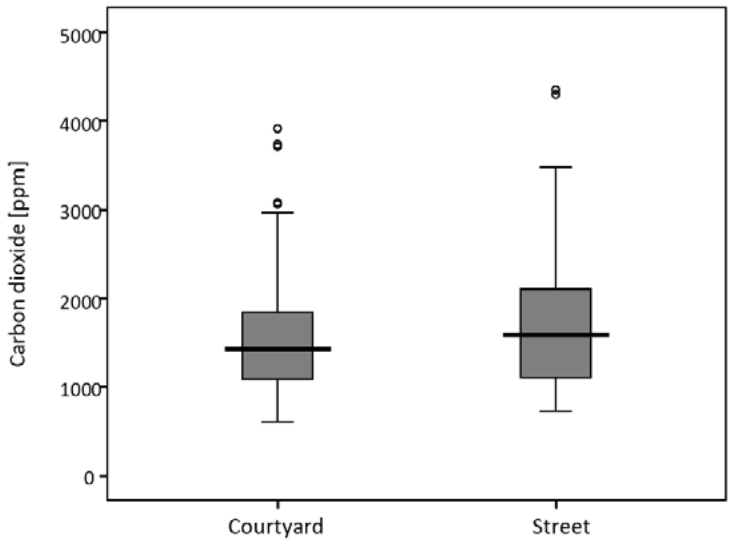


Figure 3 Illustrative drawing of protection against rain entry – Tilt window (Azevedo, 2012).

Furthermore, it was also found that the orientation of the activity room can also influence ventilation quality as in street-oriented activity rooms (median=1598; P_{25}:1081 – P_{75}:2121), higher CO_2 concentrations were recorded compared to the rooms orientated towards the courtyard (median=1436; P_{25}:1085 – P_{75}:1891) – see boxplot 2.



Boxplot 2 Relationship between CO_2 concentration and the orientation of the activity rooms.

This fact is related to the characteristics of the urban surroundings – noise levels and proximity to roads of intense traffic, as well as privacy and safety of the children. In this regard, it is observed that the classrooms facing the street – figure 4, often have their windows closed during the occupation period (71.9%), registering higher concentrations of CO_2. In comparison with rooms facing the courtyard or the rear façade – figure 5, which often have the windows open during the occupation period (61.3%), registering lower CO_2 concentrations.

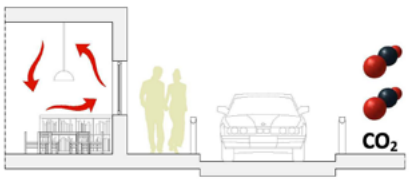


Figure 4 Illustrative drawing of street-oriented activity rooms (Azevedo, 2012).

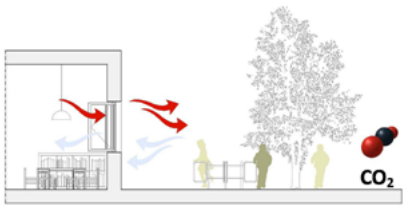
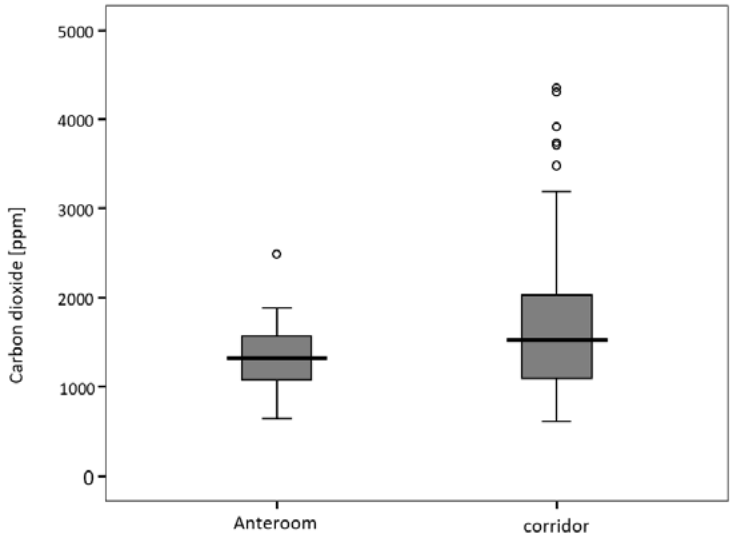


Figure 5 Illustrative drawing of the activity rooms oriented to the courtyard or rear façade (Azevedo, 2012).

Another factor influencing the ventilation quality is the access to the activity room. Higher CO_2 concentrations were recorded in activity rooms with access through a corridor (median=1526; P_{25}:1090 – P_{75}:2033), compared to rooms with access through anteroom (median=1327; P_{25}:1070 – P_{75}:1644) – see boxplot 3.



Boxplot 3 Relationship between CO_2 concentration and activity room access.

A possible justification for this result is the fact that the rooms that have access through the anteroom – figure 6, often have the doors open during the period when the rooms are occupied (63.6%), registering lower CO_2 concentrations. In comparison with rooms that have direct access through the circulation area – corridor – figure 7, frequently have the doors open during the occupation period of the rooms (73.8%), recording higher concentrations of CO_2.

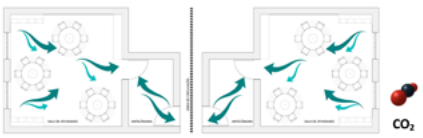


Figure 6 Illustrative drawing of the activity rooms with anteroom access (Azevedo, 2012).

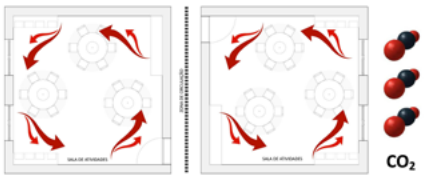


Figure 7 Illustrative drawing of the activity rooms with access through the circulation area – corridor (Azevedo, 2012).

CONCLUSIONS

This paper presents the methodology and the results obtained in the study of the relationship between characteristics of pre-school buildings and indoor environment quality, with particular focus on architectural features, a study developed under the research project ENVIRH – Environment and Health in Children Day Care Centres. The results presented show the need to improve ventilation strategies, since 92% of schools in Lisbon and 90% of schools in Oporto show indoor CO_2 average concentrations higher than the recommended limit of 1000ppm (1800mg/m^3).

Based on the results of this study, we present design guiding strategies for pre-school buildings to promote indoor environmental quality, health, and well-being of children. In this regard, we recommend that the activity rooms have the following organizational characteristics, as well as the following construction characteristics: rooms in symbiosis with patio or rear façades to jointly enhance safety, privacy, and ventilation; rooms with windows whose type of moving leaf, when open, does not invade the space where the children are to remain, and which should have different openings to direct the flow of air that enters the space to the outside of the occupation zone and which, when open, do not present problems in regarding rain entry and problems at the safety level concerning possible children falling to the outside. The windows with moving tilt leaf or tilt-turn leaf prove to be the most appropriate for spaces for the permanence of children. It is generally concluded that the functional organisation determines the appropriation of the spaces by the occupants, has an impact on the ventilation and consequently on indoor environment quality, with possible consequences on the health and well-being of the children. For these reasons, spaces should be designed to stimulate users' practices in ventilation strategies.

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