From Positive Youth Development to Youth's Engagement: the Dream Teens

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In addition to the empirical validation of 'health and happiness' determinants, theoretical models suggesting where to ground actions are necessary. In the beginning of the twentieth century, intervention models focused on evaluation and empirical validation were only concerned about overt behaviours (verbal and non-verbal) and covert behaviours (cognitions and emotions). Later on in the middle of the century, there was a shift from treating the problems to a positive approach, focused on promoting assets and individual strengths. Thus, the role of social competences, self-regulation and resilience became salient. Researchers also highlighted the importance of social cohesion and social support, as active health and wellbeing facilitators. More recently, in the twenty-first century, the population's engagement (positive engagement) has become crucial. This paper presents the evolution of this theoretical and scientific path, using Portugal as a case study, where early interventions focused on the positive aspects of both covert and overt behaviours, while more recent interventions included explicitly the perspective of youth engagement and participation, as is the case of the Dream Teens Project. It is expected that the political and professional understanding of this trajectory will allow professionals to provide better health and educational services, improving young people's engagement, quality of life, health and wellbeing.

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Introduction

In the early 1990s, a group of researchers initiated the Social Adventure Project in Portugal with the aim of studying and promoting social behaviour and health amongst young people. The first project included a range of interventions targeting vulnerable young people. The goal was to promote social competence by increasing young people's behavioural, cognitive and emotional repertoires, since it was considered that this could reduce both aggressive and inhibited patterns of interpersonal interaction and risky behaviours. Interventions were focused on young people, but also included training for professionals and families. Subsequently, other projects were developed with a focus on universal interventions following the same theoretical background and intervention model. In the early nineties, the team was involved in several national and international projects targeting young people's health and well-being, in order to provide a baseline for understanding, at a national and international level, the state of the art and the development of evidence-based interventions. The range of national and international projects included: HBSC – Health Behaviour in School-aged Children, KIDSCREEN, TEMPEST, PEER-Drive Clean, RICHE, DICE, Y-SAV, CED - *Find your own style*, and more recently, Dream Teens. All interventions, ultimately, intended to motivate young people to improve their social skills and increase their social participation, in order to achieve a healthier and happier lifestyle.

The challenge in 2010 and beyond was to understand how to best apply a positive and proactive approach in a rapidly changing, 'crisis-ridden' society, redressing the balance between programmes that focus on disease and those centred on the happiness and wellbeing of individuals and societies, valuing and promoting their competences instead of focusing on their deficits, and encouraging their active participation within a lifespan perspective. This paper discusses the course of our own work in Portugal and present a critical review of various significant perspectives and their evolution during the 20th century and the beginning of the 21st century; the cited authors are not, necessarily, the most important in the area, instead, we refer to those that, for one reason or another, were the most inspiring for our team work and trajectory. Finally, we present a critical review of the core scientific literature concerning our investigation and intervention work with adolescents, starting from an education and promotion of competences perspective, ending with a perspective committed to youth engagement and civic participation.

Critical Review

In the first historical period, intervention models oriented towards 'behaviour change' were merely concerned about *overt behaviours* (verbal and non-verbal) and *covert behaviours* (cognitions and emotions). In the area of social skills, in this initial period, *overt behaviours* were assumed as those whose learning would guarantee social competence. In a second stage, social competence was built from much more than a set of simple social skills and had to be adjusted to one's gender, age, social situation, culture, or historical period. Furthermore, social competence would not be a matter of simple *overt behaviours* but rather complex *covert behaviours* that included verbal and nonverbal aspects and also thoughts, beliefs, emotions, and physiological responses. Authors such as Felner, Lease, & Philips (1990), Matos (1997), McFall (1982) and Spence (1980) helped establish an indepth understanding of this process. Later, there was a shift to a positive

approach that would lead to promoting assets and individual strengths; in addition the role of social competences, self-regulation and resilience became more salient. During the same period, researchers highlighted the importance of social cohesion and social support as wellbeing facilitators. Authors such as Kia-Keating, Dowdy, Morgan, and Noam (2011), Lerner, Phelps, Forman, and Bowers (2009), Matos (2005), Matos & Sampaio (2009), Rutter (1979, 1987), Simões, Matos, Tomé, and Ferreira (2008) helped to promote these issues. More recently, the relevance of the populations' engagement (positive engagement) as well as a lifespan perspective have become crucial to the area (Matos, 2015; Staines et al., 2013).

