Joint Action on Mental Health and Well-being

MENTAL HEALTH AND SCHOOLS

Situation analysis and recommendations for action

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Appendix 1: International literature review (Carta et al., 2015)

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ABBREVIATIONS AND ACRONYMS:

ESL: Early School leavers

GDP: Gross Domestic Product

ISCED: International Standard Classification of Education

SEL: Social and Emotional Learning

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EXECUTIVE SUMMARY

This report has been prepared in the framework of the Joint Action on Mental Health and Well-being funded under the Second Programme for Community Action for Health 2008-2013. The report presents the findings of the review and analysis carried out by 9 European Countries (Croatia, England, Estonia, Finland, Italy, Iceland, Malta, Norway, Slovak Republic), one Region (Galicia Region, Spain) and one Municipality based in Sweden (Botkyrka) in the area of the mental health and well-being of children and adolescents.

The report provides a comprehensive introduction to the context of the analysis in terms of the current policy framework in Europe, the economic impact of mental disorders and well-being, the potential economic savings of public mental health interventions, the issue as pertaining specifically to children and adolescents, the relevance of the school setting for promotion and prevention initiatives and finally the importance of inter-sectoral collaboration as a key to achieving more effective and sustainable health outcomes.

The report describes in detail the methodological process followed for the review and analysis and presents in detail the results per country, including statistics and information on the mental health status of children and adolescents, education attainment and drop out and existing strategies relating to the mental health of children and adolescents. It also provides information on the legislative and policy framework, organisation and functioning, financing and workforce, and responsibility and delivery for promotion and prevention activities.

Examples of good practice have also been identified and analysed in the context of the project. A selected number of good practice examples have been included in the report and have as common denominators the following elements: they have been found to be effective (following evaluation), they are considered potentially replicable in other European countries/regions, they foresee community involvement and political commitment and they include a satisfactory collaboration between several stakeholders.

In terms of results and main findings, these have been organised according to thematic areas and on the basis of these findings, a number of policy recommendations have been drawn up and form the basis of a document targeting policy makers from different sectors including the education, health and social sector at European, national and regional level.

The findings highlight that despite an increased recognition of the importance of mental health and well-being of children and adolescents, this is an issue that needs to be afforded a higher priority on the public health agenda of European, National and Regional governments. This starts with a better understanding of the epidemiology of the problem and of the cost and potential economic savings of appropriate interventions.

The analysis also confirmed the school and pre-school contexts as the elective setting for promotion and prevention interventions and identified a variety of initiatives across Member States where the school collaborates with a range of stakeholders including parents, pupils, external agencies and other relevant sectors according to a whole school approach. In this regard, the need to provide all the relevant stakeholders with the necessary support, particular in terms of training emerged clearly, in order to be able to properly contribute to prevention and promotion activities according to their designated capacity.

Central to this theme is the need for a process to facilitate implementation of evidence based interventions, evaluation of coverage and outcomes, public mental health training of school staff, interventions to promote school staff mental health, in the context of a coordinated and consolidated collaboration among the relevant sectors in particularly in terms of financing, organisation and

legislation. In this regard, the investigation highlighted that such inter-sectoral collaboration was found to be consistently lacking.

The Policy Recommendations included at the end of this report are constructed on the premise that the school and pre-school educational contexts represent the core setting both in terms of reaching the target (i.e., children and adolescents) as well as in terms of promoting interaction with the significant other sectors. Therefore, they are intended to provide a structural framework for the collaboration between the health, education, social and significant other sectors for the promotion of mental well-being, prevention and treatment of mental and behavioural disorders of children and adolescents, with a special focus on the interventions carried out in the school setting. The main titles of the Policy Recommendations and specific actions can be found in the box below.

Policy Recommendations

1. Strengthen information and research on mental health and well-being among children and adolescents.

a. Establish a solid information base so as to have a detailed epidemiological frame of the mental health among children and adolescents and evidence on interventions.

b. Provide information on coverage and outcomes of interventions, including for groups at higher risk as well as on the size, impact, cost and potential economic savings of appropriate interventions.

c. Carry out a mapping and analysis of existing screening tools for early identification, from the first developmental stages, of mental health disorders and poor well-being among children and school populations.

d. Examine the potential to increase the access to information and to services through the use of web-based technologies (e-mental health) for the promotion of mental well-being and the prevention of mental and behavioural disorders.

2. Promote schools as a setting where health promotion and prevention of mental and behavioural disorders and early identification can reach all children and young people.

a. Recognise the role of early childhood education, school and peer education as having a core function for creating opportunities for collaboration among children, parents, care-givers, teachers, school staff and staff of school medical services, according to a whole school approach – WSA.

b. Mandate school administrations to develop and formalise a mental health promoting culture in their statute, so as to systematically address risk factors such as bullying and cyber-bullying.

c. Actively consult children and adolescents and their families when developing any programmes to ensure their best interests are taken into account, particularly in the definition of objectives and quality criteria.

d. Put in place evidence based interventions to combat early school leaving, since education is a protective factor for mental health and well-being of children and adolescents.

3. Enhance training for all school staff on mental health.

a. Review current practices in terms of initial and continuing professional development and carry out a consultation to define the training needs, tailored to the local context, for all school staff interacting with children and adolescents.

b. Involve in the training also representatives of other sectors, such as social, criminal justice and youth organisations, and allocate appropriate resources.

c. Ensure that training is also made available to the members of the families and caregivers of children and adolescents. Provide opportunities for meeting and training sessions involving both teachers and families, according to a community level approach.

d. Ensure that particular attention is paid also to the positive mental health and well-being of teachers and school staff via continuous support and mentoring. Relevant guidelines for mental health and well-being promotion in schools should be jointly prepared and shared among sectors, including the youth organisations, under the coordination of the education sector.

4. Consider schools as part of a wider network with other stakeholders and institutions involved in mental health of children and adolescents in local communities.

a. Ensure that the mental health and well-being of children and adolescents is considered when defining and implementing policy in different sectors, including (but not limited to) the health, education and social sector as well as the youth organisations.

b. Draw up national/regional legislation to consolidate, legitimate and regulate the terms of cooperation between sectors, also with a view to facilitating cross-sectoral budgeting and to defining the responsibilities of the different sectors.

c. Estimate the data on workforce and financing specifically dedicated to the mental health of children and adolescents per sector and ensure adequate, sustained and shared financing by the different sectors. This also includes aligning budget timetables and approval mechanisms to ensure timely and coordinated interventions, selected on the basis of their effectiveness.

d. Evaluate the effectiveness of school based interventions, also with the aim to reduce costs related to mental health in all sectors.

For the full document of Policy Recommendations, please refer to Appendix 2.

1. BACKGROUND AND RATIONALE

1.1 Mental Health, Well-being and Mental Disorders: Concepts and definitions

Mental health is defined by the World Health Organization (WHO, 2001) as a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. On the subject of this definition, Mental Health Europe (MHE) reports in its conceptual framework for Mental Health Promotion and Prevention of Disorders the following consideration on Mental Health: "According to the World Health Organization (WHO), there is no 'official' definition of mental health. Cultural differences and competing professional theories all affect how 'mental health' is defined. In general, however, most experts agree that mental health and the absence of mental illness are not the same thing. In other words, the absence of a recognised mental disorder is not necessarily an indicator of mental health". In line with this, mental health or well-being protects against development of mental disorders while mental disorders increase risk of poor mental well-being.

"Mental health is integral to overall health and well-being[1] and should be treated with the same urgency as physical health". In line with this approach, the Comprehensive Mental Health Action Plan 2013–2020 (WHO, 2013a) has, at its core, the globally accepted principle that there is "no health without mental health".

In the context of this document, the term "mental disorders" is used to denote a range of mental and behavioural disorders that fall within the International Statistical Classification of Diseases and Related Health Problems, Tenth revision (ICD-10). These include disorders that cause a high burden of disease such as depression, bipolar affective disorder, schizophrenia, anxiety disorders, dementia, substance use disorders, intellectual disabilities, and developmental and behavioural disorders with onset usually occurring in childhood and adolescence, including autism (WHO, 2013a).

1.2 The Cost of Mental Health

Mental disorders account for the largest and fastest growing categories of the burden of disease with which health systems must cope, accounting for a greater burden than cardiovascular disease and cancer (OECD [2]). The burden of mental disorders and self-inflicted injury among the 407 million population of high income European countries is 30% compared to cancer (17.1%) or cardiovascular disease (16.0%) as measured by Disability Adjusted Life Years (DALY's) (WHO, 2014a). However, even this is a significant underestimate since it does not include several mental disorders which affect a further 75.6 million people across the European Union (Wittchen et al., 2011).

The annual economic cost associated with the impacts of mental disorders is €523.2 billion across 30 European countries (Olesen et al., 2012). Literature also reports that children with co-morbid depression and conduct disorder have higher adult service use and costs than the general population or those with depression alone (Knapp et al., 2002).

Recent publications demonstrate the cost savings that can be made following investments to promote children's and adolescents' mental well-being, prevent and treat mental and behavioural disorders (Czabała, Charzyńska, et al., 2011) (McDaid & Park, 2011) (Knapp, McDaid & Parsonage, 2011) (EAHC, 2013).

1 Well-being: reflects individuals' perception and evaluation of their own lives in terms of their affective states, psychological and social functioning (Keyes, 2002).
2 *http://www.oecd.org/els/health-systems/mental-health-systems.htm*

However, despite the impact and cost of mental disorders and the existence of a range of cost effective interventions to treat and prevent mental disorder (Campion & Fitch, 2012), less than 10% of people with mental disorder in Europe receive notionally adequate treatment (Wittchen et al., 2011). This intervention gap therefore has a huge annual cost.

Moreover, there are many benefits of mental well-being 'outside health' which include improved educational outcomes, healthier lifestyle and reduced health risk behaviour such as smoking, increased productivity at work, fewer missed days off work, higher income, improved social relationships, reduced anti-social behaviour and crime (NICE, 2009; Mills et al., 2007).

Good mental health, therefore, is key for economic growth and social development in Europe and ultimately for the realisation of the objectives of the Europe 2020 strategy for reviving the European economy and creating smart, sustainable, inclusive growth (Brussels, 2010).

Similar and interrelated principles underpin the Commission recommendations "Investing in children: breaking the cycle of disadvantage" (2013) where preventing the transmission of disadvantage across generations is recognized as being a crucial investment in Europe's future with long-term benefits for children, the economy and society as a whole.

In these recommendations, high quality education that promotes the emotional, social, cognitive and physical development of children is seen as being core to breaking the cycle of disadvantage. This concept is explored further in the following paragraph.

1.3 Mental Health and Well-being of Children and Adolescents

According to 2004 data from WHO, neuropsychiatric disorders for 10 to 24 year olds ranked as the first cause of Years Lived with Disability (YLDs), with a prevalence of 45%. Moreover the recent report on Suicidal Behaviour (WHO, 2014b) reveals that suicide is the second leading cause of death in the age range 15-29 years worldwide.

Recent literature also reports that, half of lifetime, mental illness has arisen by the age of 14 (Kim-Cohen et al., 2003; Kessler et al., 2005). Mental and behavioural disorders during childhood and adolescence also lead to higher rates of adult mental disorders including common mental disorders, schizophrenia and mania, substance misuse, suicidal behaviour and personality disorders (Fergusson et al., 2005; Colman et al., 2009).

When addressing mental illness therefore, early intervention focussing on the target group of children and adolescents is critical. Indeed, it is well known that during childhood and adolescence, the development of cognitive, social and emotional skills goes through its crucial phases. Experiences made at these developmental stages play a very critical role for the construction of the positive mental health of an individual, which is fundamental for the good health and quality of life of a person.

In this regard, there is a growing evidence base (Shucksmith et al., 2007; Weare & Nind, 2011) for the effectiveness of mental health promotion in schools, in terms of both promoting positive mental health for all and treating those who suffer from poor mental health.

Indeed, school is the place where children and adolescents usually spend most of their time. The 2012 OECD report focusing on education showed that, in OECD countries, students are intended to receive 6 862 hours of instruction on average between the ages of 7 and 14 (formal requirements range from 5 644 hours in Estonia to 8 664 hours in Chile) (OECD, 2012).

Naturally, the specific choices regarding the amount of time to be dedicated to different subjects reflect national education priorities and determine a variety of school curricula; nevertheless, the time that pupils spend at school during critical developmental phases appears to be significant.

Moreover, the school is the ideal setting for intervention not only because (after the family), it is the setting that interacts most with the target population but also because it is the arena for a broad range of meaningful experiences which can help children and adolescents to build their sense of identity, establish interpersonal relationships, and develop skills such as motivation, resilience and self-control.

Indeed, when analysing the risk and protective factors that can affect the mental health of a child or adolescent, taking into account biological, psychological and social domains, WHO (2005) selects the following protective factors pertaining to the education setting: opportunities for involvement in school life, positive reinforcement from academic achievement, identity with a school or need for educational attainment. On the other side, risk factors are: academic failure, failure of schools to provide an appropriate environment to support attendance and learning, inadequate/inappropriate provision of education. Therefore, the connection between education and mental health is evident.

This intrinsic relationship between mental health and education has been recognized in the EU. The Conclusions of the Vilnius Conference (October 2013) recommend to address mental health as a priority of EU-education policy activities on early child education and care and on school education, by including mental health in future work to strengthen 'whole school' approaches and by considering inviting a study on "Mental health, educational attainment, school failure and early school-leaving in the EU".

The "Whole School Approach" (Weare, 2000) is a multi-component approach involving a wide range of people, agencies, methods and levels of intervention, and mobilising the whole school as an organisation. It foresees the promotion of mental emotional and social health within schools in collaboration with various stakeholders with a view not only to improving the quality of education (learning and teaching) but also to supporting physically, mentally and socially healthier individuals.

As part of this approach, the mental health and well-being of teachers and school staff is a key consideration. Educators have to face a number of emotions when they relate to pupils (Chang & Davis, 2009), and continued support is essential, including professional development (Weare, 2000).

Parents can also benefit from training so as to gain key competencies on how to play a more active role in the promotion of the mental well-being of their children and adolescents (Jané-Llopis, 2005). Moreover, parent-teachers combined training has demonstrated to be effective for the promotion of social competencies in children and adolescents (Webster – Stratton et al., 2001).

Generally speaking, the importance of education and educational attainment as being key to economic growth has been recognised as a priority for the European Union. One of the five headline targets of the Europe 2020 strategy covers education and proposes several objectives including reducing the rate of early school leavers to 10% from the current 15%.

Eurostat figures for 2012 show that the majority of EU Member States have made progress on the Europe 2020 education target to reduce the rate of early school leaving[3] to below 10%. However, there are still wide disparities between Member States: the share of young people leaving school early stands at 12.6% on average in the EU, down from 13.4% in 2011 (Eurostat, 2012), making early school leaving still a challenge for many EU countries.

The importance of education in the EU is also underlined in the new EU Investment Plan (EC IPE, 2014) where the priority is assigned to investment in infrastructure, which includes specifically education.

3 Early leavers from education and training are defined as the percentage of the population aged 18-24 with at most lower secondary education and who were not in further education or training during the last four weeks preceding the survey.

1.4 Inter-sectoral collaboration of the health, social and education sectors in the area of Mental Health and Well-Being of Children and Adolescents

As mentioned previously, in line with the need for a more holistic approach to the issue of mental health and well-being among children and adolescents, inter-sectoral collaboration has been recognised as being key to the success of promotion and prevention initiatives.

Inter-sectoral collaboration has been defined as "A recognized relationship between part or parts of different sectors of society which has been formed to take action on an issue to achieve health outcomes or intermediate health outcomes in a way which is more effective, efficient or sustainable than might be achieved by the health sector acting alone" (modified from WHO, Geneva, 1997). It is seen as a basic condition to achieve equity in health, as a consequence of the awareness that changes in the health sector can be determined by decisions and actions carried out in other sectors.

Already in 1986, the Ottawa Charter emphasised the task of "re-orient health services" as one of the five priorities for Health Promotion (WHO, Ottawa Charter, 1986). This innovative perspective raised awareness on the fact that the responsibility of health promotion in health services is not solely of health professionals, but it involves the community level, government and institutions. The Charter specifies that health should be on the policy agenda in all sectors, and at all levels of government. In this sense, health services were called upon to foresee a more comprehensive mandate, i.e., to open channels between the health sector and broader social, political, economic and physical environmental components.

It is clear that this basic principle should apply to all the specific areas of health promotion. In particular, the World Health Organization underlines the importance of involving all sectors when addressing mental health of children and adolescents, as "all sectors have a stake in both the present and future physical and mental well-being of young people" (WHO, 2005). The range of risk factors which may potentially affect mental health is wide, therefore responses to them need to be multi-layered and multi-sectoral.

At European level, an extensive process of reflection on mental health of the population has taken place in recent years, starting from the "Green paper – Promoting the Mental Health of the Population. Towards a mental health strategy for the EU" (2005) through to the European Pact for Mental Health and Well-being (2008) and the thematic conferences, and evolving into the Council Conclusions on the European pact for mental health (2011).

A recurrent theme that has emerged from this process of reflection relates to the subject of cooperation between sectors. It is recognized that although there has been improvement over the years, steps taken to achieve inter-sectoral collaboration remain theoretical and there remains significant work to be done in this regard. The European Council recognises the importance of an integrated approach to the promotion of mental health, and specifically recommends to the Member States, among others, to: "Build innovative partnerships between the health and other relevant sectors (e.g., social, education, employment) to analyse policy impact on mental health, to address mental health problems of vulnerable groups and the links between poverty and mental health problems, to address suicide prevention, to promote mental health and well-being and to prevent mental health disorders in different settings, such as workplaces and educational settings".

In line with this approach, in the recommendations "Investing in children: breaking the cycle of disadvantage" (2013), the Commission calls for enhanced coordination between the key actors involved in developing and implementing policy initiatives to combat child poverty and social exclusion, including states, local communities and civil societies.

1.5 European Mental Health Policy

During the EU high-level conference "TOGETHER FOR MENTAL HEALTH AND WELL-BEING", which was held in Brussels on 13th of June 2008, the European Pact for Mental Health and Well-being was launched. The Pact provides an EU-framework that enables exchange and cooperation between Member States (MSs) or stakeholders in different sectors (including health, employment and education) to act on the challenges and opportunities in promoting better mental health for the European population.

The Pact identifies five key areas for policy makers and stakeholders across the EU to take action: (1) mental health in youth and education; (2) mental health of older people; (3) mental health in the workplace; (4) prevention of depression and suicide; and (5) addressing stigma and social exclusion.

Between 2009 and 2011, the Pact was implemented mainly through the organisation of five thematic conferences on the following topics:

- *Mental Health in Youth and Education, 29-30 September 2009 (Stockholm)*
- *Prevention of Depression and Suicide, 10-11 December 2009 (Budapest)*
- *Mental Health in Older People, 28-29 June 2010 (Madrid)*
- *Combating Stigma and Social Exclusion, 8-9 November 2010 (Lisbon)*
- *Mental Health in Workplace Settings, 3-4 March 2011 (Berlin)*

In parallel with the thematic conferences, the Commission set up the EU Compass for Action on Mental Health and Well-being – an online resource providing a collection of statements by Member States and other stakeholders, relevant documents and a database of standardised descriptions of good practice and policies for the improvement and promotion of mental health and well-being.

The Council (2011) invited inter alia the MSs and the Commission to set up a Joint Action on Mental Health and Well-being under the EU Public Health Programme 2008-2013 providing a platform for exchange of views, cooperation and coordination between Member States, to identify evidence based best policy approaches and practices and analyse activities in particular in the following areas:

- Tackling mental disorders through health and social systems;
- Taking evidence based measures against depression;
- Building innovative partnerships between the health and other relevant sectors (e.g., social, education, employment) to analyse policy impact on mental health, to address mental health problems of vulnerable groups and the links between poverty and mental health problems, to address suicide prevention, to promote mental health and well-being and to prevent mental health disorders in different settings, such as workplaces and educational settings;
- Managing the evolution of community-based and socially-inclusive approaches to mental health;
- Improving data and evidence on the mental health status in populations.

1.6 European projects on Mental Health and Well-being of Children and Adolescents

In line with the mental health priorities identified in terms of strategy, numerous initiatives focusing on mental health of children and adolescents have been co-funded under the EU Public Health Programmes in recent years. Most of these projects were implemented in schools, the elective setting for the prevention and the promotion of the mental health of children and adolescents.

- CAMHEE (Child and adolescent mental health in enlarged European Union), aimed at providing an overview of the challenges, existing practice and guidelines for developing effective mental health promotion and mental illness prevention policy and practice across Europe. The project also focused on conducting support activities in new and applicant member states in the field of CAMH, with special focus on implementation of effective and evidence-based policies and practices based on involvement and participation of children, families and communities. On the basis of information gathered, CAMHEE provided advice to the European Union and Member States on mental health promotion and mental disorder prevention among children and adolescents, with special focus on management of changes needed in new member states to move from inherited patterns of institutionalisation and medicalization to modern public health approaches based on involvement of children, youth, parents and communities (*http://old.mhe-sme.org/our-projects/past-projects/camhee.html*).
- SEYLE (Saving and Empowering Young Lives in Europe), aimed at leading adolescents to better mental health through decreased risk-taking and suicidal behaviours; evaluating and comparing the outcomes of three preventive interventions based on different approaches; recommending culturally-adjusted intervention models that effectively promote adolescent mental health and well-being in European countries (*http://www.seyle.eu/*).
- SCMHE (School Children Mental Health Europe), aimed at building up a set of indicators across seven different countries in the EU in order to be able to collect and monitor primary school children's mental health and its major risk factors in an efficient methodology (*http://www.scmheproject.com/*).
- SUPREME (Suicide Prevention through Internet and Media Based Mental Health Promotion) aimed at developing, implementing and evaluating an Internet and media-based, multi-language, culturally adapted, peer facilitated Mental Health promotion and Suicide Prevention intervention. The intervention comprised a highly interactive website targeted at adolescents and young adults in the age group 14-24 years, and a set of published guidelines, aimed at media that targets young audiences, such as newspapers and magazines (*http://supreme-project.org/*).

Where relevant, the context analysis and main achievements of these projects have been taken into account in the elaboration and review of the present report and of the corresponding Recommendations that have been produced in the frame of the thematic Work Package on "Mental health and Schools" (WP7) of the Joint Action on Mental Health and Well-Being.

