

Candidate Number: 213204



School of Global Studies

The Impact of CATT Tool Application on
Childcare Professionals in Armenia, in the
Context of Child Rights Approaches

Dissertation Submitted Towards MA Human Rights

Candidate Number: 213204

Word Count: 10,307

Abstract

This dissertation is based on a research placement with ACT International; a UK based mental health and human rights advocacy charity that works with children suffering from symptoms of post-traumatic stress disorder. ACT trains and supports local people working with children, both mental health and non-mental health professionals to use Children's Accelerated Trauma Technique or 'CATT' in response to conflict, violence and trauma in an international setting. This dissertation is concerned with attempting to understand the impact of CATT as a child rights focused therapy protocol, on childcare professionals in Armenia, and how it relates to the wider context of mental health and stigma.

Acknowledgements

I would like to thank ACT International, particularly Stella for this incredible opportunity and with all the help you have given me. Thank you to my academic advisor Louise for your guidance.

I would like to extend this thank you to my participants, without your insight, this research would not be possible. Lastly, to Anush for giving up your time to be my interpreter, aiding me and being incredibly supportive throughout, thank you.

Contents

Abstract

Acknowledgements

Abbreviations

List of Figures

1.0 Introduction

1.1 Methodology

1.2 Participants

1.3 Limitations to Methodology

1.4 Ethical Considerations

1.5 Structure of Research

2.0 Action for Child Trauma (ACT) International

2.1 CATT explained

2.2 Commitment to Child Rights

2.3 Armenia

3.0 Issues and Applications of Child Rights

3.1 Armenia and Child Rights

4.0 Mental Health

4.1 Stigma and Institutionalisation

4.2 Family Burden

5.0 Research Findings

5.1 Child Rights Knowledge

5.2 Child Independence and Empowerment

5.3 Changes to Child Care Professions

5.4 Changes in Perceptions of Mental Health

5.5 Classifications

5.6 Stigma

5.7 Family Burden

5.8 Inclusive Education

6.0 Conclusion

Bibliography

Appendices

Abbreviations

MHC – Mental Health Conditions

ACT – Action for Child Trauma International

CATT – Children’s Accelerated Trauma Technique

PTSD – Post Traumatic Stress Disorder

UNCRC – United Nations Convention on the Rights of the Child

UNCRPD – United Nations Convention of the Rights of Persons with Disabilities

NICE – National Institute for Health and Care Excellence

CBT – Cognitive Behavioural Therapy

WHO – World Health Organisation

List of Figures

Figure 1: CATT Protocol Diagram

1.0 Introduction

The World Health Organisation (2020) states that around 20% of the world's children and adolescents have a mental health condition (MHC), with suicide being the second leading cause of death amongst 12-29-year olds. Despite these alarming figures, the global average government health expenditure on mental health is less than 2% (2020, WHO), and the situation is only worsening, with levels of MHC and substance abuse disorders increasing 13% worldwide in the last decade (Charlson et al, 2019).

MHC can affect all areas of children's lives, including building healthy relationships with friends and family, succeeding in school and their ability to participate in the community. If left untreated, this can have a lasting effect on their future health and well-being as adults (O'Connell et al, 2009). Therefore, MHC can amass a huge amount of economic cost, with two of the most common, anxiety and depression, costing the global economy 1 trillion dollars each year (WHO, 2020).

This research is based on a placement with Action for Child Trauma (ACT) International, a charity that recognises these challenges, understanding 'Today's damaged children may become tomorrow's damaged adults, impacting their families and communities' (ACT, 2020). The main aim of the charity is to 'train and support local people working with children and young people traumatised by conflict, violence and disaster' (ACT, 2020). The training is based on Children's Accelerated Trauma Technique (CATT), a trauma-based therapy protocol designed by the founder of the charity and aimed to help treat children with post-traumatic stress disorder (PTSD). CATT is distinctive due to its focus on child rights and a child-focused technique, utilising and implementing Article 12 and 13 of the United Nations Conventions on the Rights of the Child (UNCRC) and putting the child at the centre of the process (Edwards and Raby, 2011).

The promotion of child participation is a necessary tool for upholding child rights, having beneficial effects such as 'enhancing their communication skills, addressing empowerment and developing self-esteem' (Sherlock, 2013, 724). This is recognised within the UNCRC, and States are increasingly recognising the need to

respect child rights, as demonstrated by the UNCRC being the most widely signed and ratified treaty (Mauras, 2011, p.53). However, implementation and understandings of the UNCRC vary between country (Ungar, 2005, p.4), and evidence has suggested that the endorsement of the UNCRC does not correlate with the development of specific policies or programmes to support child mental health services and participation or a reduction in social stigmas (Kieling et al, 2011, p.1515).

To combat this, the Committee on the Rights of the Child recommend for appropriate, systematic training around the UNCRC of professional groups working with and for children to ensure that children are able to express their views and be taken into account (Parkes, 2013, p.68). This is essential for children experiencing MHC, being more vulnerable and in greater need of support. By training childcare professionals in CATT, a distinctive therapy that focuses on elements of the UNCRC into their work with children, and the promotion of child participation in therapy, CATT can become a tool for upholding and implementing child rights, bridging the gap between ratification and implementation.

This research will focus on training undertaken by ACT in Armenia with childcare professionals, both mental health and non-mental health trained, whom treat children that have experienced a range of traumas. There is limited research on CATT training, coupled with child mental health in Armenia being a widely under researched area. Therefore, different topic areas will be brought together to create a more in-depth understanding. This research will focus briefly on the efficiency of CATT in terms of its perceived benefits, such as the impact it has on childcare professionals' knowledge on child rights. This will be alongside understandings of implementation and changes in childcare professions in a country that has signed and ratified the UNCRC, and a wider discussion on the barrier's children with MHC and their families face. Ultimately arguing the need for further tangible implementation of the UNCRC, greater psychoeducation and support for families with a child with MHC, and policies on the de-stigmatisation of mental health.

1.1 Methodology

This study is based on both quantitative and qualitative research, with the aim to draw on participants understanding and experience of CATT training as well as discussions on child rights and mental health. The first stage of the research was a 10-point questionnaire sent to participants with the aim of gathering key statistics about the children treated and general views about whether CATT training had impacted their work. The questionnaire was translated into Armenian by an interpreter, who was also present if needed by participants during interviews. An initial analysis of the questionnaires built upon the semi-structured interviews, which were recorded via zoom and ranged in length from 25 – 90 minutes depending on the participant. The interviews allowed for a relaxed atmosphere and for participants to expand on their previous answers, gaining more insightful data guided by the conversation.

Transcripts were coded to find re-occurring themes and indicators of important topics, creating main research findings that have been collaborated under the following categories in section 5.0:

1. Child Rights Knowledge
2. Child Independence and Empowerment
3. Changes to Child Care Professions
4. Changes in Perceptions of Mental Health
5. Generational Differences
6. Classifications
7. Stigma
8. Family Burden
9. Inclusive Education

1.2 Participants

In November 2019, 26 childcare professionals from various regions in Armenia completed CATT L1 training in the capital of Armenia, Yerevan, hosted by FAR (Fund for Armenian Relief). Of the 26 participants, 16 responded to the study, 7 of which completed an online questionnaire and 9 of whom completed both the questionnaire and were interviewed. All will be referred to as an anonymised letter.

The interviews took place in both English and Armenian, with the Armenian speaking participants having a translator present. There were a range of childcare professions interviewed, 6 being social workers, 6 psychologists, 2 social pedagogues, 1 team leader and 1 programmes manager, all from various age groups.