Behavioural theories advocate preventive interventions that are not solely focused on one specific risk behaviour, but on the person as a whole, including each situation's risks and strengths. When speaking about substance abuse, Bandura (2007) claimed that the perception of self-efficacy must not be defined as the (instrumental) ability to conduct simple actions (asking for a juice instead of alcohol in the context of the prevention of alcohol consumption) since it must include the ability to manage negative emotional states, resistance to social pressure, and management of interpersonal conflict (Marlatt & Gordon, 1985). Bandura (2007) strongly criticizes the idea that the consumption of alcohol, tobacco or drugs, the practice of physical exercise, weight loss or the use of condom are mere skilled-based tasks. He argued that self-efficacy is not limited to a series to automatic abilities (for example, a student's success in an oral exam does not increase automatically with the number of phonemes he masters). Perceived self-efficacy is all about an individual's confidence in the fact that competences can help him to deal with several circumstances. This confidence in the 'possibility of success' allows change in the thought process, a growth in motivation, an increase in performance, self-regulation of emotional states, or even better a permanent change in the physical and social environmental living conditions. In a recent work, Bandura (2012) argues that no factor in social sciences has invariant effects, and that socio-cognitive theory explains the conditions in which the perception of self-efficacy is related, positively or negatively, to good psychological functioning. Perceived self-efficacy represents the level of difficulty a person considers they might be able to overcome, rather than a list of current abilities. The perception of self-efficacy is not only about the belief of what one is able to do, at present, but about the confidence in being able to learn and to consistently self-regulate within all kinds of unpredictable situations, and even change circumstances permanently.

Some authors suggest that adolescents are more affected by minor details in their relationship with parents and teachers than with greater issues; that boys have significantly lower emotional intelligence than girls, and, in turn, low emotional intelligence is associated with significantly more externalising behaviours (i.e. aggression and delinquency) (Santesso, Reker, Schmidt, & Segalowitz, 2006). Other authors (Updegraff & Taylor, 2000) also suggested gender differences, namely that boys have a higher tendency to 'fight or flee' while girls have more tendency to settle and establish bonds and alliances, valuing more the social support and, therefore, developing more empathy, care taking, conflict management and negotiation skills. These aspects were evident in a study conducted by Simões (2007), which revealed that relationships with parents and friends have greater impact on psychological symptoms in girls than on boys, and that girls are better able to identify the importance of interpersonal aspects, such as conflicts with friends and peer group integration, as risk factors for behavioural problems, such as substance use and delinquency.

The importance of the promotion of personal assets and resilience is increasingly evident for the prevention of mental disorders and the recovery from adversity and/or trauma (Rutten et al., 2013). Mangham, McGrath, Reid, and Stewart (1995) define resilience as the ability that individuals and systems (families, groups and communities) have to deal successfully with adversity or significant risks. This capacity develops and is modified over time; it is enhanced by individual or environmental protective factors, and contributes to the health maintenance or promotion. Therefore, resilience is viewed not as a fixed and stable trait over time, but as something liable to change. It is a dynamic process that develops from the relationships established with the environment throughout life. A secure attachment, the experience of positive emotions and life purpose are important in the development of resilience and in overcoming adversities. However, there are individual differences in sensitivity to stress, with some studies on resilience underlining the factors involved in the type of response that overcomes adversity and life problems (Rutter, 2013). Rutter (2012) argues that risk exposure can reduce vulnerability through a strengthening effect, but it can also increase vulnerability through a sensitization effect. Therefore, a central question is how to perceive the circumstances that lead to one or other effect, as well as processes that mediate these effects.