1.7 The EU Joint Action on Mental Health and Well-Being

The EU Joint Action on Mental Health and Well-Being is a direct and concrete follow-up to a process of reflection and collaboration between MSs which started in 2005 with a consultation process when, as a first response to the WHO mental health declaration for Europe, the Commission published the Green paper "Promoting the Mental Health of the Population. Towards a mental health strategy for the EU". The green paper aimed at launching a debate with a wide range of relevant actors.

The Joint Action is therefore built on the work done under the European Pact for Mental Health and Well-Being and is meant to give follow-up to the 2011 Council's Conclusions. The action brings together 50 associated and collaborating partners representing 27 EU Member States and associated countries.

In particular, the Joint Action addresses:

- Promoting mental health at the work place and in schools
- Promoting action against depression and suicide
- Developing community mental health care and
- Promoting the integration of mental health in all policies

The overall aim of the Joint Action is to contribute to the promotion of mental health and well-being, the prevention of mental disorders and the improvement of care and social inclusion of people with mental disorders in Europe. The expected result is a more rigorous and comprehensive knowledge of mental health and well-being situation in the EU and the development of an endorsed framework for action.

This report documents the work carried out under the thematic area "Mental Health and Schools" of the Joint Action. As the title of the thematic area suggests, the school represents the core setting both in terms of reaching the target (i.e., children and adolescents) as well as in terms of promoting interaction with other sectors who play a key role in the prevention of mental disorder and the promotion of mental well-being among children and adolescents.

2. METHODOLOGY

2.1 Definition of goals and objectives

The overall objective of the thematic Work Package "Mental health and Schools" of the Joint Action was to develop an action framework for cooperation between sectors, including health, social care and the education regarding the promotion of mental well-being, prevention of mental and behavioural disorders of children and adolescents, with a specific focus on the interventions carried out in the school setting. Such an action framework was developed as a component of a broader and commonly endorsed action framework on mental health and well-being in Europe.

With this in mind, the specific objective was to produce a report documenting the analysis of the situation in the European countries involved in this topic and to build on the findings of this analysis in order to produce recommendations for policy makers at regional, national and European level.

For the project activities, the following core themes were agreed upon:

a) There is no health, without mental health;

b) Promotion of optimal cognitive, emotional, behavioural and social functioning including educational attainment across all levels of education, including early childhood education and care;

c) Prevention of mental disorders and psychosocial distress across all levels of education including early childhood education and care;

d) Improving cooperation between health, education, social and family authorities and NGOs involved in the mental health and well-being of children.

2.2 Design of methodology

The agreed methodology was carried out according to four different but inter-related steps as follows:

- **An evidence review** in participating countries to identify (i) scientific literature (ii) policies and practice (iii) good practice regarding the cooperation between the three sectors in the area of mental health of children and adolescents. This activity provided the preliminary work for the more detailed analysis to be carried out at country level as described below.

- **An analysis of the situation** in participating countries to provide evidence on which strategies are effective for addressing those needs. Specifically, each partner examined the general situation of its country/region (in terms of geographic and population data) with a detailed analysis of its education, social and health sectors, as well as of the existence of a specific strategy on mental health of children and adolescents and finally of the mental health status of children and adolescents:

    - Education sector: number of students by ISCED level, data on school attainment and drop-out; legislation and policy, organisation and functioning, responsibility and delivery of promotion and prevention initiatives, financing and workforce

    - Social services: legislation and policy, organisation and functioning, responsibility and delivery of promotion and prevention initiatives, financing and workforce

    - Health services: legislation and policy, organisation and functioning, responsibility and delivery of promotion and prevention initiatives, financing and workforce

Moreover, each partner was asked to select two strengths and two weaknesses concerning the cross-sectoral cooperation. Finally, each partner identified two examples of good practice from the review of good practices available at its regional or national level: one for mental health promotion and one for mental disorders prevention.

This analysis was key to drawing up the policy recommendations as it was important to outline not only what works but under what circumstances it works.

- **A consultation with external experts** was conducted on specific topics where the information was not readily available in the participating countries, such as for example on the subject of screening for mental health disorders as part of regular health-checks carried out in schools.

- **An International literature review** on the subject of the mental health and well-being of children and adolescents in general and also with a more specific focus on how the three sectors (health, education and social) cooperate in this regard. The purpose of this activity was to provide the overall context of the project as well as to provide a benchmark against which to present the findings. Furthermore, a review of good practices for the promotion of mental health and prevention of mental and behavioural disorders of children and adolescents available not only at European but also at International level (Australia, Canada, US) was carried out.

The review and the situation analysis were carried in the following countries and regions: Croatia, England, Estonia, Finland, Italy, Iceland, Malta, Norway, Slovak Republic, Spain (Galicia Region) and Sweden (Botkyrka).

The desk research was complemented by a number of meetings among participating partners where preliminary project findings were discussed and themes to be developed further as policy recommendations, were identified.

The International literature review included search results using the following key-words: “mental health, well-being, mental health services, mental health policy, mental health strategy, early school leaving, children and adolescents, inter-sectoral collaboration, whole-school approach, health promoting school, inter-sectoral training of school staff”. National, European and worldwide databases were consulted, and documents were collected such as WHO reports, European reports, national reports on health systems and policies, EU strategies, guides.

Reference was also made to the results of a separate International literature review that was conducted in connection with the JA on the subject of school interventions for promoting children and adolescents’ mental health and well-being (Carta et al., 2015). The main focus of this review was interventions aimed at prevention or treatment with a focus on 5 main areas: programmes aimed at promoting general health and well-being in the school; the provision of school-based programmes targeting specific mental disorders and conditions, with attention to the integration of adolescents with specific mental health disorders; Bullying; Sport; Alcohol and Drugs. The results of this study were particularly relevant to depict the situation of school based programmes and interventions at International level (see Appendix 1 for extracts).

2.3 Development of instruments

Partners were provided with common templates and guidelines to conduct the review and analysis in their respective countries, guidelines which were applied on the basis of knowledge of local context, expertise and competence of each organisation. In terms of search criteria, partners were invited to consult a variety of databases when conducting their review (e.g., Pubmed, Web of Sciences, and national or local databases) whereas for grey literature, the choice of search engines has been left up to the discretion of the researchers. The basic information of each identified article/chapter/book was summarised in a short abstract including objectives, target group, main findings, and conclusions. This abstract is available in both original language and English, in order to increase the access to the scientific evidence made available through the review, at local and International level, and can be retrieved at: *http://www.mentalhealthandwellbeing.eu/publications#reports*.

For the evidence review, the following inclusion/exclusion criteria were agreed upon.

Inclusion criteria:

- Literature/programmes-policies/good practices in own country;
- Articles, reports, programmes and good practices published/implemented after the year 2000;
- Programmes or practices that started before this time limit, lasting beyond the year 2000, may be considered;
- Include "educational contexts" as key word;
- The target population included in the study is made of infants, children and adolescents, from 0 to 17 years old;
- Include grey scientific literature; only official/under approval programmes-policies/good practices.

Exclusion criteria comprised any study/paper/policy and best practice that did not meet the above mentioned inclusion criteria.

With regard to the identification of Best Practice, reference was made to the CDC (2010)[4] definition where best practice includes field or research-tested:

- interventions
- programmes
- strategies
- policies
- procedures
- activities

that are intended to effect a change.

In line with the above-definition, participating partners were asked to include a good practice only in case results of evaluation were available at the time of the review. Furthermore, bearing in mind the objective to produce policy recommendations, the above definition was modified to consider "Programmes-policies" as distinct from "Good Practice".

4 CDC Best Practices Workgroup Definitions, Criteria, and Associated Terms, Version 1.0: September 15, 2010.

2.4 Analysis of Data

Regarding the results of the review, data cleaning was carried out through individual consultations with participating partners. Data were analysed using STATA 11.

Regarding the situation analysis, the findings have been analysed making reference to the most common areas for action for children and adolescents mental health, as suggested by WHO (2005). The list was adjusted to be consistent with the specificities of the thematic area. The final structure is as follows: information, interventions and evaluation on the mental health of children and adolescents; the importance of the school as an elective setting for early intervention; training approaches and opportunities for school staff on mental health; mental health as part of a wider national network. The information collected was reviewed independently by two reviewers from CReMPE - AOUI Verona, so as to ensure the key information was observed and documented. Any common approaches, particularly innovative aspects, or any critical issues were noted under the different thematic areas as defined above.

2.5 Limitations of the study

Given the objectives of the thematic Work Package, the study design and the instruments employed, the following limitations could have a potential impact on the findings:

- The limited number of partners led to only a description of the mental health and well-being of children and adolescents in some of the Member States, and thus not providing a picture of all European countries.

The International literature review conducted under this project has partially overcome this limit.

However, this could be addressed by opening the possibility to extend the search to all European countries, by applying the same methodology and tools.

Some tables included in chapter 4 “Main findings and discussion” do not report data from Galicia and Botkyrka. This is due to the fact that these two partners were not part of the thematic Work Package since the beginning of the project activities, and thus they were unable to perform the evidence review (literature, programmes and policies, good practices).

Moreover, some of the tables in chapter 4 “Main findings and discussion” do not include data from England due to the fact that they were presented in a different format, and therefore could not be included in the comparative tables. However, the information provided was in any case taken into consideration in sections 4 “Main findings and discussion” and 5 “Conclusions and recommendations”.

- The wide number of partners involved in this Joint Action in general and in this thematic Work Package in particular required a continuous discussion for the definition of terms to be applied during the project.

A common glossary for the Joint Action was created with the contribution of all Work Package leaders so as to ensure a common understanding of key terms.

This glossary could be the basis for future research in the field of mental health and well-being in European countries.

- Most of the partners of this thematic Work Package belong to the health sector and therefore this could have influenced the final data set.

Nevertheless, this limit was counter-balanced by involving representatives from the other relevant sectors in the process of gathering data followed by a continuous consultation on the project output.

This may be addressed in the phase of building a future partnership by highlighting the specific contribution of each potential partner.

- The limited time available and the respective financial resources for the review played a role in the management of the project.

These constraints were taken into account when defining specific selection criteria such as deciding to analyse papers, programmes and good practices published after 2000 only.

However, this may be overcome by allocating more time and financial resources to the preliminary discussion for the definition of inclusion and exclusion criteria.

- In the review phase, the English version/abstract of good practices and projects was sometimes not retrievable or unavailable in some cases: therefore those good practices were not mentioned in the report and in the policy recommendations.
- A significant limitation of data stems from the selection of the “school setting” as the elective setting for identification of literature, projects and programmes on mental well-being promotion and mental and behavioural disorders prevention of the target group.

Nevertheless, this was in line with the area of interest of this thematic Work Package and can be overcome thanks to the results that will be shared by the other thematic Work Packages of the Joint Action.

3. RESULTS

3.1 INTRODUCTION

As mentioned in the previous section, participating partners carried out a comprehensive review of evidence on the subject matter. As a result of the review process, a total of 604 records are included in the final dataset. (See Table 1 below).

Table 1: Number of records collected

394	Literature records
157	Policies or programmes
53	Good practices

Having completed this review, participating partners were then well-positioned to carry out the situation analysis.

3.2 CROATIA

3.2.1 Overview

Croatia is situated on the crossroads between Central and South-Eastern Europe.

According to 2011 census, it has 4 284 889 inhabitants: 2 066 336 males and 2 218 554 females.

The capital is Zagreb, with 790 017 inhabitants.

The surface area of Croatia is 87 661 km^2, of which 56 594 km^2 is land area with a population density of 75.7 inhabitants per km^2. This density varies greatly among different counties. Croatia is made up of 21 counties, 127 towns/cities and 429 municipalities.

The average age of population is 37.5 years (men) and 41 years (women), and life expectancy at birth is 71.1 years for men and 78.1 years for women. Natural increase is negative, - 2.2 per 1 000 inhabitants.

Concerning ethnicity and religion, 90.42% are Croats, and 86.28% of population are Catholics.

Gross domestic product per capita in 2011 was 10 205 EUR.

The school-aged population is divided as follows:

Croatian school aged population

AGE GROUPS	TOTAL	MALES	FEMALES
0-4	212 709	109 251	103 458
5-9	204 317	104 841	99 476
10-14	235 402	120 633	114 769
15-19	244 177	124 918	119 259

Source: Statistical Yearbook of the Republic of Croatia, 2012.

With regard to the educational attainment of pupils in Croatia, in 2012, the distribution of students by level of education is as follows:

Children and adolescents by level of education

LEVEL OF EDUCATION	NUMBER OF STUDENTS
ISCED 0	102 857
ISCED 1	159 945
ISCED 2	196 946
ISCED 3	183 807
ISCED 4	Not applicable

Source: UNESCO, UIS.Stat

In the school year 2011 the situation concerning school attainment is as follows:

Educational attainment of population aged 25 years and older in Croatia

LEVEL OF EDUCATION	% OF STUDENTS		
	Males-Females	Males	Females
ISCED 1	7.7	4.9	10.3
ISCED 2	18.5	14.6	21.9
ISCED 3	52.3	60.8	44.8
ISCED 4	Not applicable		

Source: UNESCO, UIS.Stat

In the school year 2011-2012, 59 968 students have enrolled institutions of higher (tertiary) education.

As regards the numbers of students dropping-out from schools in Croatia, the rates in 2011 where as follows:

Drop-out rates to the last grade per level of education in Croatia

	% OF STUDENTS
Drop-out rate to the last grade of primary education	0.56046
Drop-out rate to the last grade of general lower-secondary education	0.75028

Source: UNESCO, UIS.Stat

In 2012, there are 227.70 early school leavers from primary school (UIS Stat, UNESCO 2012).

Concerning the mental health status of children and adolescents in this country, in 2011 mental health morbidity accounted for 0.92% (in 0-6 age group) and 1.74% (in 7-19 age group) of all diseases and conditions diagnosed by primary health care.

Specifically, the leading category is “Neuroses, mood disorders, stress induced disorders and somatoform disorders”.

In the primary school population, mental health disorders ranked as the third reason to visit school medicine counselling departments (14% of all causes), followed by risk behaviours (8%).

In the secondary school population, mental health disorders also ranked third (12% of all causes), followed by risk behaviours (12%). Mental health and behavioural disorders accounted for 0.6% of all hospitalizations in age group 0-4, 1.2% in age group 5-9 and 4.8% in age group 10-19.

Out of all cases treated for drug addiction in medical institutions in 2011, 0.3% were younger than 14 and 7.2% in the age group 15-19. Mean age of the first consumption for cannabinoids is 16.3 and for heroin 16, and the main cause for beginning the use was partner or peer influence (30.2%).

Suicide rates in general population have been oscillating in the past 15 years, with a declining trend (15.9 per 100 000 in 2011, according to the Croatian Committed Suicides Registry).

The same declining trend can be observed for the age group 0-14 (less than 1/100 000) and the age group 15-19 (3.5/100 000). Nevertheless, suicide is the third leading cause of mortality in this last age group (Croatian Health Service Yearbook, 2012).

In the context of this JA, the existence of a mental health strategy exclusively targeting children and adolescents was analysed, in the different countries.

In Croatia, the Ministry of Health is responsible for the development and implementation of the **National mental health strategy 2011-2016.**

The main aims of the strategy are: promotion of mental health for all; addressing mental health disorders through preventive activities; promotion of early intervention and treatment of mental disorders; improving the quality of life of persons with mental health disorders or disability through social inclusion, protection of their rights and dignity; development of the information system, research and knowledge in the field of mental health.

All aims include children and young population. Activities specifically referring to children and youth include: promotion of parenting skills and early interaction training; raising the coping skills, with special attention to children of parents with psychiatric illness; improvement of identification of mental health problems; supporting the existing and developing new activities in the field of violence prevention; improving recognition and early intervention in children and youth with intellectual difficulties and supporting their families.

Strategic plan for the development of public health 2013-2015 also includes relevant activities such as continuing the Health Behaviour in School-aged Children (HBSC) Survey; prevention of alcohol abuse; situational analysis and establishing a screening system in primary health care, particularly aimed at depression and anxiety.

Programme for suicide prevention in children and youth 2011-2013 includes: education and counselling in order to support the development of parenting and communication skills; diagnostic follow-up of child-parent early interaction; follow-up and support to children and youth after acts of intentional self-harm, or discharge after treatment for mental disorders or addiction; support to children and youth from families in which a member has a mental disorder; education and procedures in the field of early recognition and treatment of depression, as well as early recognition of suicidal risk; increase of number and accessibility of professionals and services for protection of child and youth mental health.

The Croatian partner which contributed to the thematic area of “mental health and school” in the present Joint Action is **the Ministry of Health of the Republic of Croatia (MZRH)** and its main areas of interest and activities are:

1. Health policy,

2. Health legislation

The Ministry also manages health workforce and health services.

The Ministry of Health of the Republic of Croatia is in charge of health care and welfare. By enacting acts and by-laws, the Ministry defines the health care measures, subjects responsible for the implementation of these measures and methods of their implementation.

The Ministry is responsible for the implementation of the National Mental Health Strategy 2011-2016. **Cross-sectoral collaboration, including education is one of the 6 priority areas of the Strategy.**

3.2.2 Mental Health services for children and adolescents

Components of promotion of mental health and prevention of mental disorders are integrated in national legislation and various policies. With respect to this analysis, the most relevant components are presented below:

> *The new **Health Care Act** was enacted in 2008 and last revised in 2012. Rights of people with mental disorders, including children and youth, are additionally protected by the Law on the Protection of Persons with Mental Disorders that was enacted in 1997 and last revised in 2002.*
>
> *Apart from the **National mental health strategy 2011-2016**, the **Strategic plan for the development of public health 2013-2015**, and the **Program for suicide prevention in children and youth 2011-2013**, policies in other sectors have also been developed including elements relevant to mental health promotion and prevention of mental illness in children and youth (Narodne Novine d.d., Croatian Gazette).*
>
> ***The National Strategy for Prevention of Family Violence (2011-2016)** also has an impact on Mental Health of children and adolescents as its main aims are prevention of family violence, improvement of cross-sector cooperation, continuous education of professionals working in the field of prevention of family violence, psychosocial treatment of perpetrators, improvement of legal framework, improvement of care and support procedures for victims of family violence, and raising public awareness*
>
> ***The National program for prevention of children and youth addiction in educational system and social care system 2010-2014**: a specific policy that contributes to addiction prevention and policies in other sectors, including also the education sector.*

Mental health services for children and adolescents are provided at primary, secondary and tertiary level. Most primary level services (teams including, among others, psychiatrists, school medicine specialists, psychologists, nurses and other mental health professionals) are offered in county public health institutes and are mainly focused on counselling and addiction prevention.

One general health center (Zagreb West) offers outpatient services for this population. The Polyclinics for child protection in Zagreb offers services to children and youth, focusing mainly on abuse and violence.

Health care services on secondary and tertiary level are mainly rendered in clinical hospital departments in four regional centres (Zagreb, Rijeka, Osijek and Split), influencing the accessibility to services. There is one special psychiatric hospital for children and adolescents (in Zagreb), offering both in-patient and out-patient services.

National insurance-based health system offers universal coverage to all citizens through the Croatian Health Insurance Fund. Health care contributions in Croatia are mandatory for all employed citizens. The “dependents” (including children and youth till the end of regular education) obtain their health care coverage through contributions paid by working members of their families.

Mental health is fully integrated and there is no separate budget allocation for mental health, except for drug addictions.

From an equity perspective, citizens are generally required to contribute to healthcare services, with the exemption of some population categories including children under age of 18, and youth during regular education (up to a maximum of 8 years for university graduation).

Workforce dedicated to mental health includes the following professionals: psychiatrists, mostly subspecialists of childhood and adolescent psychiatry, medical doctors of other specialties (mostly family and school medicine), residents, psychologists, nurses, occupational therapists, and special educators.

At the moment of report writing, a data collection on medical doctors and other mental health professionals working with children and adolescents in health, education and social services was initiated. There are 146 specialists of school medicine and 17 residents in Croatia's health institutions.

The number of child and adolescent psychiatrists is particularly low (25) and this creates a huge gap in the system (Croatian Health Service Yearbook, 2012).

The Ministry of Health, the Croatian Institute for Public Health, and county Institutes for Public Health are responsible for promotion and prevention.

Services are delivered by the Croatian Institute for Public Health, county Institutes for Public Health and health care institutions including primary and secondary health care. NGOs often deliver promotion and some prevention activities and their programmes or projects can be financed by state budget, local authorities or other sponsors.

3.2.3 Social Services for children and adolescents

With regard to the current legislation and policies concerning the social services for children and adolescents in Croatia, the most relevant elements are:

> ***The new Social Welfare Act was enacted in 2012:*** *it covers a range of services important for mental health prevention such as psychosocial counselling, early childhood intervention, and social inclusion. Community services and civil society participation are promoted by the Act.* ***The National Youth Programme from 2009 till 2013,*** *the* ***National Strategy for Prevention of Family Violence 2011-2016*** *and the* ***National strategy for equal opportunities for persons with disabilities 2007-2015****, all include elements relevant for mental health promotion and prevention of mental illness in children and youth (Narodne Novine d.d., Croatian Gazette).*

Services for children and youth are provided by:

- **social welfare centers that include departments for children and families** (90 centers distributed all over the country): they provide non-institutional (ambulatory) services.
- **family centers** (one per each county - recently incorporated in social welfare centers)
- **social welfare homes for children and youth** (52 distributed all over the country), providing accommodation, food, care, upbringing, health care, schooling, training and adequate forms of professional support to children and youth deprived of parent care and children and youth with behavioural disorders.
- **homes for physically or mentally disabled children** (49 distributed all over the country), offering accommodation, food, care, upbringing, health care, education, medical and psychosocial rehabilitation and organised leisure time activities.

In 2011, out of the total beneficiaries there were 83 376 minors who received 164 635 services.

The categories of beneficiaries included children and youth under family and legal protection (36 659), children and youth with behavioural disorders (11 906), physically or mentally disabled children and youth (16 845), mentally ill or addicted children and youth (1 521) and other categories (16 455) (Statistical Yearbook of the Republic of Croatia, 2012).

As of end of year 2013, there was no separate data on social services addressing children and adolescents.

Financing is provided by the state budget. Teams consist of **social workers, psychologists, pedagogues and social pedagogues, educators and special educators, medical doctors and other expert staff. There is no data on the number of staff employed in social welfare centers separately for departments for children and families, but the collection of data has been initiated.**

In 2010, there were 851 expert staff employed in social welfare homes for children and youth, and 1 767 expert staff employed in homes for physically or mentally disabled children.