1.3 Limitations of Methodology

The sample size of this research is small, however the questionnaire represents over half of the Armenian trainees whom were trained in CATT. Although this is a small fraction of the representational childcare professionals in Armenia, I believe the depth and detail of the interviews conducted provide sufficient information and insight into the issues discussed in this research. All the research participants were women, potentially being a reflection of the female dominated human health and social work industry in Armenia (World Bank, 2017). Due to time and Covid-19, I could not attend and observe a CATT training session or discuss the research with children who have received CATT. I recognise these have their limitations and not having a child perspective and 'voice' when they are part of the subject matter is not representative (Spyrou, 2011). However, due to the research not being a direct evaluation of the benefits of CATT, but instead a critical analysis on the impact of CATT on childcare professionals and the importance of child rights and mental health policy, I felt this was not essential to the research.

The experiences discussed in this research are not my own, and the subject is sensitive and complex. The aim of the interviews was to build on previous research with first-hand experiences and knowledge. Generalisations of particular countries, cultures and industries, including the terms 'developed', 'developing' and 'Western' are from participants interviews and academia, and are not my own. I will be using the term 'mental health condition' during this research, and any other phrase used will be one used by either the participants or other academics, and do not reflect my own views. Throughout the research I will be linking MHC to disabilities, this is not my own view, but due to the context of the research it is appropriate. I have kept these generalisations and wording in the research findings and discussion to ensure that the experiences of individual participants are

respected and presented truthfully, and to highlight the varying terms used and the wider discussions around these.

1.4 Ethical Considerations

This research was carried out in accordance with the University of Sussex's Code of Practice for Research (University of Sussex, 2019), having been signed off as low risk. The research is not undertaken directly with a vulnerable group of people; however, I recognised the difficult conversations around mental health and stigma, and I am focusing on a country and experience that is not my own, therefore aiming to create a respectful discussion, utilising the participants knowledge and insight to aid my research. All participants had given their full consent when completing the questionnaire and when being interviewed, being made aware that at any time they could withdraw their consent, stop the interview and withdraw their data.

1.5 Structure of Research

This research focuses on childcare professionals in Armenia providing the necessary context of where the training took place, however, also discussing the wider theoretical literature and arguments on mental health and child rights. This is alongside the background to ACT International, their commitment to child rights and a deeper explanation of CATT therapy. It considers the theoretical literature and arguments on the UNCRC and its application, the Armenia adaptation, as well as the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and its relevance. These are grounded by a discussion on the barriers in mental health including stigma and family burden that accompany it. The research finally discusses the identified themes, with the aim of concluding the outcome of the research and making recommendations for the future.

2.0 Action for Child Trauma (ACT) International

ACT is a UK based mental health and human rights advocacy charity that aims to provide individually tailored CATT training, led by experienced child mental health and education experts. Training partners are typically non-governmental organisations that respond to conflicts and disasters, as well as local mental health and childcare professionals that work with traumatised children to treat PTSD (Act International, 2020), overall being designed so non-mental health workers can be taught how to safely treat children in their communities. Established in 2008, the charity has since taught in 15 countries around the world including South Africa, Pakistan, Turkey, Tanzania, Jordan and Armenia. The training model is one that is sustainable, sending UK based therapists to train local people or sponsoring mental health professionals in the local area to be trainers in CATT, being cost effective and not requiring the ongoing presence of ACT after the training has been complete.

2.1 CATT Explained

CATT is a distinctive trademarked trauma therapy designed by the founder of ACT to treat symptoms of PTSD in children aged 4 to adulthood. ACT follow NICE (2018) guidelines, regarding PTSD as a type of anxiety caused by distressed or frightening experiences, developing from either a traumatic event or repeated or prolonged traumatic experiences, causing symptoms such as nightmares, intrusive thoughts, difficulty sleeping, and avoidance of things related to events (2018, p.8). PTSD is a survival mechanism or change in the brain, creating responses in the body that aren't a 'natural' or 'healthy' reaction to non-life-threatening events in an attempt by the body to survive (NHS, 2017), ultimately not being able to process and move on from the traumatic event. CATT therapy is a memory-based approach devised from psychotherapy, art and play therapy and Cognitive Behavioural Therapy (CBT), with the aim to allow children to process memories from the short-term to long-term memory so that the reactions associated with PTSD are not triggered (ACT International, 2020).

CATT training is facilitated on 3 levels; L1 for non-health professionals, L2 for qualified health professionals and L3 to train those who have already participated in

CATT to teach overseas. CATT protocol has 12 steps (see Figure 1) with stage 8 and 9 focusing on creating characters through craft materials and retelling the traumatic memory that led to the PTSD. A new character is introduced to re-script or alter the 'emotional tone' (Raby and Edwards, 2011, p.4) and allow the processing of the traumatic memory so the physical reactions are no longer present. This allows the child to create a better outcome of the story, without changing the event itself.

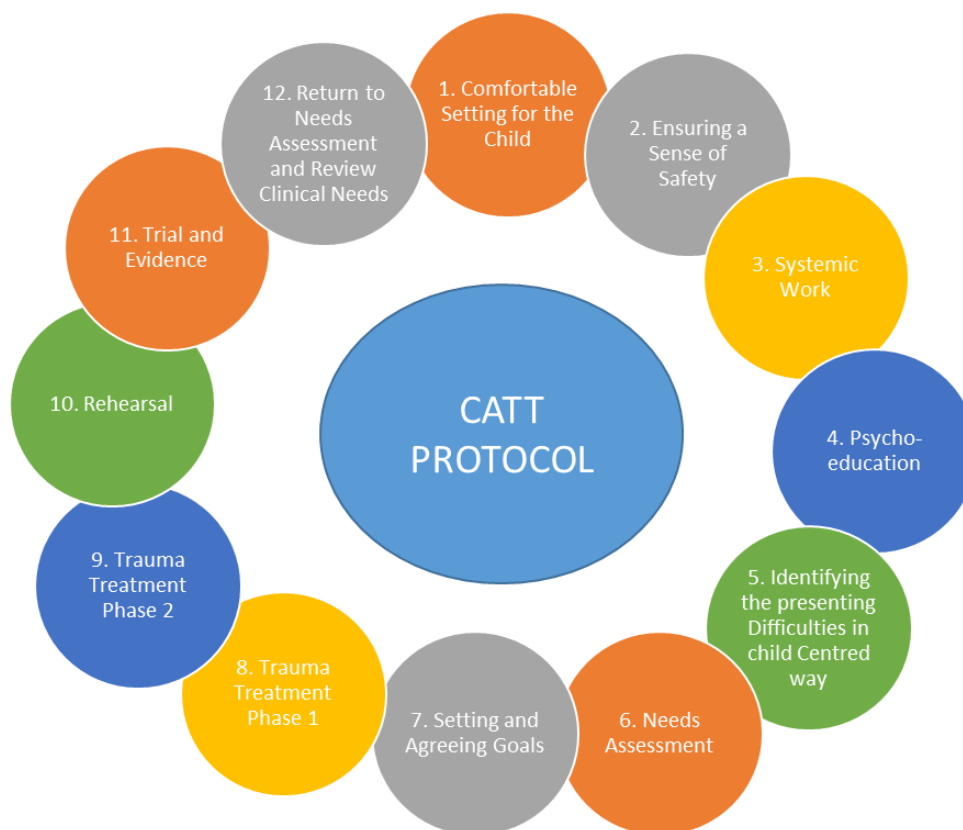


Figure 1: CATT Protocol Diagram (Raby, 2010)

2.2 Commitment to Child Rights

ACT and CATT protocol have a strong emphasis on child rights, with all 12 stages of CATT protocol being child centred. Stage 7 refers to the child being involved in decision making and stage 5 refers to child rights specifically, creating a comfortable and safe environment for the child as well as paying attention to Article 12 and 13 of the UNCRC. Article 12 and 13 place the 'children at the centre of their

care and involve them in decision making' (Raby and Edwards, 2011, p.6), recognising the child's right to be heard being based on a 'systemic practice of consulting children and listening to them in matters that affect them' (Mauras, 2011). This creates a 'child-centred' approach to treatment, focusing on elements of arts, crafts and play to help childcare professionals work with children in general, as well as treating their trauma (ACT International, 2019). Through utilising the UNCRC, CATT protocol is a distinctive therapy, putting the child first and then building the therapy technique around them.