On the one hand, research seems to indicate that when exposure to certain risks is 'controlled' (a small dose, for a short period of time, or under positive circumstances), it leads to stronger resistance to such or similar risk. The mechanisms for this increase in resistance are not completely known, but some authors (for example Kumpfer, 1999) claim that the confrontation with negative situations has the potential to provide skills and, as such, adolescents passing through these situations may exhibit a higher level of adaptation to the one previously registered. On the other hand, when risks accumulate, they tend to cause damage; even though, in some cases, the damage may not become manifest immediately because adolescents may have the resources to deal with it at the initial moment of confrontation. Thus, if the risk persists, it can lead to a depletion of these resources or to other risk processes (Garmezy, 1993). For instance with regards to association with deviant peers, the negative consequences will emerge in main life contexts such as school and family. Studies on adolescents' worries reveal that these are very focused on school, family and friends. Overall, family and friends are associated with both concerns/worries, and the perception of social support, while school is mainly a source of worry. Friends offer wellbeing and stand as a resource to deal with stress. Family is also a source of wellbeing, but it is not perceived as a resource to face concerns or worries (Matos, Gaspar, Cruz, & Neves, 2013). However, when adolescents present complex educational needs and face too many negative life events in their lives, as in the study of Simões et al. (2008), the family alone is able to help them maintain their previous levels of wellbeing, even though they rely on protective factors in all main life contexts (peers, school, community).

Self-regulation (Geldorf, Bowers, Gestsdottir, Napolitano, & Lerner, 2015) is associated with adaptive development throughout adolescence. Intentional self-regulation is developed during the second decade of life and has an increasingly important adaptive function. This offers growth in cognitive control that includes the possibility of long-term goal definition and a wider sense of personal future. Intentional self-regulation is about guiding one's interactions with physical and social environments towards certain objectives. In adolescence, attention and selection (stimuli, objective and task choices), optimization of action

(through the acquisition of new skills or resources – attention focus, emotional management, and behavioural inhibition), and compensation (recovery after difficulties, selection of new objectives, and acquisition of new skills or resources) are important processes in risk perception. According to Troy and Mauss (2011), the cognitive strategies of emotional regulation, in particular attention control and cognitive reappraisal of stressful events, when used adaptively, are protective factors with the potential to prevent the development of negative consequences, including depression. In addition, the authors suggest that attention control relating to irrelevant negative stimuli for wellbeing can have negative consequences, and that the inverse is applied when these stimuli are relevant. Also, cognitive reappraisal seems to play a protective role for depression, particularly in life contexts with high levels of stress when it is used to change the intensity of negative emotions triggered by the exposition to stressful events.

A national program (*Social Adventure and Risk*) developed and evaluated in 1999 (Matos, 2005) has the aim of developing such social and emotional competencies amongst young people. Although this program was not sustainable for external macro-level reasons, positive results were reported when it was implemented. With the same structure, the program *Find Your Own Style* was implemented and evaluated in school settings (Matos, Gaspar, Ferreira, Tomé, Camacho, Reis, & Aventura Social, 2012). The program included such skills as interpersonal communication, identification and management of cognitions and emotions, development of interpersonal relationship skills, self-regulation skills, enhancement of social capital and future expectations. Positive results were also reported, and the program was successfully incorporated into the schools culture. Both programs included already a focus on positive aspects of behaviours, seen within a broad band, including both overt and covert behaviours. They were, however, missing a last step in social participation and youth engagement. This was realised in the last couple of years with Dream Teens, a recent intervention project in Portugal, which aims to increase children's and adolescents' competence and motivation in social participation. Of course it is arguable that, before turning 13, adolescents are rarely interested in, or even comprehend how society works, having a rather personal view of things, based on themselves and their reality, but that is exactly the reason why it must be further explored how school and family can influence civic involvement and social participation (Lenzi, Vieno, Santinello, Nation, & Voight, 2014).