NGOs can offer social services provided they have expert personnel and their programmes or projects can be financed by state budget, local authorities or other sponsors (Statistical Yearbook of the Republic of Croatia, 2012).

Responsibility for coordination of promotion and prevention activities is under the **Ministry of social policy and youth** and they are delivered through social welfare centers, family centers, and social welfare homes for children and youth and less frequently by homes for physically or mentally disabled children. NGOs often deliver promotion and preventive activities and their programmes or projects can be financed by state budget, local authorities or other sponsors.

3.2.4 The Education system for children and adolescents

The essential documents concerning the educational sector in Croatia are:

> ***The Act on primary and secondary education and upbringing**, enacted in 2008 and last revised in 2012.*
>
> ***The Act on preschool education and upbringing**, enacted in 1997 and last revised in 2007.*
>
> ***The Act on science and higher education**, enacted in 2003 and last revised in 2011.*
>
> ***The National Framework Curriculum**, which defines principles, aims and areas of preschool, primary and secondary school education and upbringing. Health area including mental health is one of the curricular areas (Narodne Novine d.d., Croatian Gazette).*

The Education system includes preschool (ISCED 0), basic (ISCED 1), lower secondary education (ISCED 2), upper secondary (ISCED 3) and tertiary education (ISCED 5&6).

Preschool lasts until the age of six but is not compulsory. Basic and lower secondary education last for eight years and are compulsory for all children. Upper secondary education may last from one to four years and is not compulsory. The upper secondary education includes: grammar schools, technical and related schools, art schools, industrial and craft schools. The tertiary education is carried out through university and professional studies.

Compulsory education of disabled children and youth is carried out in special training-education groups and regular class units within the school.

In the case of major developmental difficulties, education is provided in special institutions. Upper secondary education is provided by applying individual methods in class units or educational institutions.

With regard to the financial resources that are dedicated to the Education System addressing children and adolescents, the situation in 2010 in Croatia was as follows:

Expenditure in education

TOTAL GOVERNMENT EXPENDITURE IN EDUCATION	%
As % of GDP	4.31
As % of total government expenditure	9.95

Source: UNESCO, UIS.Stat

Local authorities finance preschool attendance, but parents also contribute and the amount depends on city/region. Compulsory and upper secondary education is free for all pupils and financed by the state budget (a regular upper secondary student cannot enrol a school year more than twice).

The age limit for completing free compulsory and upper secondary education is 21.

Tertiary education is free for students who pass the entrance exam, and is financed by the state budget for regular students (a regular student cannot enrol in a school year more than twice).

Concerning human resources employed in this sector, in 2012, the situation was as in the table below:

Teachers in Croatia per level of education

LEVEL OF EDUCATION	TOTAL NUMBER OF TEACHERS
ISCED 0	8 129
ISCED 1	11 696
ISCED 2	22 525
ISCED 3	26 251
ISCED 4	Not applicable

Source: UNESCO, UIS.Stat

Responsibility for coordination of promotion and prevention activities is under the **Ministry of science, education and sports and on the Education and teacher training agency.**

Promotion and prevention is delivered in preschool and school institutions by pedagogues and/or psychologists and/or educators/special educators (at least one professional per school) and teachers during regular classes. **NGOs** often deliver promotion and prevention and their programmes or projects can be financed by state budget, local authorities or other sponsors.

3.2.5 Cooperation between sectors

In Croatia **there is no special legislation or policy** defining cross-sector cooperation, but it is a **standard practice and most policies, programmes and strategies are based on interdisciplinary approaches.**

Process indicators are defined. However the **outcome indicators are missing**. In other words, there is confirmation that the sectors are in contact and involve each other but there are no figures to demonstrate the outcome of such cooperation. This often results in lack of synergy and on the action level this can result in parallel systems of implementation.

The local experts identified the following strengths and weaknesses concerning the cross-sectoral cooperation:

Strengths and weaknesses in cross-sectoral cooperation in Croatia

STRENGTHS	WEAKNESSES
Mental health is included in all relevant policies	Cooperation among sectors is often formal
Good quality of cooperation in violence and addiction prevention	There is a need for true synergy in planning, implementation and follow-up of activities

3.2.6 Selected examples of good practice

GOOD PRACTICE IN MENTAL HEALTH PROMOTION

"Young volunteers of the healthy city of Poreč - peer helpers"

The aim of the program is to support young people (secondary school students) in specific phases of their development and encourage them to take active helping roles within their social groups. The three-year program is structured in three phases: educational (learning about human behaviour); working on individual personality (including emotions, self- confidence, and skills such as decision making, attitudes – healthy life choices) and last translating knowledge and helping other people. There was a statistically significant improvement in individual and social skills, academic achievements, socio-emotional functioning, as well as increase in trust by their peers.

http://www.zdravi-gradovi.com.hr/home/djelotvorno-znanje-za-zdravlje/zdravlje-djece-i-mladih/3i-program.aspx

GOOD PRACTICE IN MENTAL DISORDERS PREVENTION

"BUBA (acronym) Clear mind – no alcohol"

The aim of the program is to reduce alcohol consumption among primary school pupils by postponing the onset of drinking, reducing quantity and frequency of use, raising parents and community awareness about alcohol consumption among children, and improving communication about alcohol between children and parents and among children themselves. Program BUBA is a 3-year program with 12 hours of program activities per year that include: education of teachers and pupils who then train other pupils in their schools, workshops, group discussions, role-play, panel discussions, exhibitions, poster preparations and presentations. The results demonstrated a statistically significant postponement of onset of drinking, a reduction of number of pupils that drink, a reduced frequency and quantity of drinking. Better results were obtained in the general population than in the group of pupils that started drinking very early or presented other risky behaviours indicating that this group requires additional activities in future.
www.zzjzdnz.hr, www.zdravi-gradovi.com.hr/

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3.3 ENGLAND

3.3.1 Overview

According the last census, England has a population of 53 900 000 (26 500 000 male and 27 300 000 female) (ONS, 2014). Life expectancy at birth is 78.9 years for men and 82.9 years for women (ONS, 2013). The number of children and adolescents in England is as follows (ONS, 2014):

England child and adolescent population

AGE GROUPS	TOTAL	MALES	FEMALES
0-4	3 410 000	1 750 000	1 670 000
5-9	3 190 000	1 630 000	1 560 000
10-14	2 980 000	1 520 000	1 450 000
15-19	3 250 000	1 670 000	1 580 000

Source: ONS 2014

Data on children and adolescents by level of education referring to England is not available.

The level of school attainment in England, in 2011, was as follows:

Educational attainment of population aged 25 years and older in England (2011)

LEVEL OF EDUCATION	% OF STUDENTS		
	Males-Females	**Males**	**Females**
ISCED 0			
ISCED 1			
ISCED 2	13.8	12.2	15.3
ISCED 3	53.0	53.4	52.7
ISCED 4			

Source: UNESCO, UIS.Stat

Data on student drop-out from school in England is not available.

Levels of mental disorder in children and adolescents

The last national child and adolescent psychiatric morbidity survey (Green et al., 2005) found prevalence of different mental disorder in 5-16 year olds in Great Britain as follows:

- Any mental disorder: 9.6%
- Conduct disorder: 5.9%
- Emotional disorder (anxiety or depression): 3.5%
- Hyperkinetic disorder: 1.5%
- Any conduct, emotional or hyperkinetic disorder: 8.7%
- Less common disorder (including autism, tics, eating disorders and selective mutism): 1%.

Risk factors for mental disorder among children and adolescents

A range of risk factors are associated with child and adolescent mental disorder (Campion et al., 2012) although vary in level by locality (Campion & Fitch, 2012):

- Inequalities: Children and adolescents from lowest household income have three fold higher risk of conduct, emotional and hyperactivity disorders (Green et al., 2005)
- Ethnicity: White children experience an almost four fold higher risk of mental disorder compared to Indian children (Green et al., 2005)
- Pregnancy factors
  - Smoking associated with increased risk of childhood mental disorder (Murray et al., 2010; Brion et al., 2010) yet only a minority of mothers who smoke during pregnancy set a quit date
  - Prematurity associated with increased risk of mental disorder (Nosarti et al., 2011): Interventions to reduce prematurity can thereby prevent mental disorder
- Parental mental disorder: significant predictor of mental disorder in offspring and account for 12.4% of all offspring disorders (McLaughlin et al., 2012) although only a minority of parents with mental disorder receive any treatment with lack of information about adults with mental disorder who have children
- Other parental factors: e.g., 20% of children without a working parent had a mental disorder compared to 9% of children with one parent working and 8% of children with both parents working (Green et al., 2005)
- Violence and abuse:
  - Childhood adversity accounts for 30% of all mental disorders (Kessler et al., 2010)
  - Child abuse is associated with increased risk of all mental disorders which is even higher for repeated sexual abuse (Jonas et al., 2011)
  - Proportion of 11-17 year olds experiencing different types of abuse include (Radford et al., 2011):
    - emotional abuse (6.8%)
    - neglect (13.3%)
    - severe maltreatment during childhood (18.6%)
    - severe physical violence at the hands of an adult (6.9%)
    - contact sexual abuse (4.8%)
  - Only a minority experiencing different forms of abuse receive intervention
- Bullying
  - % of pupils who say they have been bullied (England 9.6%) (2009) (data from the National Foundation for Educational Research, 2010)
  - % of pupils who say their school deals poorly with bullying (England 26.0%) (2009) (data from the National Foundation for Educational Research, 2010)
  - Cyberbullying (McAfee, 2013): 16% of 10-17 year olds have experienced mean or cruel behaviour online while 22% of 10-17 year olds have witnessed the cyber-bullying of a classmate or friend

Protective factors for mental wellbeing among children and adolescents

Similarly, promoting protective factors for mental wellbeing can promote wellbeing and associated outcomes (Campion et al., 2012). Such factors include antenatal and postnatal care, early experiences including attachment and parenting, family and social support. For young children, mental wellbeing is associated with primary school context/ friendships, home life and family relationships and living in a less deprived neighbourhood while during school teenage years, mental wellbeing is associated with a school environment free from bullying and classroom disruption, feeling supported and sharing meals (Chanfreau et al, 2013).

Mental health strategy for children and adolescents

Each country analysis report requested specific information about mental health strategy focusing on children and adolescents. Both the current mental health strategy for England entitled 'No health without mental health' (HM Government, 2011) and the previous mental health (HM Government, 2009):

- Adopt a life course approach.
- Recognise the importance of child and adolescent mental health by highlighting that majority of lifetime mental disorder arises before adulthood.
- Highlight the opportunities during childhood and adolescence for treatment of mental disorder, prevention of mental disorder and promotion of mental wellbeing.
- Specific target groups and stakeholders: Highlights particular groups including looked after children
- Non-specific timeframe for implementation.

The organisation based in England which contributed to the thematic area of "mental health and school" in the present Joint Action is the South London and Maudsley NHS Foundation Trust (SLaM). The overall focus of this organisation is the treatment of mental disorder.

3.3.2 Mental health services for children and adolescents

The most relevant policy pertaining to mental health services for children and adolescents are the following:

Policy

- *HM Government (2009) New Horizons – a shared vision of mental health. Cross government mental health strategy http://socialwelfare.bl.uk/subject-areas/services-client-groups/adults-mental-health/departmentofhealth/new09.aspx*
- *HM Government (2011) No health without mental health. Current cross government mental health strategy http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf*
- *Department of Health (2011) Health visitor implementation plan 2011 to 2015 https://www.gov.uk/government/publications/health-visitor-implementation-plan-2011-to-2015*
- *Department of Health (2013) Children and young people's health outcomes forum: Recommendations to improve children and young people's health results https://www.gov.uk/government/publications/independent-experts-set-out-recommendations-to-improve-children-and-young-people-s-health-results*

Policy

- *HM Government (2009) New Horizons – a shared vision of mental health. Cross government mental health strategy http://socialwelfare.bl.uk/subject-areas/services-client-groups/adults-mental-health/departmentofhealth/new09.aspx*
- *HM Government (2011) No health without mental health. Current cross government mental health strategy http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf*
- *Department of Health (2011) Health visitor implementation plan 2011 to 2015 https://www.gov.uk/government/publications/health-visitor-implementation-plan-2011-to-2015*
- *Department of Health (2013) Children and young people's health outcomes forum: Recommendations to improve children and young people's health results https://www.gov.uk/government/publications/independent-experts-set-out-recommendations-to-improve-children-and-young-people-s-health-results*
- *Department of Health (2013) National pledge to improve children's health and reduce child deaths https://www.gov.uk/government/publications/national-pledge-to-improve-children-s-health-and-reduce-child-deaths*
- *Department of Health (England) 2014: Closing the Gap: Priorities for essential change in Mental Health. Contains 25 priorities covering both adult and child and adolescent mental health https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf*
- *Department of Health (2014) Health visiting and 0 to 5 commissioning transfer https://www.gov.uk/government/publications/transfer-of-0-5-childrens-public-health-commissioning-to-local-authorities*
- *Department of Health (2014) Achieving better access to mental health services by 2020 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/361648/mental-health-access.pdf*
- *Department of Health (2015) Future in Mind. Promoting, protecting and improving our children and young people's mental health and wellbeing https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf*

With respect to this analysis, legal aspects pertaining to mental health and MH services for children and adolescents include the following:

Legal Framework – what constrains how we do CAMHS?

Must do

- *The UN Convention on the Rights of the Child (UNCRC) which was ratified by the UK Government in 1991 places a clear obligation on health authorities and practitioners to evolve policy and practice in accordance with the best interests of children. We must act compatibly with human rights in everything we do*
- *Both commissioning services and providing services by or on behalf of the NHS are subject to the Human Rights Act*
- *The lives of patients must be protected: this includes taking special care to prevent suicide and self-harm when a patient is at risk (Article 2 of the Convention)*
- *The state must investigate any deaths that occur in hospital (Article 2)*
- *The state must investigate any credible allegations of torture or inhuman treatment (but see below) (Article 3 of the Convention on Human Rights)*
- *Compensate any patient detained under the mental health act whose detention is found by a court to have been illegal or disproportionate. (This may happen, for example because of delays in accessing a Mental Health Tribunal) (Article 5)*
- *Allow patients privacy and the right to a family life. This is a qualified right and it may be considered therapeutic to watch a patient or prevent him or her having contact with his or her family. Such actions must be proportionate (article 8)*
- *Provide patients with a place to worship if they require it (Article 9)*
- *Where a patient loses property while in hospital, the State must investigate (Article 1 of Protocol 1)*
- *We must make provision for the education of children in hospitals (Article 2)*
- *We must seek consent of the patient him or herself if she is over sixteen or if she is judged to be Gillick Competent.*

May Do

- *We may interfere with qualified human rights but interference must be legal and proportionate*
- *Where a treatment is judged necessary by a doctor using his professional judgment, it may be used even if there are unpleasant side effects (however, see reference to article 3 above)*
- *Detention on mental health grounds is a lawful interference with a person's right to liberty, as long as it is done in accordance with the Mental Health Act 1983 and is proportionate.*
  (See reference to Article 5 above)
- *We may provide treatment by force, for example when a patient is suffering from severe anorexia and his or her life is in danger (but see reference to Article 8 above)*

May not do

- *We may not interfere with any absolute human rights under any circumstances*
- *We may not interfere with qualified human rights in any manner that is prohibited under other laws.*
- *We may not interfere with qualified human rights of all patients without consideration of individual circumstances. Any interference must be proportionate.*
- *We may not, for example restrain a patient without consideration of the proportionality of that restraint. (Article 5)*
- *We may not provide a patient with food that is forbidden by the patient's religious or other beliefs. (article 9)*
- *We must not force a patient to live in a mixed-sex ward if his or her religion or other belief forbids it (Article 9)*
- *We must not treat a patient differently because of race, religion, gender, sexual orientation or disability. (Article 14)*
- *We may not seek the consent of a parent or carer when a young person over sixteen or a child considered to be Gillick competent has refused to consent.*

WHO must do WHAT?

- *Health and Social Care Act (2012) The Secretary of State for Health must*
  - *continue the promotion in England of a comprehensive health service designed to secure improvement*
- *in the physical and mental health of the people of England, and*
- *in the prevention, diagnosis and treatment of physical and mental illness.*
  - *fulfil his duties in such a way as to ensure that inequalities in the provision of services are reduced.*
  - *as far as is consistent with the interests of the health service, make sure that those exercising functions on his behalf*
- *are able to act in the way they consider most appropriate, and*
- *without unnecessary burdens being imposed upon them.*

- *Health and Social Care Act (2012) NHS England must carry out such functions as the Secretary of State may require them to carry out through regulations (including specialised services such as Tier 4 CAMHS where numbers are low and costs are high) However, NHS England is separately required to provide "High Security Psychiatric Services". This may occasionally overlap with Tier 4 CAMHS.*
- *Health and Social Care Act (2012) CCGs may commission services to secure the physical and mental health of those living in the area for which they are responsible provided they do not provide services required to be provided by NHSE instead.*
- *Health and Social Care Act (2012) Secretary of State may by Regulations require local authorities to fulfil some public health functions as follows.*
  - *Regulations may require a local authority to exercise any of the public health functions of the Secretary of State.*
  - *The making of Regulations does not prevent the Secretary of State from taking any step that a local authority is required to take under the regulations.*
  - *Any rights acquired, or liabilities incurred, in respect of the exercise by a local authority of any of its functions under such regulations are enforceable by or against the local authority (and no other person).*

Issues

1. *In making policy, we are required to take account of what is in the best interests of children. That is one of the essential reasons for this Taskforce. We believe that it is in the interests of children with mental health problems to have those problems treated and so we need to look at barriers preventing that treatment.*
2. *We need to consider the human rights of patients and others as we exercise our duties as part of or on behalf of the NHS.*
3. *Where there is a requirement on the state to provide treatment or assessment to someone with mental health problems, we need to ensure that we do not fail to do so because of gaps caused by the thresholds of the various "tiers" of CAMHS.*
4. *We need to consider how to ensure that appropriate health-based care is available for children detained under the various sections of the Mental Health Acts.*

Mental health services for children and adolescent services are separate from adult mental health services.

Commissioning of services is based on a 'four tier' system, with services commissioned by schools, local government, Clinical Commissioning Groups and NHS England.

TIER	WHO FUNDS	PROFESSIONALS PROVIDING THE SERVICE INCLUDE	WHO PROVIDES	FUNCTION/SERVICE
1	Various statutory and voluntary sector budgets	GPs Health visitors School nurses Social workers Teachers Juvenile justice workers Voluntary agencies Social services Clergy	Wide range of providers in voluntary and statutory sector	Provided by professionals working in universal services who are in a position to: * Identify mental health problems early in their development * Offer general advice * Pursue opportunities for mental health promotion and prevention
2	Many services funded by Local Authorities. Some NHS funding Schools may commission directly	Child and Adolescent Mental Health workers Counsellors Clinical child psychologists Paediatricians (especially community) Educational psychologists Child and adolescent psychotherapists Family therapists	Voluntary sector NHS Local Authority	CAMHS professionals should be able to offer: * Training and consultation to other professionals (who might be within Tier 1) * Consultation to professionals and families * Outreach * Assessment
3	Most often NHS, but some Local Authorities	Multi-disciplinary teams made up of Child and adolescent psychiatrists Clinical child psychologists Nurses (community or inpatient) Social workers and allied health professionals	NHS and LA	Services offer: * Assessment and treatment * Assessment for referral to Tier 4 * Contributions to the services, consultation and training at Tiers 1 and 2
4	Regional specialist services Funded by NHS England	Same as Tier 3	NHS	Services offer: * Child and adolescent inpatient units * Secure forensic units * Eating disorder units * Specialist teams (e.g., for sexual abuse) Specialist team for neuro-psychiatric problems

This division is a convenient way of looking at services which are spread over several services but it is not the only way to look at them and there is also a three-tier model which divides services as follows:

- Universal services are provided to all children in schools, in community health settings and in any places where many children go. These services are about outreach, offering advice and recognizing when there is a problem. They can be provided by any professional in regular touch with a child.
- Targeted services are provided in services specifically designated as CAMHS. They provide treatment, including both psychotherapy and drugs as necessary. They also assess children to consider whether they may need more specialist services.
- Specialist (and highly specialist) services often provided on an inpatient basis. Such services include ‘Tier 4’ services which are funded directly by NHS England.

The Department of Health and NHS England have both acknowledged this commissioning model is complex. In July 2013, the Minister for Care Services announced a new Taskforce on Child and Adolescent Mental Health and Wellbeing, that will look at improving commissioning practice, amongst other priorities.

Proportion of children and adolescents with different mental disorder who receive any intervention

As regards the proportion of children and adolescents with different mental disorders who are treated, the last child and adolescent psychiatric morbidity survey in Great Britain (Green et al., 2005) found that only a minority of them received any intervention:

- Emotional disorder (3.5% of 5-16 year olds):
  - 73% of parents had sought some form of help or advice
  - 64% of parents had contacted a professional source usually a teacher
  - 34% of parents had contacted family or friends
  - 29% of parents had contacted primary care health professionals
  - 24% of parents had contacted or been referred to a mental health service
- Conduct disorder (5.9% of 5-16 year olds):
  - 81% of parents sought some form of advice or help in the previous year
  - 76% of parents approached a professional source most commonly a teacher (60%)
  - 32% of parents had contacted primary care health professionals
  - 28% of parents sought advice from a mental health specialist
  - 24% of parents sought advice from special educational services such as psychologist
  - 9% were taking some form of medication
- Hyperkinetic disorder (1.5% of 5-16 year olds):
  - 95% of parents of children with hyperkinetic disorders had sought some form of help in the previous 12 months because of concerns about their child's mental health
  - 93% of parents had accessed some professional service most commonly a teachers (70%)
  - 52% of parents also sought help from, or were referred to mental health services
  - 46% of parents also sought help from primary health care
  - 37% of parents also sought help from, or were referred to educational psychologists
  - Parents of children with hyperkinetic disorders had also sought advice from informal sources such as family and friends (35%), self-help groups (7%) and the internet (11%)
  - 43% of children were taking some kind of medication

Levels of impairment or symptoms are undetected in 55% of children with autism and 57% of those with Asperger's syndrome (Russell et al., 2010).

However, assessment of the size of the treatment gap for child and adolescent mental disorder in local needs assessments is largely absent (data from Public Health England, 2015;Oliva & Lavis, 2013).