2.3 Armenia

ACT International's CATT training typically focuses on children suffering with PTSD due to conflict and violence, however Armenia provides a unique backdrop. The participants involved treat children with a range of traumas, such as loss of family, persecution, abuse and poverty. The centre where the training was hosted aims to support the Government initiatives to continue to transform the culture of children's services and policies, as well as helping to develop the national foster care system (FAR, 2020). Armenia is also currently facing an ongoing conflict at the Azerbaijan border and as well as accepting large numbers of child refugees who have fled the war in Syria, therefore, there are varying traumas present. All these factors combined with the context of Armenia gaining independence after the collapse of the Soviet Union in 1991, continuous social and economic reforms (Save the Children, 2014), including the move away from institutionalisation of people with disabilities and MHC, creates a unique reflection for ACT International's trauma training.

Since gaining independence and transitioning from a post-Soviet period, the country's mental health and child protection system have changed significantly over the last two decades (Soghoyan et al, 2009). The Soviet occupation created a highly centralised health system, guaranteeing free medical assistance, however being an expensive and insufficient system (Hovhannisyan, 2004, p.522). This system focused on in-patient care, with high levels of institutionalisation of those with disabilities and MHC, 'when individuals were valued according to their productivity and contributions to the advancement of the State' (Hallett et al, 2019, p.20). Due to

an economic collapse after independence, Armenia was not in a position to continue sustaining such a system, leading to radical reform (Hovhannisyanyan, 2004, p.522).

However, throughout the reform, the core organisation structure of the system underwent very little change, with medical services continuing to function from the previous Soviet system (Hovhannisyanyan, 2004, p.522). The Soviet style in-patient system has meant that as it stood in 2018, Armenia had an average ratio of 400 children per 100,000 living in residential care, with around 3,000 living in state-run facilities (UNICEF, 2018). A large number of these children are residing in these facilities not due to absence of family, but due to disability, poverty or other vulnerabilities, making it harder for families to care for them at home (UNICEF, 2018).

Protection for children in Armenia continues to increase significantly, with the government signing and ratifying the United Nations Convention on the Rights of a Child (UNCRC) in 1992, as well as the Convention on the Rights of Persons with Disabilities (UNCRPD) in 2010 (UNDP, 2016). The government has also created reforms to childcare through the creation of the foster care system and increased social and community services for vulnerable children and families (UNICEF, 2010), intensifying efforts in recent years and creating an inclusive education system to help reduce rates of residential care (UNICEF, 2018).

Mental health treatment in Armenia has also gone through significant reforms since independence. In 2004 the government adopted the Law on Psychiatric Care, regulating involuntary treatment and giving civil and human rights, including protections of people experiencing MHC (WHO and Ministry of Health). The law has been updated in 2006, 2009 and 2010, continually widening the scope of care (McCarthy, 2013).

3.0 Issues and Applications of Child Rights

The UNCRC was created in 1989 and has near universal ratification. States are increasingly responsible to promote, guarantee and respect children's rights

(Mauras, 2011, p.53) and the 'protection of children exposed to adversity has now become one of the central priorities of childhood interventions internationally' (Ungar, 2005, p.3). The convention has a total of forty-one substantial articles, thirty-five of which seek the protection of children's welfare, including protection from violence, education and exploitation. The six-remaining focus on political and legal rights of children, including requirements for freedom of expression and thought, conscience and religious association. On creation, the UNCRC served as a catalyst for children's opinions to be taken seriously, with increased understanding of their value in participation decision making (Hinton, 2008, p.286). However, understandings typically focus on welfare, seeing children as a protected class and recipients rather than active agents (Rehfel, 2011, p.142).

Today, over 20 years on from creation, there has been an evolution to a more child-centred approach, and the pillars of the UNCRC are Article 3 and 12, focusing on the best interests of the child and the right to be heard (Maurás, 2011, p.53). Conceptualising children as vulnerable human beings in need of protection rather than autonomous actors (Robin, 2014, p.196) is argued to be ineffective in supporting children's coping and resilience (Ungar, 2005, p.19). Ungar recognises that in some cases children need considerable support and specialist care, however he points out that children are 'not simply products of adults beliefs, training, investment and intervention but social agents in their own right' (2005, p.19). There are a multitude of benefits of recognising children as social agent's, including 'enhancing their communication skills, addressing empowerment and developing self-esteem', having beneficial long-term impact (Damodaran and Sherlock, 2013, p.724). The UNCRC recognises that children have insight into their wellbeing, as well as solutions to their problems and therefore, a need to be recognised as valid in their role in implementing those solutions (Ungar, 2005, p.19).

As of 2009, two-thirds of the fifty-two countries had incorporated the UNCRC into legislation and one-third had adopted provisions (Maurás, 2011, p.54), however to what extent Articles such as 12 have been implemented remains unknown (Parkes, 2013, p.56). Understandings of the UNCRC are still widely open to interpretation and vary dramatically, as well as facing difficulties in implementation, with many questioning how to define and deliver a child's best interests (Ungar,

2005, p.4). This ambiguity leads towards familialism, with child rights focusing on easier welfare protection, or seeking adults to act in a child's best interest, (Robin, 2014, p.196). The UNCRC committee issued a general comment on Article 12 in 2009, with several strategies to aid implementation and guidelines of minimum standards for states to improve consistency (Parkes, 2013, p.45). However, creating legislation is an important and powerful tool for advocacy and demands, but it does not push for tangible further implementation of the UNCRC (Maurás, 2011, p.54), being the biggest issue, the UNCRC currently faces.

3.1 Armenia and Child Rights

The Armenian Government has signed and ratified the UNCRC, whilst creating an adaptation to suit the Armenian context. The majority of the Articles present in the adaptation are aligned with the UNCRC, keeping many of the original Articles or variations of. However, the adaptation does not include the right for a child's best interests or the right to be heard. Instead, Article 10 explores the right of the child to have freedom of thought and conscience, ultimately resting on a child's age and maturity for a child's views, beliefs and judgements to be given consideration (National Assembly of The Republic of Armenia, 1996). As with the UNCRC, the Armenian adaptation is ambiguous, conceptualising children as helpless and dependent on adult decision making (Ungar, 2005, p.19).

The Armenian context means that the UNCRPD also needs to be taken into consideration, being signed and ratified in 2010. Academics have argued that the term 'disability' has not been formally defined within the UNCRPD, allowing individual State Parties to consider how they define disability (Szmukler et al, 2014), being a socially constructed process and therefore culturally specific (Hallett et al, 2019). Armenia's history of in-patient care has meant academics such as Hallett et al (2019), argue that in Armenia, children are deemed to be disabled if they have lost a certain percentage of 'activeness' and 'engagement', therefore MHC are considered a disability, something that will be explored later in the findings. The UNCRPD provides greater protections than the UNCRC, cementing the notion of 'best interest' of the child to be recognised in terms of community integration, rather than at the

time the UNCRC was written when best interest was deemed as remaining in institutions (Rosenthal and Ahern, 2013).

4.0 Mental Health

There is widespread recognition of the prevalence of MHC in children and adolescents, understanding that if left untreated, they can have long-lasting effects into adulthood (O'Connell et al, 2009). Evidence shows that a substantial proportion of MHC in adults, originate from early life, with research showing around half of all cases of diagnosable MHC beginning by the age of 14 (Kieling et al, 2011, p.1515). However, children have been ignored in much of the discourse surrounding mental health, in terms of policy and the development of child focused mental health services (Damodaran and Sherlock, 2013, p.723).

There is a wealth of research on mental health in children in countries coined as 'developing' or 'low- or middle-income countries', being deemed low resource countries (Kieling et al, 2011, p.1515). However, evidence has shown that there is little difference in prevalence of MHC between low, middle- and high-income countries, all averaging around 10-20% of the child population having a MHC (Kieling et al, p.1515). Therefore, addressing children's MHC is a worldwide issue, with widespread gap between needs and the availability of resources (Kieling et al, 2011, p.1515).