Adolescent's Health in Context and During Recession

The Health Behaviour in School-Aged Children (HBSC) study (Currie, Hurrelmann, Settertobulte, Smith, & Todd, 2000) is designed to provide information about young people's health behaviour and well-being in their life contexts. It is a WHO collaborative study, which in 2014 involved forty-two countries. The study began in 1983, with Portugal's first full involvement in 1998 (Matos & Equipa Aventura Social, 2000). It has involved more than 40,000 students so far (Matos & Equipa Aventura Social., 2015). The survey is based on a self-completed questionnaire using nationwide randomly selected samples, including students aged 11, 13 and 15.

In Portugal, from 1998 until now, gender differences consistently point towards a tendency for girls to internalise emotions and life threats, present more physical and psychological symptoms, be less aware of their health and well-being, have less active leisure time activities, engage more in school activities, and have

more concerns regarding body image, nutrition and diet. Boys tend to display more externalising behaviours, such as violent behaviour, and greater involvement in physical activities and sports, being more prone to accidents and injuries. They also engage more often in substance use (with the exception of tobacco, in recent years), are less frequently involved in school activities, having a better perception of their health and well-being and more active leisure time activities. In recent years, they have made more extensive use of the new information and communication technologies, with the exception of mobile phones. As far as the children's age and age groups were concerned (11, 13 and 15 year old), the results showed that older students are less healthy and happy, although bullying seems to decrease with age, and take greater precaution against HIV and unplanned pregnancy (which is, obviously developmental and accompanies the onset of puberty).

From 1998 to 2014 the analysis of national trends in Portugal across the five waves of the study, revealed an exceptional 'bad wave' back in 2002, and a specially 'worrying wave' in 2004 (Matos et al., 2015). Although a few health indicators improved steadily over time (tobacco use, violent behaviour), others remained unchanged, namely lack of physical activity, alcohol abuse). However, others reflected a worsening situation, such as an increase in screen time and sedentary behaviour. The last survey, in 2014, suggested that the steady increase in protective behaviours and the steady decrease in risk behaviours that had occurred since 2002, seemed to have stopped. Mental health seems to be the most affected area. Adolescents in 2014, compared with previous waves of the study, showed signs of mental distress with an increase in psychological symptoms, in self-harm behaviours, and in feelings of hopelessness and despair that include less positive expectations towards the future, less motivation to go to college, and less motivation for school.

In general, across the five waves, boys, younger adolescents and adolescents with a higher socio-economic status (SES), reported a higher level of life satisfaction. Girls, older adolescents, and adolescents with a low SES more frequently displayed psychological symptoms. Therefore, it seems that gender, age, and parents' SES can act as either risk or protective factors in mental health. Family wealth seems to have a significant impact on young people´s feelings of happiness and on their health perceptions. These results highlighted the influence of poverty on young people's health, an area that requires urgent attention (Matos et al., 2015).

A post hoc analysis of the HBSC study, conducted in Portugal in 2002 (Matos & Equipa Aventura Social, 2003), showed that adolescents with nationalities other than Portuguese had inferior school results and demonstrated less involvement in school work. This group reported feeling unhappier, having more distant communication with parents, and engaging in sexual intercourse more frequently, particularly unprotected sex and sex associated with alcohol and drug use. However, further analysis suggested that the association of a migrant status with poor well-being, school failure and family distance is almost fully mediated by poverty. There is also evidence of cumulative risk effects, indicating that when risks are beyond the adolescents' coping ability, they can lead to negative consequences, although studies also indicate that in the presence of assets, such as social and emotional competences, these adverse effects may not be triggered. Simões, Matos, and Morgan (2015) conducted a study with adolescents with special needs, which revealed that problem solving competences (medium or high levels), self-efficacy (high levels) and empathy (medium levels) can moderate the impact of significant adversity in wellbeing.