Financing and workforce in England

The economic impact of child and adolescent of mental disorder during childhood and adolescence is large. For conduct disorder:

- Lifetime costs of a one year national cohort of children with conduct disorder (6% of child population) have been estimated at £5.2 billion (£150 000 per case) (Friedli & Parsonage, 2007)
- Crime is responsible for 71% of the costs of conduct disorder with 13% due to mental illness in adulthood and 7% due to lost lifetime earnings (Friedli & Parsonage, 2007)
- £60 billion annual cost of crime in England and Wales by adults who had conduct disorder and sub-threshold conduct disorder during childhood and adolescence (SCMH, 2009)
- Although parenting interventions are first line intervention for conduct disorder (NICE, 2013) and hyperkinetic disorder (NICE, 2013) and result in £8 net savings for each £ spent (Knapp et al, 2011), only a very small proportion of parents of children with these disorder receive such interventions. Furthermore, information about coverage or outcomes is not routinely collected.

Expenditure on child and adolescent mental disorder in England

Concerning the national expenditure in England on child and adolescent mental disorder, the Programme budgeting aggregate PCT expenditure for child and adolescent mental disorders for past 7 years was as follows (Department of Health, 2014):

- £0.70 billion in 2012/13
- £0.71 billion in 2011/12
- £0.71 billion in 2010/11
- £0.71 billion in 2009/10
- £0.68 billion in 2008/09
- £0.62 billion in 2007/08
- £0.61 billion in 2006/07

In 2012/13, total spend on mental disorder was £11.28 billion (DH, 2014) which means that despite half of lifetime mental disorder arising by the age of 14 (Kim-Cohen et al., 2003; Kessler et al., 2005) and the opportunity to treat mental disorder early, only 6.2% of the mental health budget in England is spent on children and adolescents.

Psychiatrists

NHS Hospital and Community Health Service monthly workforce statistics (May 2014): Child and adolescent psychiatry

- Consultants: 656
- Associate specialists: 26
- Speciality doctor: 72
- Staff grade: 2
- Registrar: 267
- Senior House Office: 1
- F2: 2
- House Officer: 3
- Total: 1 029

Health Visitors

Health Visitors are important for supporting mothers in the postnatal period and detecting mental disorder. The Health Visiting Programme commenced in 2011 with the aim of providing a universal health visiting service which would give more families valuable help and support from their health visitor (DH, 2014). The Programme's aims and objectives were set out in the 2011 Health Visitor Programme – Call to Action (DH, 2011) and was delivered in partnership by the Department of Health, NHS England, Public Health England and Health Education England.

The Health Visiting Programme has increased the numbers of health visitors by almost 50% to over 4 000.

Healthy Child Programme

Healthy Child Programme is the key universal public health service for improving the health and wellbeing of children aged under-5 years through health and development reviews, health promotion, parenting support, screening and immunisation programmes (PHE, 2015).

Paediatric psychology

Provided in acute hospitals is usually funded out of the acute services tariff and does not appear in mental health spend. No information was found on numbers in England.

School nurses

School nurses are (DH, 2014):

- The single biggest workforce specifically trained and skilled to deliver public health for school-aged children (5-19).
- Clinically skilled in providing holistic, individualised and population health; assessment, with a broad range of skills at Tier 1 and Tier 2 health interventions.
- In a unique position within community and education settings to support multi-disciplinary teams, with relationships within primary and secondary care.
- Skilled in managing the relationships between child, family and school settings.

- Trusted and valued by children and young people.

Relevant government publications include:

- Department of Health (2012). Getting it right for children, young people and families. Maximising the contribution of the school nursing team: Vision and Call to Action. (*https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216464/dh_133352.pdf*).
- Department of Health (2014). School nursing: Public health services (*https://www.gov.uk/government/publications/school-nursing-public-health-services*) which includes a specific document about how the School Nurse Programme can support implementation of 'Promoting emotional wellbeing and positive mental health of children and young people'.
- Royal College of Nursing (2014). An RCN toolkit for school nurses (*http://www.rcn.org.uk/__data/assets/pdf_file/0012/201630/003223.pdf*).

Interventions to address risk factors for mental disorder and promote protective factors for mental wellbeing

As outlined in section 3.12.1, a range of risk and protective factors exist for child and adolescent mental health (Campion et al., 2012). Addressing such factors at a population level can prevent mental disorder and promote mental wellbeing.

Different organisations have responsibility for different risk factors although school is a key setting to address such factors. Concerning the delivery of services, there is no routine collection of data about the coverage or outcomes of interventions to promote mental wellbeing and prevent mental disorder. Instead, such data requires collection at local level which usually does not occur.

3.3.3 Social services for children and adolescents

Legislation and policy

With regard to the current legislation and policies concerning the social services for children and adolescents in England, the most relevant elements are:

- *Children's Act (1989) requires local authorities to publish information about services available to children in need and their families and to take steps to ensure that families know about services (including those provided by the voluntary sector).*
- *Children's Act (2004) place a statutory duty on agencies to co-operate to safeguard and promote the welfare of children.*
- *Disability Discrimination Act (2005) places a responsibility on public bodies to take action to ensure that disabled people have equal access to their services (including the provision of information).*
- *Health and Social Care Act (2012) (see section 4.2.1).*
- *HM Government (2013) Working together to safeguard children states that:*
  - *"Everyone who works with children - including teachers, GPs, nurses, midwives, health visitors, early years professionals, youth workers, police, Accident and Emergency staff, paediatricians, voluntary and community workers and social workers - has a responsibility for keeping them safe."*

- *"No single professional can have a full picture of a child's needs and circumstances and, if children and families are to receive the right help at the right time, everyone who comes into contact with them has a role to play in identifying concerns, sharing information and taking prompt action."*
- *"Feedback should be given by local authority children's social care to the referrer on the decisions taken. Where appropriate, this feedback should include the reasons why a case may not meet the statutory threshold to be considered by local authority children's social care for assessment and suggestions for other sources of more suitable support."*
- *Children's social care: www.gov.uk/childrens-services/childrens-social-care*
- *Social Care Institute for Excellence (2012). Introduction to children's social care. (http://www.scie.org.uk/publications/introductionto/childrenssocialcare/files/childrenssocialcare.pdf)*
- *Department for Education (2013) 2010 to 2015 government policy: children's social workers (https://www.gov.uk/government/publications/2010-to-2015-government-policy-childrens-social-workers).*

Organisation and functioning child and adolescent social services

Social Care Services have an important role in safeguarding which prevents mental disorder. Services offered as part of Social Care Services may include:

- Services for looked-after children, including fostering and residential care
- Court liaison and advisory services
- Adoption
- Child protection
- Family support
- Services for children with disabilities.

Local authorities also have some responsibilities to young people over 18 years – for example those with disabilities and those who have been 'looked-after'.

Childhood adversity is particularly important to address both as a safeguarding issue but also because it accounts for 30% of all mental disorders (Kessler et al., 2010). Child abuse includes physical abuse, emotional abuse, sexual abuse, neglect, bullying and domestic violence. It is associated with increased risk of following mental disorders although the impact is greater if abuse is repeated (Jonas et al., 2011).

Looked after children have a five increased risk of mental disorder (Ford et al., 2007) which can be reduced with appropriate interventions such as foster care support (DH, 2015; NICE, 2010). A range of Department for Education outcomes are routinely collected for this group by locality including:

- Rate and number
- Mental ill-health
- Educational outcomes
- Social exclusion
- Conviction, final warning or reprimand.

Other groups at several fold increased risk of mental disorder include those with disabilities/Special Educational Needs and young offenders who Social Care engage with. Taking young offenders, this group has a 3-fold increased risk of mental disorder (Lader et al., 2000) with men aged 15-17 in custody experiencing 18-fold increased risk of suicide (Fazel et al., 2005). Input from Social Care can prevent a range of associated outcomes in this group.

Routine data is collected on rates of children receiving Child Protection Plans for different types of abuse although this represents a small proportion of the total number of children and adolescents estimated to experience different types of abuse (Radford et al., 2011).

A report on Child and Social Care (Ofsted, 2015, *https://www.gov.uk/government/statistics/childrens-social-care-in-england-2015*) reviewed local authority services for children who need help and protection, children looked after, and care leavers found that:

- One third of local authorities do not run any children's homes
- Performance of local authority-run children's homes continues to be better than private or voluntary-run homes in 2014-15.

Financing and workforce for child and adolescent social services

Financing

As highlighted in the next section on education, during 2013/14, total expenditure for education, schools and young people's services for all local authorities and schools in England was £42.7 billion with £3.1 billion spent on local authority 'other education and community and £8.9 billion spent on children's and young people's services (DfE, 2014 *https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/386034/SR52_2014_Text.pdf*)

While there was no specific information on expenditure on mental health in schools, social care relevant expenditure during 2013/14 included (DfE, 2014):

- Looked after children: £3.7 billion (increase of £0.2 billion since 2012/13)
- Other Children and Family Services: £100.0 million (decrease of £10.5 million since 2012/13)
- Safeguarding Children's and Young People's Services: £2.0 billion (no change since 2012/13)
- Family Support Services: £1.0 billion (increase of £71 million since 2012/13)
- Services for Young People: £713 million (decrease of £103 million since 2012/13)
- Youth Justice: £329 million (increase of £8 million since 2012/13)

Children social care workforce

The Department for Education has published regular data on children's social care workforce since 2013.

This outlined that in September 2014, there were:

- 26 810 children's social workers in England equivalent to 24 620 full time positions (FTE)
- 16 children in need per FTE children social worker.

Responsibility and delivery of mental health promotion, mental disorder prevention and recognition/ treatment signposting of mental disorder by child and adolescent social services
Social Care Services has a key role in safeguarding and supporting groups at higher risk of mental disorder as outlined above. Their work addresses key risk factors for mental disorder and promotes wellbeing in such groups. They also have an important role in recognising mental disorder and facilitating appropriate signposting for treatment given the several fold increased rates of mental disorder in children and adolescents they work with.

3.3.4 The Education system for children and adolescents

Legislation and policy

Legislation and policies relevant to child and adolescent education and mental health in England include the following:

- *Department for Education (2013). Ensuring a good education for children who cannot attend school because of health needs. Statutory guidance for local authorities.*
- *Department for Education (2013). Education for children with health needs who cannot attend school (https://www.gov.uk/government/publications/education-for-children-with-health-needs-who-cannot-attend-school).*
- *Department for Education (2013). Participation of young people: education, employment and training. Statutory guidance for local authorities on their duties relating to the participation of young people in education, employment or training (https://www.gov.uk/government/publications/participation-of-young-people-education-employment-and-training).*
- *Department for Education and Home Office (2014). Listening to and involving children and young people. Statutory guidance about listening to the 'pupil voice' and involving pupils in decision making (https://www.gov.uk/government/publications/listening-to-and-involving-children-and-young-people).*
- *Department for Education (2014). Supporting pupils at school with medical conditions. Statutory guidance about the support that pupils with medical conditions should receive at school (https://www.gov.uk/government/publications/supporting-pupils-at-school-with-medical-conditions--3).*
- *Department for Education (2015). Mental health and behaviour in schools. Departmental advice for school staff (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/416786/Mental_Health_and_Behaviour_-_Information_and_Tools_for_Schools_240515.pdf) .*
- *Department for Education (2015) Keeping children safe in education. Statutory guidance for schools and college on safeguarding children and safer recruitment (https://www.gov.uk/government/publications/keeping-children-safe-in-education--2)*
- *Department for Education (2015) Working together to safeguard children. Statutory guidance on inter-agency working to safeguard and promote the welfare of children (https://www.gov.uk/government/publications/working-together-to-safeguard-children--2).*

- *Department for Education (2015) What to do if you're worried a child is being abused. Departmental advice to help practitioners identify the signs of child abuse and neglect and understand what action to take (https://www.gov.uk/government/publications/what-to-do-if-youre-worried-a-child-is-being-abused--2).*
- *Department for Education (2015) School exclusion. Statutory guidance on the exclusion of pupils from local authority maintained schools, academies and pupils referral units (https://www.gov.uk/government/publications/school-exclusion).*
- *Department for Education (2015) Preventing bullying. Departmental advice for schools on preventing and responding to bullying (https://www.gov.uk/government/publications/preventing-and-tackling-bullying).*
- *Department for Education (2015) Children missing education. Statutory guidance for local authorities and advice for other groups on helping children who are missing education get back into it (https://www.gov.uk/government/publications/children-missing-education).*
- *National Children Bureau (2015) What works in promoting social and emotional well-being responding to mental health problems in schools? (http://www.ncb.org.uk/media/1197143/ncb_framework_for_promoting_well-being_and_responding_to_mental_health_in_schools.pdf).*

Organisation and functioning of education services for schools and adolescents

The Department for Education publishes regular data in England on the following areas which highlights different aspects of the organisation and functioning (*https://www.gov.uk/government/organisations/department-for-education/about/statistics*):

- 14 to 19 diploma
- 16 to 19 attainment
- Admission appeals
- Behaviour in schools
- Childcare and early years
- Child death reviews
- Children's social care workforce
- Children in need
- Destinations
- Early years foundation stage profile
- Education and training
- Exclusions
- Fostering
- GCSEs (key stage 4)
- Key stage 1

- Key stage 2
- Key stage 3
- Local authority/school finance data
- Looked-after children
- NEET
- Neighbourhood (absence and attainment)
- Performance tables
- Pupil absence
- Pupil projections
- School and pupil numbers
- School applications
- School capacity
- School workforce
- Secure children's homes
- Special educational needs (SEN)
- Sure Start children's centres
- Teacher training
- Youth cohort study

Financing and workforce

FINANCE AND HUMAN RESOURCES

During 2013-14, the total expenditure for education, schools and young people's services for all local authorities and schools in England was £42.7 billion with £30.6 billion spent on local authority maintained schools, £3.1 billion spent on local authority 'other education and community and £8.9 billion spent on children's and young people's services (DfE, 2014 *https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/386034/SR52_2014_Text.pdf*). As outlined above, further detail can be found in regular Local authority/school finance data published by the Department for Education.

While there was no specific information on expenditure on mental health in schools, mental health relevant expenditure during 2013/14 included (DfE, 2014):

- Sure Start Children Centres and Early Years: £1.1 billion (decrease of £0.1 billion since 2012/13)
- Looked after children: £3.7 billion (increase of £0.2 billion since 2012/13)
- Other Children and Family Services: £100.0 million (decrease of £10.5 million since 2012/13)
- Safeguarding Children's and Young People's Services: £2.0 billion (no change since 2012/13)
- Family Support Services: £1.0 billion (increase of £71 million since 2012/13)

- Services for Young People: £713 million (decrease of £103 million since 2012/13)
- Youth Justice: £329 million (increase of £8 million since 2012/13).

However, the Department for Education is due to face an estimated short fall of £600 million in 2015-16 rising to £4.6 billion by 2018/19 (Association of Colleges, 2014,*https://www.aoc.co.uk/sites/default/files/The%20Department%20for%20Education%20budget%20after%202015.pdf*).

Workforce

The Department for Education publishes regular updates on the size and characteristics of the schools' workforce. This found that in England in November 2014, there were:

- 454 900 full time equivalent teachers in state funded schools (1.2% increase from previous year).
- 255 100 FTE teaching assistants and 232 000 FTE support staff.
- 0.9 million people work in state funded schools: 48% are teachers, 27% are teaching assistants and 25% non-classroom based support staff.

Concerning human resources employed in this sector, data is available for the entire UK and not for England only. In 2013 the situation was as in the table below:

Teachers in UK per level of education

LEVEL OF EDUCATION	TOTAL NUMBER OF TEACHERS
ISCED 0	85 157
ISCED 1	250 693
ISCED 2	146 105
ISCED 3	263 373
ISCED 4	Not applicable

Source: UNESCO, UIS.Stat

Responsibility and delivery of mental health promotion, mental disorder prevention and recognition/ treatment signposting of mental disorder

A range of mental health policy documents highlighted on page 13-14 outline the range of mental health relevant responsibilities for schools.

- Department for Education (2013) Ensuring a good education for children who cannot attend school because of health needs
- Department for Education (2013) Education for children with health needs who cannot attend school
- Department for Education (2013) Participation of young people: education, employment and training
- Department for Education and Home Office (2014) Listening to and involving children and young people.
- Department for Education (2014) Supporting pupils at school with medical conditions
- Department for Education (2015) Mental health and behaviour in schools
- Department for Education (2015) Keeping children safe in education
- Department for Education (2015) Working together to safeguard children
- Department for Education (2015) What to do if you're worried a child is being abused
- Department for Education (2015) School exclusion

- Department for Education (2015) Preventing bullying
- Department for Education (2015) Children missing education
- National Children Bureau (2015) What works in promoting social and emotional well-being responding to mental health problems in schools?

In particular, the Department for Education (2015) guidance on mental health and behaviour in schools (www.gov.uk/government/uploads/system/uploads/attachment_data/file/416786/Mental_Health_and_Behaviour_-_Information_and_Tools_for_Schools_240515.pdf) summarises the following about responsibility and delivery of school based public mental health interventions:

- **In order to help their pupils succeed, schools have a role to play in supporting them to be resilient and mentally healthy.** There are a variety of things that schools can do, for all their pupils and for those with particular problems, to offer that support in an effective way.
- **Where severe problems occur schools should expect the child to get support elsewhere as well**, including from medical professionals working in specialist Child and Adolescent Mental Health Services (CAMHS), voluntary organisations and local GPs.
- **Schools should ensure that pupils and their families participate as fully as possible in decisions** and are provided with information and support. The views, wishes and feelings of the pupil and their parents should always be considered.
- **Schools can use the Strengths and Difficulties Questionnaire (SDQ) to help them judge whether individual pupils might be suffering from a diagnosable mental health problem** and involve their parents and the pupil in considering why they behave in certain ways.
- **There are resources available to help school staff support good mental health and emotional wellbeing.** The PSHE Association has produced guidance and lesson plans to support the delivery of effective teaching on mental health issues. In addition, MindEd, a free online training tool, provides information and advice for staff on children and young people's mental health and can help to sign post staff to targeted resources when mental health problems have been identified.
- **Schools should consider if their pupils would benefit from the offer of school counselling services.** The Department for Education has published advice on how to set up and improve schools counselling services. Additionally, Counselling MindEd, which is part of MindEd, is also available to support the training and supervision of counselling work with children and young people.
- **There are things that schools can do – including for all their pupils, for those showing early signs of problems and for families exposed to several risk factors – to intervene early and strengthen resilience,** before serious mental health problems occur.
- **Schools can influence the health services that are commissioned locally through their local Health and Wellbeing Board** – Directors of Children's Services and local Healthwatch are statutory members.
- **There are national organisations offering materials, help and advice. Schools should look at what provision is available locally** to help them promote mental health and intervene early to support pupils experiencing difficulties. Help and information about evidence-based approaches is available from a range of sources

3.3.5 Cooperation between sectors

Legislation and policy

With regard to the current legislation supporting cooperation between sectors regarding children and adolescents mental health in England, the most relevant elements are:

- *Cross government mental health strategy: HM Government (2011) No health without mental health. (www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf)*
- *HM Government (2013) Working together to safeguard children*
- *Department for Education and Home Office (2014) Listening to and involving children and young people. Statutory guidance about listening to the 'pupil voice' and involving pupils in decision making (www.gov.uk/government/publications/listening-to-and-involving-children-and-young-people)*
- *Department of Health (2014) School nursing: Public health services (www.gov.uk/government/publications/school-nursing-public-health-services which is a publication by the Department of Health and Public Health England)*
- *Department of Health (2015) Future in Mind. Promoting, protecting and improving our children and young people's mental health and wellbeing (www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf) which outlines cooperation between education, mental health and NHS*

The previous sections have highlighted many examples of cross sectoral engagement. Examples of engagement between the schools and other sectors include:

- Funding and information about child and adolescent social services is by the Department for Education.
- School nurses are provided by the Department of Health.
- Particular groups at higher risk of mental disorder and Social Care.

Strengths and weaknesses in cross-sectoral cooperation in England

STRENGTHS	WEAKNESSES
Legislation and policies support cooperation	Lack of implementation and evaluation of school based effective interventions to promote mental wellbeing, prevent mental disorder, and detect mental disorder/ signpost for treatment
Numerous supporting structures and tools for cooperation	Reduced coverage of effective interventions which had been previously implemented to scale

3.3.6 Selected examples of good practice

GOOD PRACTICE IN SCHOOL BASED PUBLIC MENTAL HEALTH INTERVENTIONS PROMOTION

Department of Education (2015) advice for school staff on mental health and behavior in schools outlines how to promote mental wellbeing, prevent mental disorder and identify children with possible mental health problems. It summarises relevant interventions and commissioning and gives examples of good practice

www.gov.uk/government/uploads/system/uploads/attachment_data/file/416786/Mental_Health_and_Behaviour_-_Information_and_Tools_for_Schools_240515.pdf

Targeted Mental Health in Schools (TaMHS)

The aim of this programme was to help schools to deliver timely interventions and approaches in response to local need that could help those with mental health problems and those at increased risk of developing them. Evaluation showed it resulted in statistically significant decrease in problems in primary (but not secondary) school pupils who had behavioural problems at the outset but had no effect on emotional problems at the outset. However, the majority of schools reported using approaches developed locally rather than those that had been internationally tested and the number of schools continuing such programmes has reduced

http://webarchive.nationalarchives.gov.uk/20130401151715/https://www.education.gov.uk/publications/eorderingdownload/00784-2008bkt-en.pdf
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/184060/DFE-RR177.pdf

SOCIAL AND EMOTIONAL LEARNING PROGRAMMES

Social and emotional learning is an example of a particularly well evaluated school based intervention; a meta-analysis of 270,000 students found a 10% reduction in classroom misbehaviour, anxiety and depression, and a 11% improvement in achievement tests, and a 25% improvement in social and emotional skills (Durlak et al, 2011). SEL was adapted and implemented in the UK as SEAL (Social and Emotional Aspects of Learning) which focuses on development of social and emotional skills in students and staff and was introduced in most primary and secondary schools in England (participation is voluntary).