4.1 Stigma and Institutionalisation

There is significant research on stigma, with MHC existing throughout history, manifesting in all human societies and often being conducive with discreditation and stigma (Yanos, 2018, p.18). Stigma is defined as a sign of disgrace or discredit (Goffman, 1963) through elements of labelling and stereotyping, and ultimately leading to status loss and discrimination, disqualifying one from full social acceptance (Link and Phelan, 2013). Link and Phelan argue stigma to be an enforcement of social norms, where people come to count and invest in these norms, being annoyed when these are violated (2013, p.533). Failure to comply with

these norms cast strong social disapproval due to perceptions of flawed character, with stigma being deployed as a corrective measure (2013, p.533).

The stigmatisation of those with MHC is a global phenomenon (Wainberg et al, 2017). People are socialised to be aware that MHC are something one does not want to have, not being taught but absorbed through interactions with others, media influence and general observations (Yanos, 2018, p.93). Yanos argues this stigma happens for a multitude of reasons, including MHC being associated with behaviours seen as 'incomprehensible', not being able to be explained as motivated by coherence and also being largely influenced by mass long-term hospitalisation and their negative associations (2018, p.28).

In Europe and the USA in the 1840s, there was an 'asylum movement', creating a rapid and massive process of confining people into institutions with the aim to improve their wellbeing (Yanos, 2018). At the height of institutionalisation, the UK had around 100,000 people living in asylums, and the impetus to close them only began in the 1960s, however lack of community services meant large-scale closures didn't start until the 1980s (Jarrett, 2012). As discussed previously, the Soviet Union had the notion of 'hopeless burdens' to society, institutionalising those with MHC to 'improve' society (Yanos, 2018, p.24). Both explanations of institutionalisation seek to justify treatments of those with MHC, yet it is well documented the huge detrimental impacts institutionalisation has on the person and also the perceptions of those with MHC, due to limited interactions and lack of social inclusion (Yanos, 2018). These issues are especially detrimental when children experience institutionalisation, causing potentially irreversible psychological damage from attachment disorders and emotional trauma, with developmental disabilities increasing the longer they live within institutions (Rosenthal and Ahren, 2013, p.194).

Stigma has been cited as the major reason why children are put in institutions around the world (Rosenthal and Ahern, 2013). There have been many anti-stigma interventions, targeting negative perceptions of those with MHC. However, stigma and institutionalisation are still the dominating issue for people with MHC in Armenia, as well as being a persistent worldwide issue (Semrau et al, 2015 p.3). These are some of the greatest barriers for people with MHC globally, overall reducing

capabilities and wellbeing, and removing community inclusion and socialisation (Baelen, 2005, p.24).

4.2 Family Burden

The developments in the field of mental health, closure of institutions and the increase of community care, has made it possible for families to play a key role in the life of a person with a MHC, being beneficial for the persons wellbeing and also transferring the burden of care (Kızılırmak and Küçük, 2016). The shift towards community-based services 'requires adequate planning and careful national policy commitment in order to avoid gaps in the provision of mental health care and fragmentation of services' (Hewlett and Moran, 2014, p.209). When community services are not sufficient and stigma is not tackled, families can experience associative burden, being a multidimensional concept that poses significant challenges for family members (Sanden et al, 2014).

Families can experience both objective and subjective burden. Objective burden includes care-giving activities, disruption of normal household routines and financial hardships, whereas subjective burden includes psychological distress related to the MHC of a family member, as well as associated stigma (Sanden et al, 2014, p.710). Studies have shown that as levels of burden increases for caregivers, their own mental health can deteriorate, reducing quality of life for both caregiver and person being cared for (Kızılırmak and Küçük, 2016). Despite studies increasing awareness of the burden providing care creates, the literature on associative burden is sparse in comparison to stigma (Yanos, 2018).

Referred to as 'courtesy' or 'associated' stigma (Ostman and Kjellin, 2002), families can often experience similar discrimination and blame for a child's MHC. There are a multitude of negative perceptions still attributed to MHC association, including the notion of poor parents' skills causing MHC, genetics and contamination, ultimately creating a dichotomy of 'us' and 'them' (Aneshensel et al, 2013, Larson and Corrigan, 2008). The burden and stigmatisation threaten the physical, psychological, emotional and functional health of the family of a person with an MHC (Sanden et al, 2014, p.710). This can result in family members experiencing shame,

leading to social isolation from other family members and avoiding contact with neighbours and friends, resulting in lack of socialisation of those with MHC and detrimental impact (Larson and Corrigan, 2008, p.88).

5.0 Research Findings

The questionnaires and interviews were designed to gather participants' opinions, experiences and understandings of CATT as a child rights therapy protocol and how it relates to the social and cultural context of Armenia. Key themes have been identified and form the different sections within this findings section. The initial sections focus on the reflections from participants on child rights, as well as discussions of mental health and social and cultural changes in Armenia generally. The remaining sections cover the barriers for children's mental health, in terms of classifications of mental health, stigma, the impact on families, as well as the move towards inclusive education. This concludes with discussions on what reforms need to be made in Armenia and more generally to improve experiences of mental health for children and their families.

5.1 Child Rights Knowledge

During the interviews, all participants discussed their already established knowledge on child rights, a somewhat expected finding due to the participants being childcare professionals in Armenia, who have signed and ratified the CRC. Although participants had a pre-established knowledge, there was a general consensus in the questionnaires that the training had strengthened their knowledge on child rights and how to apply them, with 93.8% choosing either 'strongly agree' or 'agree'. This was consistent when asking whether participants felt that learning about child rights had impacted their work, with agreement from 81.3% of participants and a unanimous confirmation that CATT had helped their day to day work as a childcare professional.

Many of the participants who were psychologists stated that their work required them to know the adaptation from the Armenian Government, being in line with the attitudes used in their work and having trained every year to update this knowledge (H 06/07/20). There was recognition by one participant that training provided by ACT went back to the 'fundamentals' that attitudes towards children should be built on, and overall 'confirming' and 'strengthening' her already established knowledge (D 09/07/20).

Social workers and pedagogues seemed to gain more from the training in terms of child rights knowledge. Both were more forthcoming with details on what they learnt, suggesting the training had given them a 'formal' and more 'professional' understanding of child rights (F 13/07/20). Participant A stated it had given her a 'new point of view and direction' and helped her learn communication skills for both herself and for the children she works with (A 18/07/20).

Social workers discussed the lack of focus on a child best interests in the Armenian adaptation of the CRC, not being an integral part of the legislation and up to the 'intuition of the specialist' to decide whether something is the best interest for the child (F 13/07/20). Participant F felt that the convention offered little protection for children with disabilities and MHC, being greatly affected by 'cultural barriers and lack of knowledge' (13/07/20), something that will be discussed in more detail in the coming sections.

5.2 Child Independence and Empowerment

The concepts of independence and empowerment are particularly important for the implementation of child rights and the effective delivery of CATT, alongside the main aim of treating PTSD symptoms. Out of the 16 participants, 13 had since used CATT, and nearly 80% of those felt that the child had a reduction in distressing symptoms. Other benefits were also recorded, such as allowing the children to become 'self-confident' and 'independent thinkers' after experiencing CATT protocols and nearly two thirds of participants stated it had empowered the children. Participant B felt strongly about the benefits of empowerment:

"Empowerment is the secret. When you let the child understand that whatever they are doing is good, you are inspiring the child and making them feel more confident and giving them wings to fly" (B 06/07/20).

CATT's aim of putting the child at the centre of decision-making builds on the changes to familial relationships found by McCarthy et al's research (2013). McCarthy found parental relationships in Armenia are increasingly being built on

trust and generally encourage independence in children. This was confirmed by participants who suggest children now have more freedom and choice in both the public and private sphere and are no longer always deemed products of adult's beliefs, but rather social agents recognised as independent from the family:

“Children now form self-recognition sooner, using ‘I’ and first person from a younger age and starting to be accepted as individuals, who has his own rules and own proposes” (J 09/07/20).