Compared with other countries in the HBSC survey, Portugal presents a higher level of chronic stress associated with school homework, and a lower perception of academic achievement, along with a more favourable social perception of schooling (peers perceived as friendly) and of schools (students like school). In the 2014 wave, students were asked what they liked in school, and the most frequent answer was school breaks, followed by specific extracurricular activities, peers, and some teachers; enjoying classes came in the end of their preferences, after the residual 'other', and food in the canteen, which the students dislike even more. These results call for an imperative intervention in the school's system that may reduce the disadvantage presented by Portuguese students when compared to students from other countries.

Several studies suggest that wellbeing and quality of life in children and adolescents are related to their personal and social protective factors (Gaspar, Matos, Foguet, Ribeiro, & Leal, 2010; Simões, 2007), and, apparently, psychological factors have a greater impact on wellbeing and on the perception of quality of life, especially where emotions are concerned (Gaspar, Matos, Pais-Ribeiro, Leal, Erhart, & Ravens-Sieberer, 2012). However, in special adverse contexts, apparently, family alone provides social support effectively (Simões et al., 2008).

Adolescents' Health Assets

The idea of focusing on the positive rather than the negative aspects is presented in the '*Asset Model*' described by Morgan, Davies and Ziglio (2010). The Health Asset Model is based on Antonovsky's salutogenisis and implies the creation of maps with people's and community resources, giving their strengths and talents, both individual and collective (Kretzmann & McKnight, 1993), focusing on the creation of health instead of in the prevention of disease. Most health behaviours are not perceived as pleasant. People need to learn to enjoy them and make them their personal choices, recognizing and validating their importance. If new behaviours are integrated into a person's identity, and the person feels respected, understood and valued by others, better health results are expected; in the same way, services that provide autonomy, competence and empathic connection obtain better health results, and are more in line with human rights and with citizens' health care rights.

Adolescents seem to be more vulnerable to negative emotional experiences than adults are; however, providing new and positive experiences may contribute more effectively to their wellbeing and mental health than the mere focus on past negative experiences, or pretending there is no problem (Taskforce on Community Preventive Services, 2008). Negative school and family environments constitute risk factors. Family and school authoritarianism are now clearly recognized as having more adverse effects than excessive permissiveness or moderate negligence, which highlight the need to develop parental and professional skills (Cohen, Berliner, & Mannarino, 2010) that favour dialogue, participation in house chores, and conflict resolution, thus promoting progressive and responsible autonomy.

The development of research and knowledge in neuroscience, and the new imaging techniques identified interesting results regarding the balance between the emotional and the cognitive growth in adolescent brain, showing that in situations that do not involve high levels of emotion, adolescents may present adult reasoning. However, they are twice more at risk than adults in situations of high levels of

emotion, especially in the presence of peers (Steinberg, 2008) and in the absence of parental monitoring. However, the consequences are controversial, especially due to the implications these may have in intervention and public policies in health, education and justice, dividing researchers into two different perspectives 'protection and restrictive legislation' (Stenberg, 2008) and 'promoting competences, social support and social engagement' (Matos, 2015; Matos & Morgan, 2012; Matos & Sampaio, 2009; Matos, Sampaio, Baptista & Equipa Aventura Social, 2012; Payne, 2012).

Recent studies and research also demonstrated a clear need to manage 'environmental temptations', mainly through the control of high finance associated to the marketing of unhealthy products (food and technology that cause addictions and create an unbalanced state between action and emotion). This was well underlined in the work developed by the European Consortium TEMPEST, whose recommendations are highlighted by West and Marteau (2013).