“SEAL”

SEAL was a school-based programme designed to be integrated into the main curriculum. It aims to develop social and emotional skills through three approaches: whole school initiatives, targeted small group work for those at higher need and one-to-one interventions for those with highest need. An evaluation of SEAL in primary schools found that 90% of school staff agreed that the programme had been relatively successful overall (Hallam, 2009), All responding headteachers and 87% of teachers and 96% of non-teaching staff agreed that the programme promoted the emotional wellbeing of children, and 82% of teachers agreed that it increased pupils’ ability to control emotions such as anger. Less positive findings of a national evaluation have been explained by variable provision (Humphrey et al, 2010). A more recent evaluation highlighted the effectiveness of SEAL particularly when delivered in a whole school approach (Banerjee et al, 2014). However, the number of schools continuing such programmes has dramatically reduced.

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3.4 ESTONIA

3.4.1 Overview

Estonia is situated in the Baltic Region of Northern Europe.

According to the 2011 census, it has 1 294 236 inhabitants: 600 352 males and 693 884 females.

The capital is Tallinn, with 393 222 inhabitants.

The surface area of Estonia is of 45 227 km^2, with a population density of 30 inhabitants per km^2. Estonia is made up of 15 counties, 226 administrative units with local governments, including 33 cities and 193 rural municipalities.

The average age of population in 2011 was 37.7 years (men) and 43.4 years (women), and life expectancy at birth is 71 years for men and 81 years for women.

Concerning ethnicity 70% are Estonians (followed by 25% of Russians). Concerning religion, 54% of the population consider themselves as non-religious and 28% are Christians (mostly Russian Orthodox and Lutherans).

Gross domestic product per capita in 2012 was 23 625 USD current PPPs (OECD, 2014).

The school-aged population is divided as follows:

Estonian school aged population

AGE GROUPS	TOTAL	MALES	FEMALES
0-4	76 129	39 083	37 046
5-9	70 313	36 161	34 152
10-14	60 377	31 119	29 258
15-19	64 021	32 892	31 129

(Statistics Estonia, 2014)

The number of students by educational level (2012) is presented in the table below:

Children and adolescents by level of education

LEVEL OF EDUCATION	NUMBER OF STUDENTS
ISCED 0	52 298
ISCED 1	74 249
ISCED 2	38 072
ISCED 3	47 111
ISCED 4	10 597

(UNESCO, 2014)

With regard to the educational attainment of pupils, in Estonia, nearly 90% of children aged three and older are enrolled in early childhood education. Historically, Estonia has had high levels of educational attainment, but there are signs of increase in educational stratification among young people. In the school year 2012, the situation concerning school attainment is as follows:

Educational attainment of population aged 25 years and older in Estonia

LEVEL OF EDUCATION	% OF STUDENTS		
	Males-Females	Males	Females
ISCED 1	12.7	14.7	11.1
ISCED 2	12.7	14.7	11.1
ISCED 3	51.2	56.9	46.4
ISCED 4	51.2	56.9	46.4

(UNESCO, 2014)

Drop-out rates to the last grade per level of education in Estonia in 2011

	% OF STUDENTS
Drop-out rate to the last grade of primary education	3.02146
Drop-out rate to the last grade of general lower-secondary education	0.42659

(UNESCO, 2014)

In 2012, there were 2 385 out-of-school children of primary school age (UNESCO, 2014).

The Statistical Yearbook of Estonia 2013, reports that a **high drop-out rate continues to be a major problem in vocational education.** The number of drop-outs has increased each year. **In the academic year 2012/2013, 6 213 students dropped out of vocational schools, which is about 800 more than five years ago.**

A study of the reasons for discontinuation of vocational education was conducted, and the main reasons for dropping out resulted to be unsuitable speciality, low learning motivation, social immaturity, family-related factors, entry into employment, financial difficulties, conflicts in school and incompetence of school staff. The study also proposed solutions for reducing the number of drop-outs from vocational education: for example, improvement of career counselling at basic school level, use of professional group supervisors in vocational schools, creation of an adequate system of financial benefits (and provision of information about these) and conduct of performance evaluations with both students and teachers.

The Estonian Ministry of Education and Research has launched the programme “KUTSE” which invites vocational school drop-outs back to education – they can continue their studies or receive further training or retraining. In 2012, the programme had 463 students in total: 45 students who continued their studies and 418 adult learners (aged 25+). (Statistics Estonia, 2013)

In order to prevent pupils from dropping out of school, many European Social Fund programmes will be implemented, and the accessibility of support systems and flexible study options aimed at pupils with special education needs will be increased (activities, standards, etc. established in the Basic Schools and Upper Secondary Schools Act). The implementation of study counselling and career service systems will improve availability of specialized support to all pupils.

Concerning the mental health status of children and adolescents in this country, in Estonia **13 362 new cases of psychiatric and behavioural disorders were registered in 2011** in the age stratum 0-19 (National Institute for Health Development, 2014). The main problems were **behavioural disorders** (47% of all cases for boys and 30% for girls) and **development disorders** (34% for boys and 31% for girls).

Around 13 000 children have attention deficit hyperactivity disorder (ADHD; prevalence 5%); around 1 600 children have autistic spectrum disorders (prevalence 0.6%), and around 8 000 have behavioural disorders (prevalence 3%).

In 2013 the suicide rate in youth (age group 15-19) in Estonia was 8.0 per 100 000 (Statistics Estonia, 2014). Within the SEYLE study (Saving and Empowering Young Lives in Europe; www.seyle.eu; performed in Estonia by ERSI in 2009-2011) 2% of 14-15 years old schoolchildren were screened as acutely suicidal alarm cases. According to the WHO collaborative study **HBSC 2005/2006** (Health Behaviour in School-aged Children, www.hbsc.org) **close to 13% of 13-15 years old schoolchildren in Estonia reported suicidal thoughts** (Samm et al., 2010). The SEYLE study indicated that a widespread mental health problem among schoolchildren is deliberate self-harm, approximately 1/3 of school children (girls more frequently than boys) have injured themselves deliberately in one or another way during their life (Lumiste, 2011). In adolescents, the prevalence of depression is 11% and prevalence of sub threshold-depression 29%; anxiety was identified in 32% and sub threshold-anxiety in 6% of schoolchildren (Balazs, et al., 2013).

The good relationship with parents is a significant protective factor against suicidal thoughts and depressive feelings (Samm, The relationship between perceived poor family communication and suicidal ideation among adolescents in Estonia [Doctoral dissertation], 2012).

Alcohol consumption among adolescents in Estonia is high, with every 4th boy and every 8th girl of aged 15 reporting drinking weekly. More than half of 15-16-year-olds report having been drunk at least once during their life-time. The proportion of adolescents who have used illegal drugs has increased during the last two decades from 7% to 32% (ESPAD, 2011).

In the context of this JA, the existence of a mental health strategy exclusively targeting children and adolescents, in the different countries, was analysed.

In Estonia there is no special strategy on mental health, however mental health issues for children and adolescents are partially covered by other health-related strategic documents, as:

1. The National Health Plan 2009-2020 (Estonian Ministry of Social Affairs, 2009/2012).

The plan is designed to ensure that people of Estonia live longer, happier, healthier lives by decreasing premature mortality and morbidity.

The plan provides recommendations and directions that should be taken in the name of good health. It also assembles a large number of relevant strategic documents which have already been or will be implemented in other fields. The objectives will be achieved through action plans in five different areas, one aimed at safe and healthy development for children and youth.

The plan targets all people living in Estonia, including children and adolescents.

The stakeholders involved in the plan implementation are: policy makers, officials and specialist in health, educational and other relevant sectors.

2. The "Smart parents, Great Children, Strong Society: Strategy of Children and Families 2012-2020" (Estonian Ministry of Social Affairs, 2011)

The strategy is aimed at all children and families living in the territory of the Republic of Estonia irrespective of their gender, nationality, race, language, religion, beliefs, social origin, material standing, place of residence or family type, so they grow up and live in a safe and friendly environment. The strategic objectives are aimed at guaranteeing and improving the well-being of children and families and their quality of life, and the specific target groups are infants, children, and adolescents.

The stakeholders involved in the strategy are: policy makers, officials and specialist in health, educational and other relevant sectors.

Concluding, the most relevant risk factors for mental health in Estonia are: alcohol consumption; low acknowledgement of the mental health area; lack of integration of relevant sectors; health care system

is fragmented by policies and service delivery systems. The protective factors are: good physical and psycho-social environment in family and schools, resilience, and good social skills.

The Estonian partner which contributed to the thematic area of "mental health and school" in the present Joint Action is the **Estonian-Swedish Mental Health and Suicidology Institute (ERSI)** and its main areas of interest and activities are:

1. Prevention of suicidal behaviour (suicide, attempted suicide, suicidal ideation);

2. Protection and promotion of mental health and well-being.

ERSI also is interested in alcohol consumption as a risk factor for suicidal behaviours and mental health problems, and in the epidemiology of the external causes of deaths (injuries).

The Institute has performed in these areas epidemiological research to find out the main risk groups, risk situations, and protective and risk factors. In recent years ERSI has implemented and evaluated several school-based and web-based intervention programmes with the main aim to promote mental health, to prevent risk behaviours and to stop truancy among children and youth. An important part of the work of ERSI is the active dissemination of the results and information through various channels at different levels: to general public, to specialists and gatekeepers, to policy makers and stakeholders, to scientific community.

3.4.2 Mental Health services for children and adolescents

The most relevant policies and legislation concerning mental health services for children and adolescents in Estonia are:

- *The Juvenile Sanction Act (initial date of entry into force 01.09.1998)*
- *The Estonian Health Insurance Fund Act (01.10.2000)*
- *The Family Law Act (01.01.1995)*
- *The Social Benefits for Disabled Persons Act (01.01.2000)*
- *The Mental Health Act (12.02.1997) (children mental health care is not separately regulated)*
- *The Public Health Act (14.06.1995)*
- *The Social Welfare Act (01.04.1995)*
- *The Health Service Organisation Act (01.01.2002)*
- *The National Health Plan 2009-2020*
- *The Treatment guideline for children with attention deficit hyperactivity disorder (ADHD)*
- *The Guidelines for children and adolescent depression treatment in brochure "Treatment guide of depression for general practitioners".*

It should be underlined that an **evaluation study of the OECD** pointed out that one of the most troublesome problems of the healthcare system in Estonia is **fragmentation of policies and service delivery system** (Healthcare Association in collaboration with Ministry of Social Affairs in Estonia and World Health Organization, 2005); (OECD, 2011) .

In Estonia the mental **health services for children and adolescents are part of the general health care system.**

Regional hospitals offer psychiatric services for children, but the scope falls behind the needs - limited number of child psychiatry services are available for a limited number of children. This situation will be substantially improved between 2014 and 2016, when four regional Mental Health Centres for Children will be developed Estonia (Tallinn, Tartu, Pärnu and East-Viru) with the financial contribution from the Norwegian Financial Mechanism 2009-2014 (*www.eeagrants.org; www.eeagrants.fin.ee/en*).

Estonia's system of mental health services results too fragmented and linkages between different sectors are weak. Social sector, health care and educational system lack the capacity to collaborate in providing necessary and evidence-based help, care, treatment and interventions.

Currently in Estonia there is a need for specific long-term interventions and rehabilitation services for children who have severe or permanent mental health disorders and who are not able to control their behaviour. The need for new services is high and it should combine social services and therapies, medical and educational services. **The Ministry of Education and Research** is responsible for guaranteeing for all children in all areas the possibility to get access to support services if needed. The municipalities are legally responsible for offering supportive services (social pedagogue, school psychologist) in their schools.

The development of mental health field belongs to the area of administration of the Ministry of Social Affairs, however the following institutions deal with the sphere of mental health:

- Ministries and institutions in their area of administration: the Ministry of Social Affairs, the Ministry of Education and Research, the Ministry of Justice, the Health Care Board, the Social Insurance Board, the State Agency of Medicines, the Health Protection Inspectorate, other state authorities (such as social and health departments of county governments).
- Citizens' associations: e.g., the Estonian Chamber of Disabled People, the Estonian Mentally Disabled People Support Organization, the Estonian Patients' Advocacy Association and others.
- Speciality organisations: e.g., the Estonian Psychosocial Rehabilitation Association, the Estonian Association of Psychiatrists and others
- Providers of social and health services, specialised schools, educational and research institutions.

The biggest gaps in the area of mental health in Estonia are financing and **lack of integration of relevant sectors and services.** Estonia is one of the few European countries where the **financing of children's mental health services has decreased** even though the **prevalence of mental health and substance abuse** problems among children and youth have **increased**.

In Estonia all people below 19 years are covered with health insurance that is administered by the Estonian Health Insurance Fund. The resources for health insurance are collected into an integrated budget and used on the basis of the solidarity principle.

Mental health services in Estonia are funded in line with other healthcare and social services based on pricelists of defined services. In 2012 the GDP amounted at 13 006.70 EUR and the share of total health expenditure was 5.9% and it has decreased from 2009 (6.9%), while in 2013 GDP per capita was 13 784 EUR.

There is no specific information available about financial resources dedicated to mental health.

Currently the field of **mental health in Estonia is strongly supported by the Norwegian Financial Mechanism 2009-2014, Public Health Programme.**

The main objective of the programme is to improve population health in Estonia and reduce health inequalities. Main areas of action include **improvement of mental health services for children, improvement of access to and quality of mental health services, enhanced collaboration between different sectors, increased prevention and reduction of lifestyle-related diseases.** The actions are planned in areas and in a manner that builds a network that is sustainable after the programme period. The estimated total cost of the programme is 10 848 706 EUR (from Norway 8 912 000 EUR, Estonian co-financing 1 572 706 EUR).

Workforce dedicated to mental health includes the following **professionals**: in 2012 there were 165 psychiatrists (12.8 per 100 000 inhabitants); there are 22 practicing child psychiatrists in Estonia, but the need is for 60 child psychiatrist and 120 clinical psychologists. A limited number of child psychiatric services is available for limited number of children. Finally, there are 245 school psychologists and 197 social pedagogues in Estonian schools.

Development, implementation and evaluation of prevention and promotion activities for mental health belong to the area of administration of the **Estonian Ministry of Social Affairs and of the Ministry of Education and Research.**

The Ministry of Social Affairs elaborates national policy of health care, social care and welfare, and organises health and social care services. The Ministry of Education and Research is responsible for ensuring that all children in all areas have access to support services if needed (psychological and social counselling, speech therapy, etc.).

The municipalities are legally responsible for offering supportive services in their schools. The National social care and welfare is organised through the Social and Health Departments of the county governments. The Estonian network of health promotion specialists is responsible for organising health promotion activities on county level.

Activities of prevention and promotion of mental health are implemented in Estonia on grassroots level by different organisations, including NGOs. In **2012** the **Estonian mental health and well-being coalition** was established by the Estonian-Swedish Mental Health and Suicidology Institute (**ERSI**) and is **supported by the Ministry of Social Affairs.**

More than 60 organisations active in the field of mental health have joined the coalition (NGOs, health and social service providers, research institutions, professional organisations, schools for children with special needs, etc.).

3.4.3 Social Services for children and adolescents

With regard to the current legislation and policies concerning the social services for children and adolescents in Estonia, the following elements were identified as the most relevant:

- *Social Welfare Act (08.02.1995): it establishes roles and responsibilities for the institutions (at national, local, and county level), regulating the financing and monitoring of local promotion and prevention activities*
- *Family Law Act (12.10.1994)*
- *State Family Benefits Act (01.11.2001)*
- *Social Benefits for Disabled Persons Act (13.10.1999)*
- *Republic of Estonia Child Protection Act (08.06.1992)*
- *Republic of Estonia Child Benefit Act (1992)*
- *Parental Benefit Act (10.12.2003)*
- *Mental Health Act (01.09.2012): the children mental health-care is not separately regulated*
- *Development Plan for Children and Families 2012-2020*
- *National Health Development Plan 2009-2020*

In Estonia, social services are not part of the health-care services and have a separate budget.

Local governments are responsible for the organisation of the provision of social services and emergency social assistance in Estonia.

The following individuals are entitled to have access to social services: permanent residents of Estonia, foreigners living in Estonia on a legal basis, refugees in Estonia.

The state provides help for children by organising the following services:

- **Rehabilitation service:** a personal plan is drawn up to facilitate independent living and employment, on the basis of which service and guidance is provided to the person in need;
- **Provision of prosthetic, orthopaedic and other assistive devices;**
- **Substitute care:** care for a child outside his or her own family – i.e., guardianship, provision of a substitute home or care for the child in substitute family;
- **Child care:** service supporting parents' employment, studying or general coping.

Local governments (municipality, city, city district) may be contacted for obtaining the following services:

- **Home care services:** includes home assistance and nursing assistance in the home environment, which helps the person in need to cope in his or her familiar, accustomed environment;
- **Support person:** for both children and adults. Assisting one or more persons living together in daily life;
- **Child care:** service supporting the parents' employment, studying or general coping;

- **Personal assistant:** for assisting a disabled person and reducing caregiving workload on his or her family members;
- **Social housing:** providing housing for individuals and families not capable or able to procure it themselves;
- **Social transport:** for those with physical or mental disability or visual impairment;
- **General care at home:** for those who need auxiliary assistance and nursing care service in a social welfare institution.

Social services and social benefits are financed from national budget, local governments' budgets, funds provided by legal persons and natural persons who voluntarily engage in social welfare, and other funds.

National budget covers the following: national social welfare management, national social programmes and projects, welfare of children, persons with special psychiatric needs and disabled people (rehabilitation services, partial compensations for prostheses and medical devices), national social benefits, other expenses related to performance of national social welfare duties and events. Specific financial data is not available.

Local governments' social care and welfare expenditures are covered from the local governments' budgets to fulfil those tasks that the state has imposed by law on the municipality.

Children's welfare is organised on both the national and municipal levels.

Based on expert estimation and local research that has not been published, in Estonia there are approximately 700 people working in the field of social services at the municipal level (social services' managers, social workers, juvenile workers, child protection workers, etc.).

The organisation of social protection in Estonia is divided between three institutions: **state, local government (institutions) and family (physical persons).**

Under the Law of Social Care and Welfare the organisation of social care is the responsibility of the **Ministry of Social Affairs and local governments.**

Social care and welfare on the level of municipality is the responsibility of the **local government.**

The Ministry of Social Affairs elaborates the national policy of social care and welfare. County government is the extension of the Ministry of Social Affairs in counties; furthermore, a large slice of the work of the Ministry of Social Affairs is based on data obtained from the county governments and the propositions made by them. National social care and welfare is organised through the Social and Health Department of the county government.

The County governor monitors the quality of social services and other aid provided in the county and the use of funds allocated by the state for social care and welfare.

Concerning the issue of responsibility, the State must take care of the citizens who are unable to earn their own living and provide them with a minimum income level. The State has the obligation to ensure the person's right to state assistance in case of insufficiency.

The Estonian Welfare Act regulates that the responsibilities of the municipalities are: planning, financing and monitoring of local promotion and prevention activities. Local governments are responsible for identifying people in need of assistance and for organising provision of social assistance and benefits.

Local governments have to work out local social welfare development plan, organise social protection, provide social services and social assistance, and administer provision of social benefits.

With regard to the concrete **delivery of services,** it is **local governments' duty** to provide social services, social assistance, and other aid to individuals in need of help.

3.4.4 The Education system for children and adolescents

The essential documents concerning the educational sector in Estonia are:

Acts that regulate the general education system, such as:

- *Development plan for 2015-2018 of the area of the Estonian Ministry of Education "Smart and active people" (2014)*
- *The Education Act of the Republic of Estonia (1992), which provides general principles for the framework of the general educational system, specifies the structure and organisation principles of the education system, such as compulsory school attendance, the activities of educational institutions, the types of documents certifying education, etc.*
- *The Development Plan for the General Education System 2007-2013, approved by the republic government in 2007, which defines the arranged long-term development objectives and goals of the general education system.*
- *The Basic School and Upper Secondary Schools Act (2013)*
- *The Private Schools Act (1998) (referring to the form of ownership of the educational institution)*
- *The Pre-school Child Care Institutions Act (1999)*

Acts that regulate other areas of education, containing also provisions dealing with general education:

- *The Estonian Lifelong Learning Strategy 2020*
- *Vocational Educational Institutions Act (1998)*
- *Adult Education Act (1993)*

The Estonian education system is divided into the following parts:

- **Pre-school education:** the state and local governments are responsible for children's education and studies in pre-school institutions.
- **Basic education:** compulsory school attendance generally begins at the age of 7 and lasts until completion of basic education or up to the age of 17. Basic education is acquired in basic schools, or in general upper secondary school and which cover the grades 1-9. Basic school is divided into three stages:
  - stage 1: grades 1-3;
  - stage 2: grades 4-6;
  - stage 3: grades 7-9.

An academic year must include no less than 175 days and lasts from September 1st until June.

There is a uniform grading system with range one to five, where "5" represents the best result and "1" the worst result. There are several options for continuing one's education after graduating from basic school. It is possible to acquire general secondary education either in upper secondary school or in secondary vocational education institution.

- **Upper secondary education:** is the level of education that is based on basic education. Secondary education is divided into general secondary education and vocational education. In order to complete

secondary education, a three-year study period has to be completed. A student must pass at least three state examinations in addition to school examinations in order to receive a general secondary education certificate.

- **Vocational education** (vocational upper secondary education): the main aim of vocational education lies in acquiring professional skills and practical experience. Vocational education may be acquired either after graduation from basic school or after graduation from upper secondary school.

Since 2006 it can also be acquired by people who have not obtained their basic education. The duration of studies in the post-secondary vocational education curricula on the basis of secondary education is from 0.5 to 2.5 years.

- **Higher education:** higher education may be acquired as professional higher education or academic higher education.
- **Adult education.**

With regard to the financial resources, **Estonian educational system is largely supported by public funds: Ministry of Education and Research (67%), other ministries (5%) and local governments (28%).**

In recent years, Estonia has invested **14–15% of its total public expenditure in education** (Estonian Ministry of Education and Research, 2014). **Total public expenditure on education in 2011 was 828 millions of Euro,** divided as follows:

- general education: 382 millions of Euro;
- vocational education: 118 millions of Euro;
- higher education: 203 millions of Euro;
- other expenditures (expenditure for kindergartens): 125 millions of Euro.

Despite significant decrease of enrolments between 2000 and 2009, Estonia increased the expenditure on education by 47% during this time. **In recent years, expenditures on education have decreased.**

The majority of general education is provided by municipal schools.

The state budget and local governments fund basic education and secondary education, and vocational education institutions are primarily funded by the state. There are also private schools.