Participants recognised these changes to the family have occurred slowly since independence from the Soviet Union and both F and H argued that younger families and professions such as psychologists are leading the change from the ‘old’ style expectation of children:

“I remember when a child has his opinion and wants to express his opinion, adults can always say that, you're a child, you should not talk when adults are talking. You cannot have an opinion right now because your opinion cannot contradict the opinion of the adult” (F 13/07/20).

5.3 Changes to Child Care Professions

There was unanimous agreement in the questionnaire that CATT was in keeping with these wider social and cultural changes happening in Armenia regard to the public sphere of childcare professions. These changes for many participants as with familial relationships, were rooted in independence from the Soviet Union, and participant F argued that the open borders and changes towards greater protection for children, had been an influencing factor (F 13/07/20). F suggested international trainings and awareness raising activities had created more openminded childcare professionals in Armenia and worldwide, being eager to learn and observe new and ‘out of the box’ approaches to support child participation (F 13/07/20). B argued this was evident in Armenia in the push towards more child rights protection through ‘closing orphanage housing and reinforcement of the foster family programme’, making a ‘big difference’ for children and families (B 06/07/20).

These changes were also discussed by Participant J, who reflected on the growing numbers of psychologists in Armenia in comparison to when she was younger, having 'no psychological services at all' (J 09/07/20). Participant D and B echoed the increasing demand for childcare services, being deemed a 'developing' and popular field in Armenia (D 09/07/20). However, participants felt there are still 'many things to work on to become a more child centred society' (C 07/07/20).

Participants D and F, both psychologists, discussed how they felt there are varying consensus of approaches and concepts towards childcare professions, due to a lack of regulation, resulting in different professional backgrounds:

"In our country, we don't need any licence to work with children. You don't need to have anything. You can just participate in one training and start to work with children, or you can even not participate in any training and work with children.

So, it is not recognised in a professional way" (D 09/07/20).

D stated that without regulation, each person can work in an individualistic way, 'losing control of the process', and creating a sphere of un-specialised workers, having a negative knock-on effect on public perceptions of childcare professionals:

"We have that image as it is developing, but not in the right way. It is a mentality problem. It is thought here that working with children is a very easy thing to do and not professional. It is just mixed in our culture and people think it's playing when you work with children" (D 09/07/20)

However, participant H argued that this was a somewhat positive element of perceptions on child psychologists, arguing that children are perceived as just playing with the therapist, therefore it is not deemed as 'serious' as a doctor and not 'medical treatment'. Whereas for adults it is deep rooted in stigma, being discussed later in the findings:

“An adult will think twice before going to see a psychologist, but nobody is thinking for very long before taking a child to a psychologist. That’s why child therapists always have plenty of work” (H 06/07/20).

5.4 Changes in Perceptions of Mental Health

Participants identified two problem areas when discussing mental health. The majority of participants felt that mental health recognition and treatment in Armenia is generally poor, only being acknowledged by around 60% of the population according to Participant A (18/07/20). Participant D felt that knowledge on mental health was generally concentrated in psychological professionals, and the general public’s understanding of mental health revolved around limited personal experiences only, with significant gaps in psychoeducation (D 09/07/20). These gaps C argued, put mental health professionals in a box, in which understandings are limited to detrimental notions of ‘just treating crazy people’, when in reality ‘it’s about social interaction, relationships, personal growth and mental health’ (C 06/07/20).

Participant F and B both explained the difficulties they felt children with MHC faced, describing how children with MHC were widely unrecognised and their rights are often being violated when they were experiencing poor mental health or ‘psychological issues’, as there is a limited number of child-orientated support, resulting in children being placed in institutions:

“We still have many problems because we are lacking in child-centred support, providing social and medical assistance to children with poor mental health and mental difficulties. A lot of times these children are just placed together with adults in institutions who have severe mental health disorders. And this is not good. This is not the right thing to do.” (F 13/07/20)

5.5 Generational Differences

Two participants stated that they felt there were generational differences when it came to willingness to learn new things and wanting to work with children with varying needs. Participant C (07/07/20) stated she felt that many people within older

generations, including teachers, psychologists and social workers weren't as motivated as younger generations to participate in trainings, develop their professions and learn new things. C acknowledged that this was her opinion and that there were exceptions, but generally felt that there is a 'cool new generation' working 'learning new, better and more effective approaches to working with children' (C 07/07/20).

However, participant J (09/07/20) contradicted this, being classed as part of the 'older generation' yet recognising the need to self-criticise and develop:

"A negative mark for your work, is a good mark, sometimes you have to present your work without fear of judgement, and in every part of my life I am learning"
(J 09/08/20)

This could be reflective of Armenia's Soviet history, as many participants discussed a cultural shift happening in the last 20 years.

5.6 Classifications

Hallett et al (2019) states that in Armenia, children are deemed to be disabled if they have lost a certain percentage of 'activeness' and 'engagement'. Participants all generally agreed with this statement, with the exception of participant C, who currently works with young adults rather than children, so didn't feel comfortable answering the question. Many participants however stated they felt this description was 'a little bit offensive' (E 07/07/20) and that people should be 'a little gentler around this topic' (B 06/07/20). Participant B explained that she had a friend who has a MHC, who had felt uncomfortable with being classed as disabled and generally struggled with having a diagnosis which meant she had to go to the psychiatrist and take medication (B 06/07/20). Participants generally discussed diagnosis as undesirable, with many sharing the negative connotations connected to the term disability, being suggested by participant E to use the term 'limited abilities' for those experiencing MHC to be more respectful (07/07/20).

5.7 Stigma

The discourse around the negativity of the term disability and MHC was identified when discussing stigma, being experienced by both children and adults. All the participants interviewed emphasised stigma as accompanying MHC, being the most deeply discussed topic, yet one that, particularly social workers, seem to find the hardest to answer. In the questionnaire there was a mixed response from participants when asked if it was hard to overcome stigma, 18.8% stated they 'strongly agreed', 56.3% stated they 'agreed' and 25% stated they were 'not sure'. This was echoed in the interviews, as participants recognised stigma existed, but many reflected on the changes Armenia has made since Soviet occupation.

Participants stressed significant changes in perceptions of MHC in the last 10-20 years. Participant F stated that stigma towards those with MHC is deep rooted in lack of acknowledgement and disregard of people with disabilities during the Soviet occupation, being a 'widely spread opinion that these people just didn't exist' (F 13/07/20). These negative perceptions have permeated into Armenia today, as many 'representatives of this culture, who think that disabilities are shameful still exist' (F 13/07/20). This enforces the societal norms that cast disapproval to those who are deemed as having 'flawed character' (Link and Phelan, 2013, p.533).

Participants identified how a dichotomy of 'us' and 'them' has been created, perpetuating negative stereotypes of MHC (C 07/07/20). These stereotypes were explained by C, D and H, such as 'mad', 'crazy', 'ill', 'insane', 'diseased' and 'not being able to control themselves'. Participant C felt that this was an easy way for people to dismiss people with MHC, arguing MHC to be part of their personality (C 07/07/20). These negative perceptions have led to the avoidance of MHC diagnosis before a child turns 18. J explained that by stopping diagnosis until a child became an adult, but continuing psychiatric and medical treatment, the child can get help without experiencing stigma, making 'a lot of positive changes in their lives' (J 09/07/20).