Relevant and Effective Programs

In order to speak about intervention programs with propriety, it is necessary to identify a theoretical framework as well as empirical evaluation of the process, the program's outcomes, and its impact. Apart from the program's effectiveness, it is also important to assess how and in what conditions the program's components act, such as which contexts and what experience and training is required for trained program facilitators, and understand change in the light of an explicit theoretical framework. It is important to understand the effect of change in terms of the type of implementation and the targeted population, as well as the type of technicians, their training, experience and access to supervision (Jané-Llopis & Barry, 2005). School-based approaches seem to be more effective when they include the entire school, use a social skills promotion model, include peer education, favour student participation and initiative, use interactive and participatory methodologies, last several years, and become a part of the school's culture. New programs should be integrated into existing ones, and partnerships and networking with structures within the community encouraged for the benefit of the program. New structures, building skills development and higher levels of participation are also recommended. The 'entire school' and 'entire community' approach joined a public health perspective and are based on positive psychology, which privileges the development of positive traits such as positive emotions, resilience and optimism, and highlight the 4D's from the Appreciative Inquiry: Discovering what people value, Dreaming which changes match what people value, Designing ways to change according to the objectives, and Delivering a proper intervention to reach these objectives (Jané-Llopis, Barry; Hosman, & Patel, 2005). Studies on school interventions that aim to promote social and emotional wellbeing suggest that problem solving is the best short-term strategy for the promotion of pro-social behaviours, although peer mediation provides long-term success (Blank et al., 2010).

Besides a theoretical framework, defined objectives, professional training and supervision, research quality, logistic support and infrastructure support, the evaluation studies also mention the importance of a strong relationship between stability and innovation, and the adequacy and adaptation to other cultures (Jané-Llopis & Barry, 2005). Innovation has to fit the community, be easy to understand, easy to disseminate, and be able to be applied relatively fast. In a community there are always those who adopt changes too fast and

others too slow or even those too slow to allow change or understand its relevance. Furthermore, no one voluntarily chooses to change for the worse. Change has to be (or at least be perceived) as a source of pleasure and success for whoever is undergoing change. The period of time for changes to go from extrinsic to intrinsic is short, as well as to make it successful and long lasting. The changeover plan has to include the notion of 'end of effort', incorporate a new identity, and convey a long-term perception of enjoyment (Matos, 2015; West, 2007; West & West, 2008).

Another important point is that intervention programs should be delivered as earlier as possible. *RESCUR,* a project funded by the European Commission, aimed at developing a universal curriculum to promote resilience-related competences in children aged between 4 and 12 years old, with special attention to vulnerable groups such as children with disabilities, special educational needs, and children from minorities and refugees. The curriculum is implemented in school context, but families are also involved since an ecological approach is essential for the success of resilience promotion programs (Cefai et al., 2014). The curriculum presents six main themes, namely Developing Communication Skills; Establishing and Maintaining Healthy Relationships; Developing a Growth Mindset; Developing Self Determination; Building on Strengths; and Turning Challenges into Opportunities. These have been identified following a literature review and an analysis of the current socio-economic, educational and cultural needs of children and young people in Europe. A pilot implementation showed that teachers observed a positive change in the learners' behaviour related to the theme implemented, as well as a positive change in the classroom climate. Teachers found the activities and the resources available in the curriculum meaningful and highly motivating for the learners; in general, the parents found the programme relevant for their children (Cefai et al., 2015).

In a recent model (COM-B), Susan Mitchie and her colleagues (2011) showed, following a systematic revision, that to achieve long lasting change there is need for Competence, Motivation and Opportunity. The authors stressed that this assumption must be considered in all attempts to design programs and public policies that aim at change in health. The *Behaviour Change Wheel* (BCW) (Mitchie, van Stralen, & West, 2011) was a proposal based on a systematic literature review where the authors identified issues relevant in providing change. All seem to fit into three clusters: competence, motivation and opportunities (the COM-B system). The authors used them for an analysis of institutional conditions (nine institutional type of interventions) and macro-level political issues (seven types of political actions). In the last decade (see Matos, 2015; Matos & Sampaio, 2009; Staines et al., 2013, for a review), studies have suggested the need 'to give a voice to young people', including students as active participants in all phases of interventions: problem identification, planning implementation, and evaluation.