Expenditure in education (2011)

TOTAL GOVERNMENT EXPENDITURE IN EDUCATION	%
As % of GDP	5.15
As % of total government expenditure	12.33

(OECD, 2014)

In 2012, the number of teachers per level of education was distributed as follows:

Teachers in Estonia per level of education (2012)

LEVEL OF EDUCATION	TOTAL NUMBER OF TEACHERS
ISCED 0	7 669
ISCED 1	6 431
ISCED 2	4 750
ISCED 3	5 420
ISCED 4	194*

(OECD, 2014), * refers to 2008

The most recent data specifically concerning human resources employed in this sector refer to the 2013/2014 academic year: 137 680 pupils have been engaged in daytime study in general education schools, a total of 14 682 teachers are working in general education schools.

Teachers average age is a little over 45 and 14% of the teachers are men. There are 9.9 pupils per teacher. During the 2012/2013 academic year, a total of 2 200 teachers were working in vocational education level schools (Information System of Estonian Education, 2014).

The Estonian Ministry of Education and Research is responsible for developing, implementing and evaluating health promotion and prevention activities in the educational area.

The main tasks of the Ministry of Education and Research are to guarantee the expedient and effective development of education, research, youth and language policies and the high level and competitiveness of research and development activities.

The new Basic Schools and Upper Secondary Schools Act was adopted in **2013**, and introduces **significant changes in the organisation of education.** New provisions have been added for **protecting people's mental and physical safety and solving emergency situations in schools.**

The Ministry of Education and Research is responsible for providing all children in all areas with the supportive services should they need any.

Municipalities are legally responsible to offer supportive services (social pedagogue, school psychologist) **in their schools.**

3.4.5 Cooperation between sectors

In Estonia **there is no legal framework for cooperation between the health, social and educational sectors.** In the area of health-related services one of the likely drivers of fragmentation is **that health and social care systems are budgeted separately.** Mental health services in Estonia are funded in line with other healthcare and social care services, based on pricelists of defined services.

The service lists are separate for healthcare and social care systems that have also separate funding.

Estonian National Health Plan 2009-2020 is the main strategic document that coordinates policy areas including health, social care, environment, etc. (Estonian Ministry of Social Affairs, 2009/2012). Cooperation between organisations is rather casual and project-based.

In particular, the local experts identified the following weaknesses concerning the cross-sectoral cooperation:

Weaknesses in cross-sectoral cooperation in Estonia

WEAKNESSES
Cooperation between organisations is rather casual and project-based
Social sector, health care and educational system lack the capacity to collaborate in providing necessary and evidence-based help, care, treatment and interventions.

3.4.6 Selected examples of good practice

GOOD PRACTICE IN MENTAL HEALTH PROMOTION

"MHP-Hands project"

This is an EC public health programme project (2010-2013).

Throughout MHP-Hands a set of handbooks for mental health promotion were produced. Mental health promotion handbook provides the users in the schools with a set of validated tools to promote mental health. Furthermore, the handbook provides methods by which to implement actions to promote mental wellbeing. The users will learn how to implement interventions designed to improve students' well-being. The handbook presents examples of suitable interventions for promoting mental health and provides the description of tools and processes involved.

Designed and tested by multinational team experts, the handbook provides mental health promotion materials and exercises that can be easily used by teachers and other school staff.

www.mentalhealthpromotion.net

GOOD PRACTICE IN MENTAL DISORDERS PREVENTION

The EAAD (European Alliance Against Depression)

This project is an EC public health project (2004-2008). The main aim of this 4-level community-based intervention program was to prevent suicidal behaviours through the development of sustainable network to increase public awareness about depression and to disseminate knowledge for early recognition and treatment of depression.

The four intervention levels were: 1) Co-operation with GPs (training sessions, videos, phone hotline); 2) PR activities (posters, flyers, brochures, media campaigns, cinema sports, and website); 3) Training sessions for community facilitators (school personnel, social workers, priests, police, media, etc.); 4) Special offers for high risk groups and self-help activities. ERSI, as a project partner, coordinated all activities during the two EAAD stages in Estonia.

www.eaad.net

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3.5 FINLAND

3.5.1 Overview

Finland is situated in the Eastern part of the Scandinavian Peninsula.

According to the statistics, at the end of 2013, Finland has a population of 5 451 270, of which 2 680 364 were men and 2 770 906 women (Official Statistics of Finland, 2013).

The capital is Helsinki, with 614 535 inhabitants.

The surface area of Finland is of 338 424 km^2, of which 90% is land area. According to 2009 statistics, the density of the population is of 17.6 inhabitants per km^2 (EC, 2013, EuroPoPP-MH).

The average age of population is 40.5 years (men) and 43.3 years (women), and life expectancy at birth is 77.5 years for men and 83.4 years for women. Natural increase is positive, 0.46 per 1 000 inhabitants.

Concerning ethnicity and religion, 75.3% of population are Lutherans, 1.1% belongs to the Greek Orthodox Church, and 1.5% to the other churches and 20.1% of population have no religion affiliation (or their religion affiliation is unknown).

The gross domestic product per capita in 2011 was 10 205 EUR (Official Statistics of Finland, 2014).

In 2013 the total number of pupils in the comprehensive schools was 540 500 pupils (ages 7-16): 49% girls and 51% boys. The school-aged population is divided as follows:

Finland school aged population

AGE GROUPS	TOTAL	MALES	FEMALES
0-4	303 006	154 901	148 105
5-9	300 873	153 815	147 058
10-14	291 142	148 863	142 279
15-19	313 546	159 903	153 643

Source: Official Statistics of Finland, 2013

With regard to the educational attainment of pupils in Finland, in 2012, the distribution of students by level of education is as follows:

Children and adolescents by level of education

LEVEL OF EDUCATION	NUMBER OF STUDENTS
ISCED 0	165 779
ISCED 1	347 245
ISCED 2	182 047
ISCED 3	233 458
ISCED 4	415 505

Source: UNESCO, UIS.Stat

In the school year 2011, the situation concerning school attainment is as follows:

Educational attainment of population aged 25 years and older in Finland

LEVEL OF EDUCATION	% OF STUDENTS		
	Males-Females	Males	Females
ISCED 0	28.8	29.1	28.5
ISCED 1	28.8	29.1	28.5
ISCED 2	28.8	29.1	28.5
ISCED 3	38.6	41.6	35.8
ISCED 4	38.6	41.6	35.8

Source: UNESCO, UIS.Stat

As regards the numbers of students dropping-out from schools in Finland, the rates in 2011 were as follows:

Drop-out rates to the last grade per level of education in Finland

	% OF STUDENTS
Drop-out rate to the last grade of primary education	0.44827
Drop-out rate to the last grade of general lower-secondary education	0.07606

Source: UNESCO, UIS Stat

In 2012, there were 263 early school leavers from primary school (UNESCO, UIS Stat).

Concerning the mental health status of children and adolescents in this country, according to interviews with parents of 8-year old children, the prevalence of general anxiety is 5.2%, depression 6.2%, specific fear 2.4%, conduct disorder 4.7% and ADHD 7.1% (Almqvist et al., 1999).

While the prevalence of mental disorders among adolescents results as follows: any psychiatric disorders 23%, mood disorders 11%, anxiety disorders 11.5%, substance use disorders 4%, conduct disorder 4.5%, eating disorders 4.5% (Karlsson et al., 2006).

According to the HSBC survey carried out in 2009 - 2010, the findings presented here show the proportions of pupils who reported being bullied at least two or three times at school in the past couple of months:

11-year-olds: girls 11%; boys 13%

13-year-olds: girls 12%; boys 12%

15-year-olds: girls 7%; boys 8%

Moreover, the survey considered also the proportions of pupils who reported bullying others at least two or three times in the past couple of months (Currie et al., 2012):

11-year-olds: girls 2%; boys 7%

13-year-olds: girls 6%; boys 11%

15-year-olds: girls 6%; boys 12%

In the context of this JA, the existence of a mental health strategy exclusively targeting children and adolescents, in the different countries was analysed.

In Finland, the **National Plan for Mental Health and Substance Abuse Work (Mieli-plan)** outlines the core principles and priorities for the future mental health and substance abuse work until 2015. The Ministry of Social Affairs and Health of Finland launched the preparation of the Mieli - plan in 2007.

The Mieli-plan foresees the promotion of mental health and freedom from substance use, prevention and treatment of problems and adverse effects and provision of mental health and substance abuse services for all age groups (including children and adolescents) with a focus on primary and community care.

The Plan starts from the premise that mental health problems and substance abuse play a major role in public health. For the first time, the Plan outlines common national objectives for mental health and substance abuse work. The plan emphasises the strengthening of service user status:

- Ensuring that individuals with mental health problems and substance abuse have equal access to services and, while receiving services, treated equally to all other service users. This should take place through training aimed at a change in attitudes, service supervision and guaranteed access to treatment and services.
- Increasing client involvement by inclusion of user experts and peers in the planning, implementation and evaluation of mental health and substance abuse work.
- Implementing a national programme to reduce the use of coercive measures in psychiatric hospital treatment – and to increase the safety of patients and staff.

The **National Development Plan for Social Welfare and Health Care (Kaste Programme)** 2012-2015 is a strategic steering tool that is used to manage and reform social and health policy. The targets of the Kaste programme are: 1) Inequalities in well-being and health will be reduced 2) Social welfare and health care structures and services will be organised in a client-oriented way.

The Kaste programme consists of 6 sub-programmes that complement each other: 1) Improving the opportunities of risk groups for inclusion, well-being and health, 2) Reforming services for children, young people and families with children, 3) Reforming the structure and content of services for older people, 4) Reforming the service structure and basic public services, 5) Adjusting the information and information systems so as to support clients and professionals, 6) Supporting the restructuring of services and well-being at work by means of management (Sosiaali- ja terveysministeriö – Kaste, 2012).

The Finnish partner which contributed to the thematic area of “mental health and school” in the present Joint Action is the **National Institute for Health and Welfare (THL)** and its main areas of interest and activities are:

1. Promotion of the health and welfare of the population, prevention of diseases and social problems, and development of social and health services,

2. Research, development, evaluation and follow-up, performance of official tasks, and engagement in extensive International co-operation.

The National Institute for Health and Welfare (THL) is a research, development and expert agency. THL is the statutory statistical authority in health and welfare and maintains a strong knowledge base within its own field of operations. The institute is also responsible for the application of this knowledge.

3.5.2 Mental Health services for children and adolescents

The aim of Finland's family policy is to create a safe environment for children to grow up in and to provide parents with the material and psychological means to have and raise children. The state's responsibility to promote welfare, health and security is rooted in the Constitution. The Ministry of Social Affair and Health (MSAH) is responsible for national planning, guidance and monitoring of mental health work. The MSAH is responsible for family policy as well as maintaining and developing the welfare of children, youth and families **jointly with other Ministries**. The MSAH's scope of responsibility is particularly dedicated to developing social and health services and safeguarding incomes for families with children. The ministry also promotes the reconciliation of work and family life. The development of family services is part of the National Development Programme for Social Welfare and Health Care (Kaste).

The Ombudsman for Children supervises the implementation of children's rights. Children's are enshrined in the UN Convention on the Rights of the Child. Finland ratified the Convention in 1991. The agreement binds the state, municipalities, parents and other adults to the implementation of children's rights in various fields. In Finland, the Ombudsman for Children oversees the implementation of the convention.

With respect to this analysis, the most relevant legislation pertaining to mental health and MH services for children and adolescents are presented below:

- *Primary Health Care Act 66/1972*
- *Act on Specialized Health Care 1062/1989*
- *Health Care Act, 1326/2010*
- *Mental Health Act, 1116/1990*
- *Mental Health Decree 1247/1990, Chapter 2 a (28.12.2000/1282): Mental health services for children and young people. The Decree stipulates the first care guarantee for child and adolescent psychiatry in Finland. Moreover, the Decree provides for specific timings for cure: an individual must get access to examinations in specialised medical care within three weeks from reception of the referral, and to treatment within three months*
- *The Act on the Status and Rights of Patients 785/1992*
- *Decree on Welfare Clinic Services, School and Student Health Services, and Preventive Oral Health Services for Children and Youth 380/ 2009*
- *Child Welfare Act 417/2007: This Act rules the support for schooling, psychologist and social worker services concerning pupils receiving pre-primary, basic and voluntary additional basic education and preparatory instruction within the municipality under the Basic Education Act (628/1998). NOTE: New Act on Student's Welfare 1.8.2014.*

Finland's health care system and social welfare is founded on government-assisted municipal health care and social welfare services. In addition to the public sector, services are available from various private companies. Finland also has an extensive network of non-governmental health care and social welfare organisations that provide services both free of charge and for a fee.

Mental health services in Finland include:

- guidance, advice and, when necessary, psycho-social support,
- psycho-social support in crises,
- examination, treatment and rehabilitation for mental health disorders.

Municipal social and health services deal with the prevention of mental health disorders, early diagnosis, treatment and rehabilitation. Treatment chiefly uses outpatient and primary social and health services. Mental health services are also organised under specialised health care at psychiatric clinics and psychiatric hospital care. Municipal social services arrange housing services, home services and rehabilitative work activities for people undergoing mental health rehabilitation.

Child welfare is divided into preventive child welfare services (e.g., municipal maternity and child health clinics, child guidance and family counselling clinics, day-care, schools) and child and family specific services (e.g., specialized healthcare at psychiatric clinics and psychiatry hospital care).

A key role in prevention is played by municipal maternity and child health clinics, child guidance and family counselling clinics, day care, schools, youth work, and family centres that assemble family services.

As regards the responsibilities of Social welfare and health care system in Finland, the following webpage of the Ministry of Social Affairs and Health can be consulted: *http://www.stm.fi/en/social_and_health_services/responsible_agencies*

In Finland, the Mental Health Services are financed mainly by the State, municipalities and KELA (the Finnish Social Insurance Institution) as well as households, private insurance, non-profit organisations serving households and employers. In 2011, the health expenditure as a proportion of GDP was 9.0%. In 2010, in comparison with the health expenditure of other countries, the Finnish health expenditure as a proportion of GDP was below the OECD average of 9.7% and the EU (15) average of 10.4%.

In 2011, the expenditure on psychiatric care totalled EUR 749 million while the psychiatric inpatient care expenditure was EUR 425 million in specialised health care.

The outpatient primary health care costs of mental health care were of EUR 152.6 million, prenatal, child and family planning clinics EUR 135.1 million and school health care EUR 66.2 million.

Specific statistics addressing the mental health of children and adolescents are not available (Matveinen & Knape, 2013).

The Ministry of Social Affairs and Health is responsible for overall health policy; promoting health in all policies is the key principle in Finnish health policy.

Regional State Administrative Agencies are responsible for health promotion (general steering, and overseeing).

Municipalities are responsible for developing, implementing and evaluating promotion and preventive services. The Municipal council approves the Child and Adolescent Welfare Plan (mandatory by Child Welfare Act) and takes it into consideration in its strategy and budget. The aim of the Plan is to develop all services concerning children and adolescents as one unity, focusing on prevention and promotion activities involving different sectors including parents and young people themselves. The Child and Adolescent Welfare Plan is a tool for steering and developing welfare work at municipalities' level. The Plan can be implemented by a municipality or several municipalities together. Representatives of different service sectors are making the plan together: workers at grass-roots level (professionals and employees working with children and families), authorities and political decision makers included. Inhabitants, service users, children and families are included at work to gather information and plan services.

Moreover, **THL** is actively developing, implementing and evaluating children's and adolescents' mental health promotion and prevention services. In addition, several NGOs are involved in mental health promotion services.

3.5.3 Social Services for children and adolescents

With regard to the current legislation and policies concerning the social services for children and adolescents in Finland, the most relevant elements are:

- *The state's responsibility to promote welfare, health and security is rooted in the **Constitution** of Finland 731/1999 (Finlex). This enshrines the right of everyone to income and to care, if they are unable to manage adequately. The Ministry of Social Affairs and Health (MSAH) is responsible for family policy as well as maintaining and developing the welfare of children, youth and families jointly with other ministries. The MSAH's scope of responsibility is particularly concerned with developing social and health services and safeguarding incomes for families with children. The MSAH also promotes the reconciliation of work and family life. The development of family services is part of the **National Development Programme for Social Welfare and Health Care (Kaste).** The Ombudsman for Children supervises the implementation of children's rights.*
- *The duties of municipal authorities throughout Finland to arrange social and health care are stipulated by **laws on social and health care planning** and the central government transfers their implementation to local government. **The law on social welfare** stipulates the services that municipalities must produce. **The law on the status and rights of social care clients** includes issues of data security. **Special legislation covers child welfare, child day care Child Welfare Act 417/2007 (Finlex)**, Family Carer Act 312/1992 (Finlex), family care, etc. **There are laws** also dealing with ascertaining paternity, **child maintenance** and security, **child care** and implementing rights of access, adoption counselling **Adoption Act 153/1985 (Finlex)**, and family conciliation matters. **Legislation also covers the professional standards of social and health care personnel** (Ministry of Social Affairs and Health, Finland, see also 3.4.2).*

Services for children and youth are provided by:

- The **Ministry of Social Affairs and Health** prepares legislation and guides its implementation; directs and guides the development of social welfare and health care services, and social welfare and health care policy; defines social welfare and health care policy guidelines; prepares key reforms and guides their implementation and coordination. MSAH is responsible for links with political decision-making
- The **Agencies and institutes under the Ministry's administrative branch** are in charge of research and development within the administrative branch
- The **Regional State Administrative Agencies** guide and monitor municipal and private social welfare and health care services and evaluate the availability and quality of basic services provided by municipalities
- The **National Supervisory Authority for Welfare and Health Valvira** guides, monitors and manages the administration of licences for the social welfare and healthcare sector, alcohol administration and environmental health and protection
- The **Municipalities, private service providers and organisations** are responsible for organising social welfare and health care. They can provide basic social welfare and health care services alone, or form joint municipal authorities with other municipalities.

Child welfare is divided into preventive child welfare services and child and family specific services.

A key role in prevention is played by municipal maternity and child health clinics, child guidance and family counselling clinics, day care, schools, youth work, and family centres that assemble family services. Child protection directed at children and families becomes applicable in municipal social work when:

- a child welfare report has been made about a child,
- there is an application for child welfare service,
- a child welfare worker has otherwise received information that a child is in need of protection (Ministry of Social Affairs and Health).

In 2012, social protection expenditure in Finland as a proportion of GDP was 31.2 per cent: 10.6% of the expenditure was used for families and children (equivalent to EUR 6 388 million). The expenditures included both cash benefits (maternity grant, parents' benefits, salary during entitlement to parents' benefits, child home care allowance, child allowance, maintenance allowance, child increase) and benefits in kind (child day care, private day care allowance, institutional care of children and young people, home help, etc.) (Tanhua & Knape, 2013).

In 2010, the social welfare and health care sector in Finland employed a total of 372 300 people, of whom approximately three quarters (approximately 74%) worked in the public sector. Approximately 16% worked in private enterprises and just over 10% in nongovernmental organisations. In social services, the two largest sectors were services for the elderly (residential nursing care, sheltered housing as well as home help services) and child day care, which together employed 2/3 of the total number of social services personnel.

The same year, 61 500 persons were working in child day care, covering different profiles such as child care management, nurse, psychologists, social services coordinators, child care workers, learning support assistants, child day care assistants. Child day care personnel are included in social welfare and health care services in statistics and especially International statistics (Ailasmaa, 2013).

Since in Finland the Ministry of Social Affairs and Health is responsible for both health and welfare policy, with a strong inter-sectoral approach, the organisation and delivery of social services follows the same structure described in the section 3.4.2 "Mental health services for children and adolescents".

3.5.4 The Education system for children and adolescents

The essential documents concerning the educational sector in Finland are:

- *Children's Day care Act stipulates the entitlement of children to day care and the responsibility of municipalities to arrange day care*
- *Children's Day care Decree covers its practical arrangement*
- *Basic Education Act prescribes the principles of basic education as well as pre-primary education, education for immigrants and voluntary additional basic education*
- *Basic Education Decree prescribes the working time, instruction, groups, evaluation and assessment, pupils' rights, etc.*
- *General Upper Secondary Schools Act prescribes the aims of general upper secondary education, its organisation, instruction, curricula, publicity of education, assessment, matriculation examination, etc.*
- *General Upper Secondary Schools Decree legislates on e.g., instruction, counselling, planning the education, assessment, legal rights of the student.*
- *Decree on the General National Objectives of Upper Secondary Education and the Distribution of Lesson Hours*
- *Act on the provision of matriculation examination*
- *Decree on the provision of matriculation examination prescribes the organisation, examinations, examiners, assessment and examinees*
- *Vocational Education and Training Act legislates on the vocational upper secondary education and vocational upper secondary degrees, e.g., provision of education and training, instruction, curricula, on-the-job learning, apprenticeship training, special needs education, evaluation and assessment*
- *Vocational Education and Training Decree prescribes the following: studies and their scope, counselling, on-the-job learning, apprenticeship training, special needs education, assessment and evaluation*
- *Acts and decrees related to students (e.g., financial aid), teachers (e.g., qualifications) and administration (Ministry of Education and Culture, Finland).*

One of the basic principles of Finnish education is that all people must have equal access to high-quality education and training. The same opportunities to education should be available to all citizens irrespective of their ethnic origin, age, wealth or place of residence. Education policy is built on the lifelong learning principle. The basic right to education and culture is recorded in the Constitution. Public authorities must secure equal opportunities for every resident in Finland to get education also after compulsory schooling and develop themselves, irrespective of their financial standing. In Finland, education is free at all levels from pre-primary to higher education. The key words in Finnish education policy are quality, efficiency, equity and internationalisation.

The Education and Research Development Plan is the key document of the Finnish education and research policy. The Development Plan is adopted by the government every four years, and it directs the implementation of the education and research policy goals stated in the Government Programme. The focus in the period 2011–2016 is on alleviation of poverty, inequality and exclusion, stabilizing the public

economy and fostering sustainable economic growth, employment and competitiveness. Decisions on the contents of legislation on education and research are made by the Parliament based on government proposals. The Government and the Ministry of Education and Culture, as part of it, are responsible for preparing and implementing education and science policy. The Finnish National Board of Education (FNBE) is the national agency subordinate to the Ministry of Education and Culture. The FNB is responsible for drawing up the national core curricula.