Participants explained how these negative stereotypes has led to society deeming MHC as non-desirable, creating widespread avoidance. Participant A experienced

families changing from one specialist to another as they do not believe or trust the specialist, making sure it is the right diagnosis and sometimes even rejecting medical treatment if it is psychiatric (A 18/07/20). Participant H explained how she had treated cases where adults had 'kept their problems very close' until it had affected their quality of life, being reluctant to go to a psychologist until they had tried medicines first (H 06/07/20). A (18/07/20) confirmed these, explaining that often parts of society are 'afraid' of being diagnosed with an MHC, feeling the need to hide it from those around them. She used the clinic where she works as an example, with people being willing to seek help in primary care setting rather than in speciality mental health settings due to stigma (Shim and Rust, 2013, p.774). The clinic where A works has a psychiatric department, however, is not clearly named as being for psychological help. Instead she discussed how they have changed it to be deemed a primary care department for the whole family, making people less afraid to visit. A felt that this is a significant issue facing those with MHC:

"I wish we will get to the level of when person who, for example is in acute phase of the illness, they can get a good treatment and then live their lives in an ordinary way without getting to social isolation." (A 18/07/20).

The want to hide diagnosis has meant social isolation is common (A 18/07/20). H, shared an experience of a friend who when they first moved to Armenia, felt that there weren't many people with disabilities. However, realised after several years of living there that 'they are closed in their apartments, not working in the streets' (H 06/07/20). H pointed out a vicious cycle; the more stigma people experience, the more likely people are to isolate, meaning there are less interactions between people and the more people have 'excessive reactions', 'mistreatment' and 'avoidance' towards those with MHC. This she felt, could be changed by more psychoeducation:

"Armenian people tend to help someone who is need, but because the education is not very good in this topic, they are just afraid of doing something wrong, or it would be safer to ignore, so that's why some of them are choosing this kind of treatment" (H 06/07/20).

Participant J and F noted how social stigmatisation differed depending on the area you live in, generally feeling that in urban areas and in the capital city of Yerevan, it was more widely accepted to take your child to the psychologist. Participant F (13/07/20) described her experiences when working in villages, after meetings and trainings, parents would approach her in secret asking for advice on their child's 'strange behaviour', not wanting those around them to know. J confirmed location variations of acceptability, however pointed out that there have been significant changes within the last 20 years, being more accepted in urban areas, and in the last 10 years more so in villages (J 09/07/20).

5.8 Family Burden

When participants were asked if CATT would help educate children and their families about mental health and reduce the stigma they are feeling, over 85% felt that it could. Participants discussed both objective and subjective burden when discussing families of those with MHC (Sanden et al, 2014), arguing that often the family are in a 'worse psychological condition than the child' as they are the ones on the 'front line' (G 07/07/20), resulting in many vulnerable families (B 06/07/20). Discussion of family burden focussed on financial but also emotional burden, identifying discourse around shame and guilt from being classified and stigmatised from both society and within families:

“Even though they are of course, it is their child, they learn their personality, but still there is pressure and treatment from society and this stigmatisation, surely it effects them. They don't want to be but are ashamed of having a child with mental health issues” (C 07/07/20).

Participant C and J identified that stigmatisation exists within families and relatives of those with children who have MHC, blaming MHC conditions on bad parenting skills or genetics (Aneshensel et al, 2013). C discussed a recent example when treating someone with psychotherapy; the women had discussed the shame and upset she felt surrounding having a child with a MHC. This shame came from negative reactions towards her and the child from various family members such as grandparents and uncles, resulting in them not attending birthday parties and

generally avoiding them (C 07/07/20). J also discussed similar examples when working with families with children with MHC, where in-laws have looked through the generations for other MHC, blaming the mother for the child behaving in this way:

“Usually mothers take all the negativity, with parent’s in law thinking, you were strange. I always noticed you were strange. That’s why your children behave this way” (J 09/07/20).

This ‘associated stigma’ has meant many families who perceive MHC as a ‘very big tragedy’ due to the judgement around them being so severe. This can often result in families trying to hide the diagnosis (H 06/07/20), keeping it a secret from neighbours and other community members so that the child wouldn’t experience any judgement (F 13/07/20), as discussed earlier, resulting in isolation.

As well as stigma, participants discussed the emotional impacts on families, and J shared a personal story of MHC from her family when she was younger and the lasting impact it has had on her own mental health. J spoke about her aunt, who had witnessed someone being killed during war, and subsequently ‘lost her mind’. The aunt had lived with J when she was young, and she remembers experiences of waking up in the night to her aunt crying and the emotional burden caring for someone with MHC can take when there is little support.:

“I love her very much, but during my childhood, the biggest threats was the time she stayed at my home. It was very, very difficult. Our family has a very strong bond and because she’s in a bad situation, we did everything for her. I have a lot of a lot of fears after her. I think that in case of my children, I couldn’t let someone with such kind of problems stay at my home. Because it created stress in me which couldn’t be overcome. It would leave some footprints” (J 09/07/20)

Participants identified the need for more emotional support for families experiencing MHC. The absence of support and reassurance for parents are due to systematic issues coming from ‘higher levels’ D felt. Participant D recognised that often when treating cases, she would be the only person to tell parents to be

'positive' and 'open-minded' about MHC, remembering that 'every person has uniqueness and goodness' (D 09/07/20). D felt that by allowing psychologists to give a diagnosis and support the family, it would stop parents feeling that the doctors were 'just writing the diagnosis and labelling the child, giving no explanation', and no recommendations of specialists or treatments (D 09/07/20). Participant D and A argued that by not giving families support, it often puts the impetus on the parents to make decisions about treatments, having to find their 'own solutions', and often being 'negative and dangerous' if they are not well informed (A 18/07/20).

As well as emotional support, participants acknowledged the need for more financial aid for families suffering from objective burdens (Sanden et al, 2014). Participants spoke about provisions not being equal to the amount of children needing support (F 13/07/20), often resulting in a year's waiting list for various day-care centres and foundations (H 06/07/20). Participants argued that this often means one parent has to stay at home to care for the child, losing a source of income, as well as extra costs such as medications (H 06/07/20) and travel:

"We have a lot of vulnerable families; the only income is the social aid which is nothing in comparison with the child's needs. If they are living in far region, there are not many services, to get socialised, to get better skills, they need to bring the child to the capital. Or maybe there is not free service, it is quite complicated. From the social-economical point of view there are many vulnerable families, to have a child with mental health issues, they need extra support" (C 07/07/20).

Participant F explained passionately about the limitations of free medical accessibility in Armenia, being written into the constitution, but in reality, children not getting access to free mental health treatment (F 13/07/20). F feels this is a contradiction of child rights, as often families will have to save up for treatment or not be aware of the available treatments, meaning people 'accept' that MHC are an 'untreatable disease' (F 13/07/20). When in reality, F and H both feel that with good medical treatment, support and education people could gain a greater understanding that children with MHC 'can have a better condition that they initially had' (F 13/07/20) and get the 'maximum abilities' from the child (H 06/07/20).

C recognised the strongly connected nature between community support and family's mental health and wellbeing. This support, C argued allows the parents to socialise, which in turn allows the child to socialise, have a better life, better education and generally expand the child's abilities:

“When a child was included in some non-governmental organisation, that deals with people with disabilities, and when the parents were also involved, they themselves have different attitude, about themselves and also the family, they feel less effected by stigmatisation, because they have a community that helps them to step out stronger” (C 07/07/20).

5.9 Inclusive Education

As of 2012 there was a push for all schools in Armenia inclusive, moving away from previous special education centres and slowly integrating them into mainstream education. This was written into law in the capital, Yerevan, in a bid to improve wellbeing and reduce societal stigma. However, many participants stated that there was still significant barriers and stigma around children with MHC being included in mainstream education, with parents of children with MHC constantly having to protect the rights of the child (F 13/07/20). Participants discussed issues on all levels of inclusive education, including systematic, teaching and parental.

Participants determined the difficulties in 'introducing a new culture' though inclusive education to be systematic, due to a 'lack of focus' from the Ministry of Education and the State having 'other priorities' (F 13/07/20). Participant G, who works in a specialist school for children with mental and physical disabilities, discussed the problems lie within regulations from the government. G stated how children are eligible to a full education of 12 years, however, those in specialised schools are deemed eligible to only 9 years of education, pre-establishing importance of a child's education dependent on their abilities.