Concluding: Why Dream Teens?

According to the Positive Youth Development (PYD) perspective, the development of competence, character, social connection, compassion, and confidence are successful outcomes in youth (Benard, 1996; Lerner, Phelps, Forman, & Bowers, 2009). A key aspect of a PYD framework is that all young people, and not just those at risk, are involved in maintaining or developing healthy behaviours, and helping others to

engage in positive development actions as well. As a result, youth become more active and participative in their life contexts and society.

Dream Teens aimed at promoting social capital and preventing social alienation, which are among the most effective strategies for the promotion of health and well-being in youth (Morgan & Haglund, 2009; Seeman, 1959). *Dream Teens*' objective was to ensure a nationwide opportunity for Portuguese youth to be included and empowered as agents of change, to have their voices heard, and at the same time to participate as partners in decision making about issues that affect their lives and communities. The *Dream Teens* included three key elements, namely youth participation – opportunities for youth participation in leadership of activities; skill building - emphasis on the development of life skills; and adult mentorship - a context of sustained and caring adult-youth relationships. Young people interacted via *Facebook* and were called to react and debate the topics of interest regularly posted by the senior staff team. These were named 'teasers' and were developed by senior researchers to draw attention to some of the issues that young people had previously reported they would like to debate. They were called to join general topics related to health and lifestyles, and six specific topic sub-groups related to their initial research motivations, namely personal resources and well-being; social capital and social relationships; love and sexuality; addictions and injuries; life-style; and citizenship and social participation. All sub-groups were coordinated by senior researchers who supported youth with logistics, facilitation and consultation in their research projects. *Dream Teens* was grounded in a positive and proactive view of promotional interventions with young people. As in the COM-B model (Mitchie et al, 2011), 'Motivation' was addressed in order to acquire and increase 'Competences' and 'Opportunities to participate'.

The results (Matos, 2015) showed no concerns in increasing motivation and competence among young people, and the project was evaluated as 'very satisfactory' by the adolescents involved. At an institutional level, many difficulties surfaced that impaired the creation of opportunities and the sustainability of the project. A very preliminary team group discussion about the possibility of creating and maintaining youth-led networks lead to the consideration that during these two years, adolescents seemed eager to participate and get involved in their social community, but there was not a community readiness to change yet (Kretzmann & McKnight, 1993). The majority of the barriers identified were related to the macro system, namely schools and local authorities. In sum, although Steinberg (2008) underlines adolescents' brain immaturity and consequent uselessness of direct intervention with young people, the evolution of theoretical models and evidence-based interventions allows the defence of direct interventions with young people in real life situations, helping them to make decisions, identity threats and potential pitfalls, and become better informed about brain immaturity features and their limitations, seeking to develop additional ways of coping.

Working with peer and families in order to promote greater social cohesion, increase social capital, and develop social networks and social support is thus strongly recommended. Schools and leisure time activities represent good starting points for cross-cultural and intercultural social interaction and health promotion. Having 'weak ties' is seen as a valuable aid in the promotion of adolescents' openness to diversity, especially social and cultural diversity (Granovetter, 1983). In sum, parents, school, peer groups, neighbours and the whole local community must all be jointly involved in a process of increasing social

cohesion. The ultimate aim is the promotion of well-being, competence, autonomy, personal sense of responsibility, a sense of belonging and personal achievement, social participation and commitment, in order to empower young people to face the challenges of the 21st century: being able to cope with change, to be innovative, and to become an entrepreneur. Young people definitely have a specific place in human development, and the political and professional understanding of this fact will not only allow young people to have a voice, but it will also allow professionals to provide better health and educational services.

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