The national education administration is organised at two levels. Education policy is the responsibility of the Ministry of Education and Culture. A national agency, the Finnish National Board of Education, is responsible for the implementation of the policy aims. It works with the Ministry to develop educational objectives, content and methods for early childhood, pre-primary, basic, upper secondary and adult education. Local administration is the responsibility of local authorities, most commonly municipalities or joint municipal authorities. These make the decisions on allocation of funding, local curricula, recruitment of personnel. The municipalities have also the autonomy to delegate the decision-making power to the schools. Typically, the principals recruit the staff of their schools (Ministry of Education and Culture, Finland).

The Finnish education system is composed of: nine-year basic education (comprehensive school) for the whole age group, preceded by one year of voluntary pre-primary education; upper secondary education, comprising general education and vocational education and training (vocational qualifications and further and specialist qualifications) and higher education, provided by universities and polytechnics.

With regard to the financial resources that are dedicated to the Education System addressing children and adolescents, the situation in 2011 in Finland is as follows: EUR 323 million are used for Pre-primary education and EUR 4 231 million for comprehensive school education (Official Statistics of Finland, 2013).

Expenditure in education

TOTAL GOVERNMENT EXPENDITURE IN EDUCATION	%
As % of GDP	6.76
As % of total government expenditure	12.24

Source: UNESCO, UIS.Stat

Most institutions providing basic and upper secondary level education in Finland are maintained by local authorities or joint municipal boards. Responsibility for educational funding is divided between the State and the local authorities. Most private institutions do not differ from those that are publicly maintained: they follow the national core curricula and qualification requirements and also receive public funding.

The education is free at all levels from pre-primary to higher education. In pre-primary and basic education the textbooks, daily meal and transportation for students living further away from the school are free for the parents. At secondary level and in higher education the students themselves or their parents purchase their own books. At secondary level, the students have the right to a free meal and in higher education meals are subsidised by the state. To ensure the opportunities to study for everyone there is a well-developed system of study grants and loans. Financial aid can be awarded for full-time study in an upper secondary school, vocational institution or institution of higher education.

Teachers in basic and general upper secondary education are required to hold a Master's degree. Also teachers in vocational education and training have to hold a higher education degree. The high level of training is seen as necessary as teachers in Finland are very autonomous professionally. Teaching and guidance staff within day-care centres (e.g., kindergarten teachers, bachelors of social services, child minders, practical nurses) generally have Bachelor's degrees. Pre-primary teachers in schools hold a Master's degree. Teachers are recognised as keys to quality in education. Therefore continuous

attention is paid to both their pre-service and continuing education. Responsibility for the operations of basic education schools and upper secondary schools rests with principals. Principals are generally required a higher academic degree and teaching qualifications. In addition, they are required to have appropriate work experience and a certificate in educational administration or the equivalent.

Concerning human resources employed in this sector, in 2012, the situation was as in the table below:

Teachers in Finland per level of education

LEVEL OF EDUCATION	TOTAL NUMBER OF TEACHERS
ISCED 0	15 611
ISCED 1	25 609
ISCED 2	20 673
ISCED 3	24 170
ISCED 4	Not applicable

Source: UNESCO, UIS.Stat

The **Government and the Ministry of Education and Culture,** as part of it, are responsible for preparing and implementing education.

The Finnish National Board of Education (FNBE) is responsible for the implementation of the policy aims. FNBE works together with the Ministry to develop educational objectives, content and methods for early childhood, pre-primary, basic, upper secondary and adult education. The FNBE is responsible for drawing up the national core curricula.

Local administration is the responsibility of local authorities, most commonly **municipalities** or **joint municipal authorities.** They decide the allocation of funds and the local curricula, based on the national core curricula and requirements. Municipalities are responsible for developing, implementing and evaluating promotion and preventive services. They have the autonomy to delegate the decision-making power to the schools.

The Regional State Administrative Agency performs tasks related to implementation, steering and oversight in the field of education and culture.

THL is developing, implementing and evaluating children's and adolescents' mental health promotion and prevention in cooperation with the Ministry of Education and Culture (e.g., Yhteispeli- Get together-programme) and with the Finnish National Board of Education (e.g., TEA-viisari).

In addition several **NGOs** (e.g., Finnish Association of Mental Health), **universities** (e.g., University of Turku, Kiva-school) and single schools are doing mental health promotion and prevention work in schools.

3.5.5 Cooperation between sectors

In Finland the **National Development Programme for Social Welfare and Health Care (Kaste) includes a subprogramme to reform services for children, youth and families, with particular attention to developing pupil and student welfare and mental health services.** The Student Welfare Act (1.8.2014) takes account of the services provided by educational institutions and their municipalities. The Government's intention is that the availability of and cooperation between the pupil welfare services (education, health and social) is improved. The funding for ensuring pupil welfare services is planned in the Government's Basic Public Services Programme.

The Child Advisory Board is a state level body composed of representatives of various administrative sectors, the regional and local levels, non-governmental organisations and other bodies, established by

the government. The Ombudsman for Children is the chairperson of the Advisory Board. The duty of the Ombudsman for Children is to promote the interests of children and the implementation of their rights on a general societal level together with other actors in the field. The Ombudsman's collaborative partners in this work are other authorities, municipalities, churches, non-governmental organisations, researchers and other actors and specialists in the area of child policy.

The work done under the framework of The National Development Programme for Social Welfare and Health Care (Kaste) is gathering authorities from health, social and schools sector.

The Child and Adolescent Welfare Plan is implemented at municipal level together with representatives of different sectors. Local core curricula issues concerning students welfare and school-home--collaboration have to be prepared with social and health authorities of the municipality.

At school level, the student welfare groups regularly meet multiprofessional groups, which offer both preventive and remedial help at individual and group/community level.

The local experts identified the following strengths and weaknesses concerning the cross-sectoral cooperation:

Strengths and weaknesses in cross-sectoral cooperation in Finland

STRENGTHS	WEAKNESSES
Legislation and policies support cooperation	No systematic collection of national data on children's mental health, risks and protective factors (while data on adolescents is collected by School health promotion study)
Numerous supporting structures and tools for cooperation	Little scientific research done on programmes developed in Finland or adapted from elsewhere (compared with all the activity in the field)

3.5.6 Selected examples of good practice

GOOD PRACTICE IN MENTAL HEALTH PROMOTION

"Yhteispeli-Get together"

The programme has been developed since 2006 based on knowledge on evidence based practices to promote children's social and emotional skills at schools and their mental health. The objective of the programme is to test the features of known good practices of Finnish school contexts and to include those feasible in the programme. The programme was started by THL and the Ministry of Social Affairs and Health and since 2010 it has been financed mainly by the Ministry of Education and Culture. The programme was developed and implemented by teachers, psychologists, principals and child psychiatrists and teachers, parents and students are involved during the development work. In the period 2013-2015, a study on safety, feasibility and perceived impact finalized and randomized effectiveness study including 84 schools across Finland is taking place.

Yhteispeli was developed under the principle of whole school as recommended by C. Weare: social and emotional skills are taught to children as part of everyday school life, and not only in special classes. The programme previews also the promotion of teachers' communication skills and sharing of information among them as well as the well-being of the whole school community. In addition, the programme supports the co-operation between teachers and parents and children, securing the transition from day care/pre-school to school.

http://www.yhteispeli.fi/mita-yhteispeli-on/
www.yhteispeli.fi

GOOD PRACTICE IN MENTAL DISORDERS PREVENTION

"KiVa School"

KiVa School is a research-based anti-bullying program that has been developed in by the University of Turku and funded by the Ministry of Education and Culture. It has spread at national level: 90% of all comprehensive schools in the country are registered KiVa schools implementing the program. The KiVa program involves both universal and indicated actions to prevent bullying and to tackle cases of reported bullying. Efforts are made to influence the group norms and to build capacity in all children to behave in constructive ways, to take responsibility for not encouraging bullying, and to support the victims. KiVa reduces anxiety and depression and has a positive impact on students' perception of their peer climate. In addition, positive effects on school liking, academic motivation and achievement have been reported. It addresses multiple forms of victimization, including verbal, physical and cyberbullying. The effectiveness of KiVa demonstrated a significant reduction of both self- and peer-reported bullying and victimization.

www.kivaprogram.net

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3.6 ICELAND

3.6.1 Overview

Iceland is a 103 000 km^2 island located in the North Atlantic Ocean, east of Greenland and immediately south of the Arctic Circle. The inhabited areas are mainly around the coast line, particularly in the southwest, whereas the central highlands are uninhabitable. The country is a part of the Nordic Countries and had a population of 326 340 at the end of the 1st quarter in 2014.

The average age of the population is 37.2 years, 36.6 for men and 37.8 years for women, and life expectancy at birth was 80.8 years for men and 83.9 years for women in 2012 (Statistics Iceland, 2014).

Iceland is an independent democratic nation with no standing army.

Gross domestic product per capita in 2013 was 33 976 EUR.

Children and adolescents under the legal adult age of 18 were 80 040.

Children are only required to complete the primary and lower secondary school level, which usually takes place between the ages of 6 and 16. Nevertheless, 95-97% of children between the ages of 2 and 5 attend preschool and 95-97% of adolescents between the age of 16 and 18 enrol in non-compulsory upper secondary school.

In 2011, the total school-aged population (pre-, primary and secondary school until 18 years) in Iceland was 69 977.

The school-aged population is divided as follows:

Icelandic school aged population in 2014

AGE GROUPS	TOTAL	MALES	FEMALES
0-4	23 153	11 793	11 360
5-9	22 480	11 557	10 923
10-14	21 176	10 670	10 506
15-19	22 445	11 521	10 928

Source: Statistics Iceland, 2014 – Population by sex and age

With regard to the educational attainment of pupils in Iceland, in 2011, the distribution of students by level of education was as follows:

Children and adolescents by level of education

LEVEL OF EDUCATION	NUMBER OF STUDENTS
ISCED 0	12 822
ISCED 1	29 432
ISCED 2	13 107
ISCED 3	22 110
ISCED 4	272

Source: UNESCO, UIS.Stat

In the school year 2005 the situation concerning school attainment was as follows:

Educational attainment of population aged 25 years and older in Iceland

LEVEL OF EDUCATION	% OF STUDENTS		
	Males-Females	**Males**	**Females**
ISCED 1	4.0	3.2	4.7
ISCED 2	33.4	28.4	38.5
ISCED 3	28.3	34.6	22.0
ISCED 4	2.0	3.3	0.6

Source: UNESCO, UIS.Stat

At the age of 24, 60% of young people have completed upper secondary school. According to Statistics Iceland, in 2012, 29% of people aged 25-64 only had compulsory schooling.

As regards the numbers of students dropping-out from schools in Iceland, the rates in 2010 were as follows:

Drop-out rates to the last grade per level of education in Iceland

	% OF STUDENTS
Drop-out rate to the last grade of primary education	2.90968
Drop-out rate to the last grade of general lower-secondary education	1.19656

Source: UNESCO, UIS.Stat

In 2011, there were 125 early school leavers from primary and lower secondary school (UNESCO, 2011).

Concerning the mental health of children and adolescents in this country, the status of Icelandic youth is thought to be similar to the status in neighbouring countries.

About **80% of children are in good mental health and do not require any mental health services.** About **15%** of children have **mild problems** and are in some need of service while around **5%** of children have **severe problems that require specialized treatment.** In a survey sent out by the **Center for Child Health to every primary and lower secondary school in Iceland in 2005,** 19.25% of children were reported to have long standing health problems. Thereof, about a third, or **6% of all primary and lower secondary school children,** were reported to have **ADHD**, which was the largest category in this age group. A Nordic comparative study in 2010 showed that 5.5% of Icelandic adolescents rated their mental health as poor and 21% as fair. **A 2008 study** on time trends in adolescent anxiety and depressive symptoms and health specialist service use showed that **symptoms of anxiety and depression had increased among Icelandic adolescents in the previous decade.**

In the context of this JA, the existence of a mental health strategy exclusively targeting children and adolescents was analysed, in the different countries.

At the moment of report writing, a national policy for children and adolescent's mental health does not exist in Iceland. Several reports, parliamentary resolutions and action plans have been issued over the past decade that call for increased and coordinated mental health services in children's local environments, access to multidisciplinary mental health care in primary health clinics, etc. Unfortunately, due in part to the 2008 financial crisis, many of these proposals have not yet been realized. However, **work is now underway to propose a comprehensive Mental Health Policy that will address the urgent need for a governmental policy and action plan in this area. Furthermore, the proposed National Health Plan until 2020, contains specific objectives and actions regarding children's and adolescents' mental health,** e.g., estimate the need for service among children with substance use or mental health problems and increase awareness of the importance for children and adolescents to spend time with their family.

The Icelandic partner which contributed to the thematic area of "mental health and school" in the present Joint Action is the Directorate of Health in Iceland (DOHI) and among its main areas of interest and activities are:

1. Advising the Minister of Health and other government bodies, health professionals and the public on matters concerning health and well-being, and

2. Initiating and supporting public health activities within the country.

The DOHI also has the role of collecting and processing data on health and health care services, and monitoring health care workers and issuing licenses to practice.

3.6.2 Mental Health services for children and adolescents

Legislation concerning mental health, social services and education for children and youth is partly generated from International obligations Iceland has adopted, e.g., the United Nations Convention on the Rights of the Child. The Icelandic Constitution has general provisions on legislator's duty to provide children and adolescents with care and protection. Furthermore, the Constitution, as well as the International Covenant on Economic, Social and Cultural Rights has general provisions on legislator's obligation to ensure to everyone the right to general education.

With respect to this analysis, the most relevant components are presented below:

- *Compulsory School Act No. 91/2008 (primary and lower secondary): This act specifies the municipalities' responsibility for providing specialist services within primary and lower secondary schools, preventive measures in the form of screening and check-ups, and assessment of psychological or social difficulties. Parents can request a developmental or psychological assessment for their child on the basis of this act that is free of charge (art. 40).*
- *Regulation on Primary Health Care Services No. 787/2007: This regulation specifies that primary health care services are responsible for providing preventive actions, mental protective services and special youth receptions. Also, to manage pre- and postnatal care, provide regular check-ups for children from birth until 15 years of age (through postnatal care and school health care) and perform developmental assessments among children at 2 1/2 and 4 yrs*

- *Act on the Affairs of Disabled People No. 59/1992: This act ensures disabled people (including children/adolescents with severe mental disorders) equality of rights and standard of living comparable with that of other citizens. According to the law, municipalities are responsible for the organisation and administration of services to disabled people, including the quality of services.*
- *Act on the State Diagnostic and Counselling Centre No. 83/2003: The aim of this act is to ensure that children with severe developmental disorders receive counselling and other remedies aimed at ameliorating consequences of their disorders and ensure the acquisition, maintenance and dissemination of knowledge and skills in this field. For this purpose, the state is obliged to operate through an institution, the State Diagnostic and Counselling Centre, to serve the whole country.*

Mental health services for children and adolescents are provided by the general health care system and managed by the state. Some services are available through school nurses (e.g., prevention in schools) and school psychologists (e.g., diagnosis for mental, behavioural, developmental or educational difficulties) but usually not treatment.

Treatment for mild to moderate mental and behavioural difficulties usually takes place at the private offices of child psychologists or psychiatrists or at the Center for Child Development and Behaviour. This institution, however, mainly provides diagnosis and treatment for ADHD in children up to adolescence.

Sometimes mental health services for children and adolescents are available at primary health care clinics but that is rare. Some service or counselling is also available through NGOs, such as the Red Cross (e.g., family counselling and an emergency telephone hot line). **There is no consistent provision of multidisciplinary mental health services to youth and families throughout the primary health care system in Iceland.** However, all children born in Iceland receive postnatal care with regular check-ups and vaccinations until the age of 18 months. **Children also undergo developmental assessment at 2 1/2 and 4 years of age. Serious, complex or longstanding mental and behavioural difficulties are treated at tertiary mental health clinics, such as the Division of Child and Adolescent Psychiatry and Landspitali-University Hospital and the Child and Adolescent Psychiatric Unit at Akureyri Regional Hospital. All mental health providers,** whether they work in schools, primary care clinics, private offices or public hospitals, are **accountable to the DOHI and the Ministry of Welfare.**

It is not possible to state in any certain manner the financial resources dedicated to this field but in 2011, 9% of the GNP went to health care in general. Mental health services are provided on the one hand by the state and on the other hand by the municipalities but to a much lesser extent.

The municipalities in Iceland are 74 in total and they are responsible for various services that have relevance for children's and adolescents' well-being, e.g., social services, child protection, day care, pre-, primary and lower secondary schools. They do not, however, manage health care. The state runs most primary health care services in Iceland, although a few health clinics are private.

Regarding human resources the following specialists are engaged in services in the field of children's mental health: **psychiatrists, psychiatric nurses, school nurses, primary health care nurses, psychologists, guidance counsellors, social workers, and developmental and occupational therapists.**

The DOHI, which serves under the Ministry of Welfare, is legally responsible for addressing mental health promotion and prevention on a population level, including planning, financing, monitoring and delivering initiatives.

In addition, primary health care clinics are responsible for providing services that protect mental health and municipalities are responsible for including preventive services for students in pre-, primary and lower secondary schools.

3.6.3 Social Services for children and adolescents

With regard to the current legislation and policies concerning the social services for children and adolescents in Iceland, the most relevant elements are:

- *Regulation on Specialized Services by the Municipalities for Pre-primary and Compulsory Schools and Pupils Protection Council in Compulsory schools No. 584/2010: This regulation states that municipalities shall initiate collaboration with specialized services within the community that provide state-based diagnostic and treatment services on behalf of individual students. The municipalities shall ensure mutual exchange of information between service levels, as appropriate and in consultancy with parents, and set standards for how these services are used. Principals shall initiate collaboration between specialized services within the municipality, social services, child protection and health authorities for students with special needs or long-term illnesses.*
- *Regulation on the schooling of foster children in Compulsory schools 547/2012. Specifies the cooperation between the school sector and the welfare sector both professionally and financially.*
- *Regulation on the responsibility of duties of the school community in Compulsory Education no. 1040/2011. Specifies the responsibility and duties of the pupils, staff and parents in terms of creating a positive school culture and protective environment in all aspects of compulsory education, including bullying, violence and behaviour.*
- *The Compulsory School Act No. 91/2008: specifies that municipalities managing compulsory schools are responsible for initiating collaboration with social and health care authorities in cases of students with special needs or long-term illnesses. They are also responsible for ensuring continuity of services between school levels (pre-primary and upper secondary) and provide specialized services within compulsory schools.*
- *Child Protection Act, No 80/2002: the objective of this Act is to ensure that children (up to 18 years old) who are living in unacceptable conditions or children who place their health and maturity at risk receive the necessary help.*
- *Social Assistance Act, No. 99/2007: this act ensures child pension in connection with school studies or vocational training.*
- *The Act on Payments to Parents of Chronically ill or Severely Disabled Children No. 22/2006: specifies parents' rights to financial assistance if they are unable to pursue employment or education due to the special care of children suffering from chronic illness or severe disabilities, including mental illness.*
- *Municipalities' Social Services Act, No. 40/1991: The law covers the duty of the social services committees within municipalities, in cooperation with parents, educational and health care professionals, to secure the welfare of children and youth and protect their interests in every respect (art. 30).*

The Icelandic social system consists of local social services and child protection committees within each community.

- The **District Commissioner within each municipality has mandate from the National Social Insurance Administration (which is under the Ministry of Welfare) to provide financial support,** such as disability, rent subsidies, etc. for residents within the municipality.
- The **Government Agency for Child Protection, under the Ministry of Welfare,** is in charge of the day-to-day administration of child protection services. Among the Agency's responsibilities is to

monitor the work of local child protection committees, supervise and monitor institutions and homes operated by or supported by the Government for children and youth, and operate specialized services in child protection, such as the center for the investigation of sexual abuse cases ("The Children's House") and treatment facilities for children and youth with behavioural or substance-related difficulties.

The social services and health care services are not formally connected. However, in some areas, the social and health care services collaborate closely and health care professionals often seek assistance from social services and vice versa when needed. Also, health care providers as well as school staff, are required by law to seek assistance from child protection committees when there is reason to believe that a child's well-being is at risk.

The social services are often linked to the educational sector within local "service centers" and municipal offices that are responsible for matters related to pre- and primary school as well as local social services. The **social services provide advice and assistance to the schools when required.**

The local social services and child protection committees are financed and managed by the municipalities. The Government Agency for Child Protection is financed by the state as well as the Social Insurance Administration, which provides subsidies, e.g., parental leave, child benefits, etc. According to Icelandic Statistics, in 2010, about 3.13% of the GNP went to the social services for children and families (e.g., parental leave, child support, single parent's allowance), child support and child care (subsidies for preschool and childcare), child protection agencies and activities.

The state is accountable for the legislation regarding the social services as well as child protection and health services. The municipalities are mostly responsible for the implementation of the social services and child protection, both the planning, delivery and the financing of promotion and prevention. As of today there are no formal channels for the evaluation of promotion and prevention within the social sector. However the National Statistics collects statistical data from all the local authorities every year where one can view the development of the provision of services.

The state is accountable for the implementation of health services, both the planning, delivery and the financing for the promotion and prevention.

The Directorate of Health is in charge of the promotion as well as evaluation of health services. Several NGOs are very much engaged in promotion and prevention activities but their activities are not systematically evaluated.

Local child protection committees are responsible for addressing concerns regarding the **accommodation and family environment of children and adolescents** and intervene when there is reason to believe children's well-being is at risk.

The local social services are responsible for providing financial and social assistance to families in need and thereby prevent more serious social problems. Some social services are also available through NGOs (e.g., the Red Cross, the Icelandic Family Assistance and the National Church Family Assistance) that provide community services in terms of food, clothing and social support.

The Government Agency for Child Protection is responsible for **monitoring the work of local child protection committees,** e.g., reviewing annual reports, but **the Ministry of Welfare** is the ultimate authority in matters of child protection and social welfare. After the economic crisis in **2008**, the **"Welfare Watch"** was established, which has the main role of monitoring determinants of social status and well-being in the general population, including a special focus on children and adolescents.