Participant F argued that this is also reflected within the inclusive education schools and the classes themselves, as she has experienced children being

separated by distinctions such as good marks, those deemed as coming from poor families as well as those who have disabilities. This was confirmed by Participant C (07/07/20) who noted, although there is a push for teachers to be more accepting, there is still a separation between 'inclusive' and 'mainstream' children within inclusive schools. C argued, on the surface the attitude towards children deemed 'inclusive' are respectful, however recognises a need for 'many, many' years of work and training of teachers and school workers as many are 'still getting used' to how to treat children with varying needs (C 07/07/20).

An influencing factor in the separation and distinction between the children participants argued, is influenced by parental opinion. Many participants discussed how the mindset of the general public was still widely negative, with parents arguing that 'normal' children had been assaulted, and that 'children with diseases, mental health problems and disabilities' should not attend the same classes as them (F 13/07/20), with parents demanding their children change classes (H 06/07/20). Participant F clearly stated her frustration with parents' negative views:

"These children have the right to come and participate and nobody has right to deprive them for being a part of education process. But this parent still feels that they have a right to make these orders" (F 13/07/20)

However, one participant J (09/07/20), sympathised with mothers who were negative about inclusive education, arguing that:

"Theoretically, it's easy to be open minded person. When it comes to your own life, it's much more difficult" (J 09/07/20)

J recalled a case she worked on where a child had been assaulted by another child with MHC:

"It's very difficult. Look, I'm a mother. I believe that all these values are very important and equal rights and opportunities for everybody. But sometimes I can understand women who have problems with it. For example, I had case when a mother brings me her son who was abused by a child with a mental

health problem. Yes, I am for equal opportunities, but we must do a lot of things, a lot of steps to work it out" (J 09/07/20).

J was the only participant who showed understanding towards negative reactions from parents, however, emphasised that children without MHC can also have bad behaviour (09/07/20). J recognised that her opinions would be seen as 'old points of view' from younger psychologists, and that she did need to 'overcome' these views, potentially being reflective of a generational gap and changes in the last 20 years discussed by psychologists.

However, J identified how ultimately, she felt that inclusive education was a positive step for acceptance of children with MHC, as children are receptive and 'flexible' when young, leading to children 'overcoming differences' between each other (J 09/07/20). The majority of participants felt that there is a great need for psychoeducation and interaction, being argued as one the biggest factors as to why there are still societal stigmas. Yanos recognises that stigmas are learnt through interactions with others (2018), therefore inclusive education is a way for children to learn how to treat and interact with a variety of children, in principle reducing societal stigmas.

6.0 Conclusion

This research has aimed to briefly examine the efficiency of CATT, a therapy protocol that focuses on a child rights framework, as well as analysing its impact on childcare professionals in Armenia and the wider social and cultural changes happening. The research also focused on a general discussion on the need for more tangible implementation of the CRC, evidence for greater psychoeducation, support for children with MHC and their families, and policies on de-stigmatisation.

I recognise the limitations of this research in the sense of it being a small number of participants, being only based in Armenia and questions were designed so participants could draw on personal experiences and understandings. Due to these limitations, research findings are based on individual and subjective opinions,

however elements of this research can be used to reflect and question on wider discussions.

The research found that CATT was well received, being used by the majority of participants, and being in-keeping and building on the changes to childcare professions and perceptions on mental health in Armenia. Participants noted the benefits of CATT, being deemed as an effective way to improve a child's distressing PTSD symptoms, the main aim of the protocol. The other benefits included empowerment and child independence, being considered 'a good tool to have in your arsenal' (H 06/07/20). CATT also improved or strengthened childcare professional's child rights knowledge, bridging the gap between ratification and implementation of child rights. Psychologists had a greater understanding of child rights in comparison to social workers and pedagogues, who gained more from the training, building on the knowledge base from the Armenian adaptation. Therefore, in terms of child's rights, it is clear that non-mental health workers have benefitted and learnt more about Article 12 and 13 of CRC, highlighting the importance of working with both non-mental health and mental health childcare professionals as the benefits of CATT extend past therapeutic protocols.

This research has also touched on issues that are beyond the scope of ACT International's training. All of the participants interviewed felt that there is not enough being done to support children with MHC and their families in Armenia. Although there has been a move away from in-patient care, the success of de-institutionalisation depends on the development of alternative mental health services within the community (Hewlett and Moran, 2014, p.209). The dominating thoughts from participants was the need for more systematic changes to reduce family burden. These changes focused on state-run support services such as free day-care centres in the community, particularly in more rural areas. Participants identified the link between day-care centres and greater financial stability for families of those with MHC, allowing parents to work and in turn generally improving the wellbeing of both parent and child through reduction of social isolation and family burden.

These systematic changes also focused on emotional support, and participants identified the need for greater psychoeducation in society with the aim to

reduce stigmatisation, being argued as one of the greatest barriers for children with MHC worldwide (WHO, 2020). Inclusive education is a positive way to combat stigma, giving children the opportunity to connect and learn from children of varying abilities (Yanos, 2018). However, participants felt parental negativity has a detrimental impact on the possibilities of inclusion, highlight the essential need for campaigns and policies to combat this stigma. It is evident from research that family burden is a widely under researched area, and there is a great need for further focus on the impact MHC and stigmatisation has on a family's emotional, physical and financial wellbeing, having a knock-on effect on the possibilities of in-community care.

MHC affects children worldwide (WHO, 2020), and Hallett et al (2019) argues that by examining the practices in other national contexts, it creates the opportunity to turn a critical lens back on our own practice, as well as the practice of the United Nations. The research confirms that signing and ratifying the CRC doesn't correlate with universal understandings and implementation, especially with the 'pillars' of the CRC (Mauras, 2011), or the development of specific policies or programmes to support child mental health services (Kieling et al, 2011, p.1515). Therefore, there needs to be further discourse around child's rights internationally and more provisions put in place to guarantee implementation and extensive support for children with MHC, as well as general focus on the impact of mental health on children. This discussion needs to extend to stigma and family burden, being evident that both create significant barriers for the rights of those with MHC and their families, being global phenomena (Wainberg et al, 2017) that needs further focus and reform.

Bibliography

Journals and Books

Aneshensel, C.S., Bierman, A., Phelan, J.C., (2013). *Handbook of the Sociology of Mental Health*, Dordrecht: Springer Netherlands.

Charlson, F., Van Ommeren, M., Flaxman, A., Cornett, J., Whiteford, H., Saxena, S., (2019), 'New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis', *The Lancet*, 394 (10194) p.240–248.

Kieling, C., Baker-Henningham, H., Belfer, M., Conti, G., Ertem, I., Omigbodun, O., Augusto Rohde, L., Srinath, S., Ulkuer, N., Rahman, A., (2011), 'Global Mental Health 2: Child and adolescent mental health worldwide: evidence for action', *The Lancet*, 378, (9810).

Damodaran, J., Sherlock, C., (2013), 'Child rights and Child and Adolescent Mental Health Services (CAMHS) in Ireland' 182(4).

Hallett, F., Allan, D., Hallett, G., (2019) 'Reconsidering Inclusion: Western theory and post-Soviet reality', 39(2).

Goffman, E., (1963), *Stigma: Notes on the Management of Spoiled Identity*. Simon and Schuster.

Hewlett, E., (2014) *Making Mental Health Count: The Social and Economic Costs of Neglecting Mental Health Care*. Paris: OECD Publishing.

Hinton, R., (2008), 'Children's Participation and Good Governance: Limitations of the Theoretical Literature' *Theorising Children's Participation: International and Interdisciplinary Perspectives*, 16(3).

Hovhannisyan, S.G., (2004), 'Health care in Armenia', *British Medical Journal*, 329(7465).

Jarrett, S / English Heritage Disability History Web Content Simon. (2012) *Disability in time and place*.

Kızılırmak, B., Küçük, L., (2016), 'Care Burden Level and Mental Health Condition of the Families of Individuals With Mental Disorders', *Archives of psychiatric nursing*, 30(1).

Larson, J.E., Corrigan, P., (2008), 'The Stigma of Families with Mental Illness', *Academic Psychiatry* 32(2).

Mauras, M., (2011), 'Public Policies and Child Rights: Entering the Third Decade of the Convention on the Rights of the Child', *The Annals of the American Academy of Political and Social Science*, 633(1).

Mccarthy, J., Harutyunyan, H., Smbatyan, M., Cressley, H., (2013), 'Armenia: Influences and Organization of Mental Health Services', *International Journal for the Advancement of Counselling*, 35(2).

National Assembly of the Republic of Armenia, (1996) *The Law of the Republic of Armenia on Children's Rights*, Yerevan.

O'Connell, E., Boat T., Warner K. E. (2009), *Preventing mental, emotional, and behavioural disorders among young people: Progress and possibilities*, Washington: National Academies Press

Ostman, M., Kjellin, L., (2002), 'Stigma by association: Psychological factors in relatives of people with mental illness', *Br J Psychiatry* 181(6).

Parkes, A., (2013). *Children and International Human Rights Law: The Right of the Child to be Heard*. London: Routledge.

Phelan, J.C., Cruz-rojas, R., Reiff, M., (2002), 'Genes and Stigma: The Connection Between Perceived Genetic Etiology and Attitudes and Beliefs About Mental Illness', *Psychiatric Rehabilitation Skills*, 6(2).

National Institute for Clinical Excellence (2018) *Post Traumatic Stress Disorder*, NICE Guidelines. Available at: <https://www.nice.org.uk/guidance/ng116/resources/posttraumatic-stress-disorder-pdf-66141601777861> (12/06/2020).

Raby, C., Edwards, D., (2011), 'Unrecognized hospital trauma as a source of complex psychiatric symptoms: A systematic case study with implications for children's rights and evidence-based practice', *Psychotherapy Research*, 21(5).

Rehfeld, A., (2011), 'The Child as Democratic Citizen', *The ANNALS of the American Academy of Political and Social Science*, 633(1).

Robin, P., (2014) 'The Participation of Children in Care in the Assessment Process' in Stoecklin, D, 18(2), *Children's rights and the capability approach: challenges and prospects*, Childhood, pp.195-212

Rosenthal, E., Ahern, L., (2013), 'Segregation of children worldwide: the human rights imperative to end institutionalization', *Journal of Public Mental Health* 12(4).

Semrau, M., Evans-Lacko, S., Koschorke, M., Ashenafi, L., Thornicroft, G., (2015), 'Stigma and discrimination related to mental illness in low- and middle-income countries', *Epidemiol Psychiatr*, 24(5).

Soghoyan, A., Hakobyan, A., Davtyan, H., Khurshudyan, M., Gasparyan, K., (2009), 'Country profile: Mental health in Armenia', *International Psychiatry*, 6(3).

Spyrou, S., 2011. The limits of children's voices: From authenticity to critical, reflexive representation. *Childhood* 18, 151–165.
<https://doi.org/10.1177/0907568210387834>

Szmukler, G., Daw, R., Callard, F., (2014), 'Mental health law and the UN Convention on the rights of persons with disabilities', *Int J Law Psychiatry* 37(3).

Ungar, M., Ebrary, I., (2005), *Handbook for working with children and youth: pathways to resilience across cultures and contexts*, SAGE Publications.

UN General Assembly (1989) *Convention on the Rights of the Child*, Adopted 7 March 1990, United Nations.

UN General Assembly (2007) *Convention on the Rights of Persons with Disabilities*, Adopted 24 January 2007, United Nations.

UNICEF (2010), *Towards Alternative Child Care Services in Armenia: Costing Residential Care Institutions and Community Based Services*. UNICEF

UNICEF. (2012), *The Right of Children with Disabilities to Education: A Rights-Based Approach to Inclusive Education*. Regional Office for Central and Eastern Europe and the Commonwealth of Independent States (CEECIS): Geneva.

University of Sussex. (2019), *Code Of Practice for Research*. Research and Enterprise Services: Sussex.

Van Baelen, L., Theocharopoulos, Y., Hargreaves, S., (2005), 'Mental health problems in Armenia: low demand, high needs', *The British journal of general practice: the journal of the Royal College of General Practitioners*, 55(510).

Van Der Sanden, R.L.M., Stutterheim, S.E., Pryor, J.B., Kok, G., Bos, A.E.R., (2014), 'Coping With Stigma by Association and Family Burden Among Family Members of People With Mental Illness', *J Nerv Ment Dis*, 202(10).

Wainberg, M.L., Scorza, P., Shultz, J.M., Helpman, L., Mootz, J.J., Johnson, K.A., Neria, Y., Bradford, J.-M.E., Oquendo, M.A., Arbuckle, M.R., (2017), 'Challenges and Opportunities in Global Mental Health: a Research-to-Practice Perspective', *Current Psychiatry Reports*, 19(5).

WHO, Ministry of Health (2009), *WHO-AIMS Report on Mental Health System in Armenia*. Yerevan: WHO.

World Bank, (2017), *Republic of Armenia Levelling the STEM Playing Field for Women: Differences in Opportunity and Outcomes in Fields of Study and the Labour Market*. World Bank.

Yanos, P.T., (2018), *Written Off: Mental Health Stigma and the Loss of Human Potential*. Cambridge: University Press.

Websites

ACT International (2020), ACT International. Available at: <https://actinternational.org.uk/howwehelp> (Accessed 6/4/20).

NHS (2020), *Post-traumatic stress disorder (PTSD) – Causes*, Available at: <https://www.nhs.uk/conditions/post-traumatic-stress-disorder-ptsd/causes/> (Accessed 8/11/20).

UNICEF (2018), Child protection. Available at: <https://www.unicef.org/armenia/en/what-we-do/child-protection> (Accessed 9/15/20).

Save The Children, (2014), Development perspectives of foster care in Armenia: Research Analysis Results. Available at: https://resourcecentre.savethechildren.net/node/7961/pdf/armenia_foster_care_study_final1.pdf (Accessed 8/19/20).

The FAR Children's Center (2020) *FAR (Fund for Armenian Relief)* Available at: <https://www.farusa.org/child-protection> (Accessed 6/4/20).

WHO (2020), *Mental health*, Available at: https://www.who.int/health-topics/mental-health#tab=tab_1 (Accessed 8/17/20).

Interviews

- 1.) Interview with 'A' (18/07/2020)
- 2.) Interview with 'B' (06/07/2020)
- 3.) Interview with 'C' (07/07/2020)
- 4.) Interview with 'D' (09/07/2020)
- 5.) Interview with 'E' (07/07/2020)
- 6.) Interview with 'F' (13/07/2020)
- 7.) Interview with 'G' (07/07/2020)
- 8.) Interview with 'H' (06/07/2020)
- 9.) Interview with 'J' (09/07/2020)

Appendix A – Research Questions (Semi Structured Interview Questions)

- 1.) Please can you give me a brief introduction of yourself and your work?
- 2.) How has CATT protocol changed your day to day work as a childcare professional and how you relate to children?
- 3.) What do you feel are the positives and negatives of CATT training?
- 4.) How extensive was your knowledge on child rights before the training and what did you further learn about child rights?
- 5.) In your opinion, what are the wider social and cultural changes happening in Armenia in regard to childcare professions?
- 6.) Do you feel mental health is widely recognised and discussed in Armenia?
- 7.) What are the stigmas people face when experiencing poor mental health in Armenia and do you feel these have changed at all?
- 8.) I recently read that mental health issues in Armenia are classed as a disability if it affects a child's 'activeness' and 'engagement'. Is this generally true and do you agree?
- 9.) How has the treatment/care of mental health changed for children in Armenia?
- 10.) How does having a child with mental health issues impact the family?
- 11.) Do you think enough is being done to support children with mental health problems and what, if any, improvements could be made?
- 12.) Do you have any changes/improvements you would like to see in CATT training to suit childcare professions in Armenia better?