3.6.4 The Education system for children and adolescents

The essential documents concerning the educational sector in Iceland are:

- *Pre School Act No. 90/2008: this Act covers preschool activities. The preschool constitutes the first level of education in the school system and is intended for children below the compulsory school age. According to this law, children shall be provided with care and education, offered a healthy and encouraging environment to grow up in, as well as safe conditions to learn and play.*
- *Compulsory School Act No. 91/2008: this Act covers compulsory schools (primary and lower secondary schools) run by municipalities and other education at compulsory school level. The role of the compulsory school, in cooperation with the home, is to encourage pupils' general development and prepare them for active participation in a democratic society that is continuously developing. This act, among other things, specifies that it is the municipalities' responsibility to initiate collaboration with social and health care authorities in cases of students with special needs or long-term illnesses. They are also responsible for ensuring continuity of services between school levels (pre-primary and secondary), providing specialized services within primary schools, preventive measures in the form of screenings and check-ups, and assessment of children with psychological or social difficulties. Parents can request a developmental or psychological assessment for their child on the basis of this act that is free of charge (art. 40).*
- *The Upper Secondary School Act No. 92/2008: the objective of Upper Secondary school is to encourage the overall development of all pupils and encourage their active participation in democratic society by offering studies suitable to the needs of each pupil. The upper secondary school prepares pupils for employment and further studies.*
  In the frame of policies:
- *The Icelandic National Curriculum Guide for Preschools.*
- *The Icelandic National Curriculum Guide for Compulsory Schools.*
- *The Icelandic National Curriculum Guide for Upper Secondary Schools.*
  The National Curriculum Guides contain the frame and conditions for learning and teaching based on the principles of existing laws, regulations and International conventions. Six fundamental pillars (Literacy, Sustainability, Health and welfare, Democracy, Equality, and Creativity) have been developed within this frame that form the essence of the educational policy.

The educational system in Iceland consists of the **preschool level (0-5 years), compulsory (primary and lower secondary school 6-16 years) and secondary school (16-20 years).**

Only primary and lower secondary school are compulsory but 95-97% of children aged 2-5 attend preschool and up to 20% of 1 year olds. About 96% of youth under the age of 18 are enrolled in upper secondary school. Before preschool, private child-care is available and usually takes place in private homes.

It is subsidized and regulated by the welfare divisions within individual municipalities but otherwise private. Local educational offices within the municipalities run, organise and finance the pre-, primary and lower secondary school level.

The local educational offices serve under the Icelandic Association of Local Authorities. Primary and lower secondary school is free but day-care and preschool is not, although it is subsidized by the

municipalities. The upper secondary school level serves directly under the Ministry of Education, Science and Culture and is financed directly from there, as well as the university level.

With regard to the financial resources that are dedicated to the Education System addressing children and adolescents, the situation in Iceland is as follows: **the public compulsory school system is free in Iceland, and is financed and managed by the municipalities.** Parents/guardians pay for school meals and voluntary after-school programmes with subsidies from the municipalities. According to Icelandic Statistics, there were 168 compulsory schools in Iceland in 2012, thereof were 10 private schools with 2% of the pupils where parents pay a tuition. The preschool level is not free but is subsidised by the municipalities who manage and run most Icelandic preschools.

Expenditure in education in 2010

TOTAL GOVERNMENT EXPENDITURE IN EDUCATION	%
As % of GDP	7.60
As % of total government expenditure	9.56

Source: UNESCO, UIS.Stat

According to Statistics in Iceland, there were 262 preschools in Iceland in 2012, thereof 38 were privately run (17%) where parents often pay a higher tuition. **Upper secondary schools are managed and financed by the state.** They are non-compulsory and mostly free of charge to students except they pay for the teaching materials. Registration fees vary and tuitions vary between private schools. **About 5.75% of the GNP goes to the educational system, excluding the University level.**

Concerning human resources employed in this sector, in 2012, the situation was as in the table below:

Teachers in Iceland per level of education

LEVEL OF EDUCATION	TOTAL NUMBER OF TEACHERS
ISCED 0	2 532
ISCED 1	3 034
ISCED 2	n/a
ISCED 3	1 804
ISCED 4	n/a

Source: UNESCO, UIS.Stat

The municipalities are responsible for the planning, financing and delivery of mental health promotion and prevention within pre, primary and lower secondary schools (ages 6-16). The national government is responsible for the planning, financing and delivering of prevention and promotion at the upper secondary school level.

3.6.5 Cooperation between sectors

In Iceland **there is special legislation defining cross-sector cooperation within certain domains.**

The Regulation on Specialized Services by the Municipalities for Pre- and Compulsory Schools No. 584/2010 (art. 3) states that municipalities are to ensure that appropriate specialist services are provided in pre- and primary schools, determine its form and facilitate its implementation in schools. They are responsible for rendering and financing the service. **Municipalities shall specify in their school policies how the objectives of this Regulation will be met.** In the delivery of specialist services, the municipalities shall focus on, among other things, prevention in order to effectively contribute to the welfare of students, early assessment and counselling because of learning difficulties and social and psychological problems. **The Regulation further states (art. 5) that municipalities shall initiate**

collaboration on behalf of individual students with specialist services within the community that provides state-based diagnostic and treatment services. The municipalities shall also **ensure mutual exchange of information between service levels,** as appropriate and in consultancy with parents, and be able to set standards for how these services are used.

Principals shall initiate collaboration between specialist services within the municipality, social services, child protection and health authorities for individual students with special needs or long-term illnesses.

The Municipalities' Social Service Act states that public authorities responsible for projects or running institutions in the field of social services under the auspices of the municipalities shall cooperate as closely as possible, both on the organisation of services and the affairs of individual persons receiving assistance (art. 62) and counselling in the field of finances, housing, children's upbringing, divorce, including cases concerning custody and rights of access, adoption, etc. shall be applied in cooperation with other parties, e.g., schools and health care centres (art. 17).

The municipalities and schools are required to initiate collaboration with social and health care authorities when students present social or psychological difficulties. However, the requirements within the social and health care services to initiate collaboration between themselves and with the educational sector is less clear. There appears to be a **lack of comprehensive structure within the system that ensures cooperation between the health, social and educational sectors regarding children's mental health and well-being.**

However, **successful cross-sectoral collaborations have been established in several municipalities and within local communities in the Capital area.** In these instances, representatives from the local social services, local primary health care, local compulsory schools and local town offices meet regularly to discuss and co-ordinate actions and services for children with mental health or socio-economic difficulties. This collaboration appears to have been formed at the initiatives of the relevant service providers and specialists at the Division of Child and Adolescent Psychiatry, instead of being mandated or regulated by the relevant authorities.

The following strengths and weaknesses concerning the cross-sectoral cooperation have been identified:

Strengths and weaknesses in cross-sectoral cooperation in Iceland

STRENGTHS	WEAKNESSES
A legislation is in place that to some extent specifies the legal obligations of the municipalities regarding rendering and financing services, collaborations between the three sectors and information exchange between different parties involved in child and adolescent mental, educational and social well-being.	The existing legislation mostly applies to children and adolescent with existing mental health problems, but less focus is placed on mental health promotion and prevention.
Strong interest in increased collaboration among service providers within the three sectors. Several examples exist where tertiary care services and local social and health care services have formed successful collaborations that could serve as prototypes for further implementation.	There is a lack of legislative framework describing the respective roles, forms of collaboration and exchange of information between different levels of mental health services for children and adolescents.

3.6.6 Selected examples of good practice

GOOD PRACTICE IN MENTAL HEALTH PROMOTION

"Zippy's friends"

This is a 12-lesson universal prevention curriculum that aims to enhance children's coping skills and ability to cope with difficult situations and adversity in daily life. The curriculum is intended for 5-7 year old children in preschool and elementary school. Research indicates that the program has significant positive effects on children's coping and social skills.

http://www.partnershipforchildren.org.uk/zippy-s-friends.html

GOOD PRACTICE IN MENTAL DISORDERS PREVENTION

"Mind and Health"

This 14-lesson program is intended for 14-15 year old adolescents who are at risk for major depression.

The program focuses on providing adolescents with the skills to deal effectively with issues and problems they face in everyday life. Emphasis is placed on the idea that young people can influence their own behaviour and mood by thinking about and evaluating situations in a positive and constructive way. In addition, adolescents are taught to deal effectively with various social situations. The program has been shown to be effective in preventing first episodes of depression and/or dysthymia at 6 and 12 months following completion of the program. Survival analyses of the 12-month follow-up data showed that only 2 of the prevention program participants report an initial episode of MDD/DYS at the end of 1st year following the completion of the program versus 13 of the assessment-only control participants.

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3.7 ITALY

3.7.1 Overview

Italy is situated on the Southern part of Europe. According to data as of 31 December 2012, it has 59 685 200 inhabitants of which 28 889 600 males and 30 795 600 females.

The capital is Rome, with 2 617 175 inhabitants (as per 2011 Census).

The surface area of Italy is of 302 073 km^2, of which 258 876.56 km^2 is land area with a population density of 197.1 inhabitants per km^2 (above the average of the EU-27). Italy is made up of 19 regions (that include 110 provinces) and 2 autonomous provinces.

The average age of the population as of 1 January 2013 is 44 years, and life expectancy at birth in 2011 is 79 years for men and 84.5 years for women. Natural increase in 2012 is negative, - 1.32 per 1 000 inhabitants.

Concerning ethnicity and religion, 92.65% are Italians, and according to Censis 2012, the majority of the population is Catholic.

Gross domestic product per capita in 2012 was 25 200 EUR.

As of May 2010, the national coordination of the Health Commission was assigned to the Veneto Region.

The Veneto Region is located in the North-East part of Italy. As of 2011 it has a resident population of 4 857 210 with a life expectancy of 79.8 years for men and 85.0 years for women. Natural increase in 2012 is negative, - 0.54 per 1 000 inhabitants (Istat, 2014).

As of 2011, the school-aged population of Italy was divided as follows:

Italian school aged population

AGE GROUPS	TOTAL	MALES	FEMALES
0-4	2 749 928	1 413 825	1 336 103
5-9	2 781 095	1 431 307	1 349 788
10-14	2 795 020	1 439 901	1 355 119
15-19 (15-17)	2 869 465 (1 674 590 in 2013)	1 479 402	1 390 063

Source: Istat, 2014

With regard to the educational attainment of pupils in Italy, in 2011, the distribution of students by level of education was as follows:

Children and adolescents by level of education

LEVEL OF EDUCATION	NUMBER OF STUDENTS
ISCED 0	687 840
ISCED 1	2 827 564
ISCED 2	1 787 467
ISCED 3	2 842 838
ISCED 4	22 993

Source: UNESCO, UIS.Stat

In the school year 2012 the situation concerning school attainment was as follows:

Educational attainment of population aged 25 years and older in Italy

LEVEL OF EDUCATION	% OF STUDENTS		
	Males-Females	Males	Females
ISCED 1	18.7	15.9	21.3
ISCED 2	28.4	32.2	25.0
ISCED 3	33.7	35.5	32.1
ISCED 4	0.8	0.7	0.9

Source: UNESCO, UIS.Stat

As regards the numbers of students dropping-out from schools in Italy, the rates in 2010 were as follows:

Drop-out rates to the last grade per level of education in Italy

	% OF STUDENTS
Drop-out rate to the last grade of primary education	0.48225
Drop-out rate to the last grade of general lower-secondary education	1.00607

Source: UNESCO, UIS.Stat

In 2011, there were 2 736 early school leavers from primary school (UNESCO, 2014).

Concerning the mental health status of children and adolescents, the PrISMA study (Italian Project on Mental Health of Adolescents – "*Progetto Italiano Salute Mentale Adolescenti*") and ESPAD (European School Survey Project on Alcohol and Other Drugs) present relevant data.

PrISMA (2007) represents the first investigation conducted at national level aimed at evaluating the prevalence of mental disorders, according to DSM-IV and ICD-10 criteria, in preadolescents aged 10-14 years who live in urban areas. The results showed that 9.8% of screened participants are "probable" cases with emotional and behavioural disorders, while 8.2% of participants met criteria for at least one mental disorder at the time of the investigation. Emotional disorders (anxious and depressive disorders) were more common than externalizing disorders, which were diagnosed less frequently than in other studies. In adolescents with emotional and behavioural disorders, assessed using the CBCL (Child Behaviour Checklist), the probability of using a support teacher and of requesting the support of mental health services was (approximately) five times higher than for adolescents not affected by these problems. Moreover, the presence of psychological difficulties and mental disorders highlighted a correlation with a number of school difficulties, such as failures and the need to use a support teacher. In conclusion, PrISMA results (Frigerio, Rucci et al., 2007) are in line with those of other investigations carried out in Western countries applying a similar methodology, except for the lower prevalence of externalizing disorders in Italian adolescents.

ESPAD, which brings together teams of researchers from more than 40 European countries and represents the largest trans-national research project on adolescent substance use in the world aims to systematically collect comparable data on substance use among students aged 15-16 years in as many European countries as possible.

According to ESPAD (2011), the volume of alcohol consumed by Italian students (15-16 years old) on the latest drinking day is below the ESPAD average, and the proportion reporting heavy episodic drinking in the past 30 days is lower as well. On the other hand, higher proportions of the students in Italy reported that they had used alcohol and cigarettes during the past 30 days. The Italian students also more commonly reported lifetime use of cannabis and non-prescribed use of sedatives and tranquillisers. Overall, though, the Italian differences from the ESPAD average are not striking. Apart from this, it can be concluded that Italy is relatively well in line with the average ESPAD country (2011).

Italian 2012 data shows that more than a third of the students (15-19 years old) also admitted to binge drinking. The majority refers to one or two episodes per month (60% of males and 68% of females), but more than a fifth repeats this experience from three to five times. The highest binge-drinking rate is among residents in northern Italy. Compared with the 2011 study, the data remains constant whilst the geographical location of these particular consumers changes. Trentino Alto Adige and Veneto remain stable, while Sardinia stands out from the totality of regions with numbers above the national average.

To the question "At what age did you try drugs for the first time?" the majority of respondents answered "between fourteen and fifteen." Over 52% of students to whom these were prescribed at least once, then continued to take them without medical supervision. Unlike all other psychoactive substances, the consumption of these drugs is more frequent among females. The most used are sleeping pills (7% of girls and 3.6% of boys), followed by dieting drugs (3.4% of girls and 1.6% of boys). Least common are those intended to intervene on issues related to mood (ESPAD, 2012).

In the context of this JA, the existence of a mental health strategy exclusively targeting children and adolescents was analysed, in the different countries.

Since the end of the 90's , the Italian Ministry of Education and Research has foreseen as general objective of the public education system the attainment of several key-competencies of life-long learning. Such competencies are in line with the recommendations defined by the European Parliament of 18 December 2006, as follows:

- Communication in the mother-tongue;
- Communication in foreign language;
- Mathematical competence and basic competences in science and technology;
- Digital expertise;
- Learning to learn;
- Social and civic competencies: personal, interpersonal and inter-cultural competencies, and active social inter-action;
- Sense of initiative and entrepreneurship: to translate ideas into actions;
- Cultural awareness and expression: the importance of expressing ideas, experiences and emotions in a large variety of communication media.

Key competences thus meet, through the ordinariness of the vertical development of the school curriculum from childhood to upper secondary degree, the psychosocial skills whose lack can lead to taking on negative personal manifestations (Possamai, 2013).

The "Piano di azioni nazionale per la salute mentale (PANSM)" (National Mental Health Action Plan, 2013) includes a specific section dedicated to children and adolescents that defines the objectives to be achieved, the actions to be implemented and the indicators to be used to verify the results.

The Italian partner which contributed to the thematic area of "mental health and school" in the present Joint Action is the "Mental Health Sector, Health Programmes Implementation Unit, Veneto Region" through the Veneto Region Coordination Centre for European Project Management (CReMPE-AOUI Verona) and its main areas of interest and activities are:

- guarantee of equal minimum standard of mental health services to all citizens living in the Region,
- Guidance, planning, coordination, monitoring and evaluation of all mental health services run by the Local Health Authorities, including both hospital and community-based services and aiming at the integration between social and health services

The Veneto Region Mental Health Sector is also involved in health care in penitentiaries, a duty transferred from the Judiciary Administration to the Health sector since 2008, which includes health care of prisoners, the closure of Judicial Psychiatric Hospitals and the community-based care of drug-addict and/or psycho-social distressed minors and young adults.

3.7.2 Mental Health services for children and adolescents

Components of promotion of mental health and prevention of mental disorders are integrated in national legislation and various policies. With respect to this analysis, the most relevant components are presented below:

- ***Law No. 180 of 1978 on Mental Health, as implemented by Law No. 833 of 1978 establishing the National Health System (arts. 33, 34, 35, 64).*** *Its main goal has been to warrant that psychiatric patients are treated adequately while preserving their dignity, recognizing and protecting their rights. To this purpose, it established four principal components: a) the gradual phasing out of Mental Hospitals through the cessation of all new admissions; b) the establishment of General Hospital Psychiatric Units for acute admissions; c) more restrictive criteria and administrative procedures for compulsory admissions; d) the setting up of Community Mental Health Centres.*
- ***The Target Project "Mental Health Protection 1998-2000"*** *(still in force): As part of a systematic reorganisation of services assigned to mental health care, it also envisages the establishment of the Departments of Mental Health*
- ***The Mother and Child Project*** *(under the National Health Plan 1998-2000): the prevention, diagnosis and treatment of neurological and psychological pathologies in developmental age*
- *In 2004, the* ***National Centre for Disease Prevention and Control*** *(Ccm) was created, a coordination organism between the Ministry of Health and the Regions for surveillance, prevention and timely response to emergencies; it is involved in research, funding and monitoring prevention projects*
- ***Mental Health National Guidelines (2008)*** *state that the community-based services addressing children and adolescents are affected by the diversity of models and deadlines the different Regions have in their activities. The Strategy recognises the importance of the mental health as an essential element for children's health, in particular:*
  - *Involvement of the family in the implementation of programmes for primary prevention of mental disorders and promotion of mental health from infancy and primary school age;*

- *Dealing with the topic of emergencies related to mental disorders during adolescence;*
- *Improving the collaboration and coordination between child neuropsychiatric services, mental health departments and general paediatric care networks;*
- *Reviewing the essential levels of care in the mental health for children and adolescents.*

- ***The 2011 National Prevention Plan*** *for the first time includes mental health which was then confirmed and reinforced by the National Action Plan for Mental Health (PANSM).*
- *The* ***National Action Plan for Mental Health 2013****, approved by the Joint Conference, identifies strategies, objectives and specific actions in the area of childhood and adolescence mental disorders:*
  - *Multi-disciplinary teams shall be involved in the interventions;*
  - *The long term monitoring of the development shall be much more frequent (screening in schools) and the rehabilitation is an essential component in the process of treatment;*
  - *The family and school are actively involved together with the education and social contexts.*

Under Italy's National Health Service (Servizio Sanitario Nazionale (SSN), founded in 1978, the organisation and provision of health care is a regional responsibility. Like other regions, the Veneto Region is linked to the national government via the Standing Conference of the State and the Regions and Autonomous Provinces, known in short as the State-Regions Conference (Conferenza Stato-Regioni). The Regional Health and Social Care Plan establishes the objectives for the health system, which also reflects the priorities and requirements laid out in the National Health Plan, and the agreements reached at the State-Regions Conference.

As highlighted in the Objective Project 1998-2000, health care is provided by the public sector or by the accredited and authorized private sector according to regulations in force for the public service. The integration and close cooperation between the various mental health services were two factors with a high priority.

The SSN covers the whole population and regions must provide a nationally defined basic level of care (i.e., a health benefit package to which each Region may add supplementary services) to all of their residents; this is known as the essential levels of care (*livelli essenziali di assistenza, LEA*).

The National Plan on Mental Health foresees that treatment shall be provided by both specialised mental health services (mental health departments for adults and the services for neuro-psychiatric disorders of children and adolescents) integrating also the health, social and education of services.

In Veneto Region, the Departments dealing with neuropsychiatric disorders, psychological and psycho-social disorders of children and adolescents have different titles and organisational models in the regional Local Health and Social Care Units (ULSS). However, they are usually part of the "General Operational Units" (*Unità Operativa Complessa - U.O.C*) for children, adolescents and families, that include also Family Counselling, and in some cases Community-based Paediatrics as part of the network of other social and health care services and collaborating with the community based social and education agencies.

No financial data specifically focusing on the mental health services of children and adolescents are available. However, in Italy, 5% of the total health budget is spent on Mental Health, and 8.7% of the GDP is spent for health in general (EC, 2013).

Funds are allocated by the State from the general health budget, but the allocation for specific sectors, such as mental health, is done at regional level, with a wide variability in percentages (WHO, 2011).

Concerning the workforce, in 2011 the number of professionals working in the mental health services was as follows:

PROFESSION	NUMBERS OF PROFESSIONALS/100 000 INHABITANTS
Psychiatrists	7.8
Nurses	19.3
Psychologists	2.6
Social workers	1.9
Occupational Therapists	2.2

Source: Mental Health Atlas, 2011

Concerning Veneto Region, in 2012, the workforce dedicated to Mental Health of children and adolescents (under 18 years of age) was 8.4 professionals every 10 000 minors. Out of these professionals, the psychologists were of 1.7 every 10 000 minors (around 20% of the professionals) (from: *www.regione.veneto.it/salutementale*).

The Regions have the main responsibility for organising programmes within the national strategies of prevention and promotion of mental health and they implement a large number of local programmes. The **prevention of mental disorders** is expected to be performed by the Local Health Units and by the professionals of the **mental health services**, also in collaboration with other institutions (for example schools) or **NGOs (for example Cooperatives and Associations).**

It should also be pointed out that in Italy Local Health Units have **Prevention Departments which collaborate with various specific sectors for formulating and implementing preventive programmes. In the Veneto Region,** this department includes a specific service for **Prevention and Health Promotion *(SEPS-Servizio di Educazione e Promozione della Salute-Health Education and Promotion Service)*,** cooperating with both health services and education sector for the implementation of projects targeting children and adolescents (EC, 2013).

3.7.3 Social Services for children and adolescents

With regard to the current legislation and policies concerning the social services for children and adolescents in Italy, the most relevant elements are:

The most recent national laws governing social services are:

- ***Law 23rd December 1978, No. 833, "Establishment of the National Health Service".*** *It started the process of integrating social and health care nationwide.*
- ***Legislative Decree 30th December 1992, No. 502 "Reorganisation of the regulations on health in accordance with Article 1 of Law 23rd October 1992, No. 421"****. It determines the final regionalization of the National Health Service and the corporatization of local health units. It strengthens the process of integrating social and health care.*
- ***Legislative Decree 31st March 1998, No. 112, "Transfer of State administrative functions and duties to the Regions and Local Authorities thereby implementing the first clause of Law No. 59 of 15th March 1997"****. It establishes the integration of social and health care and defines the powers of the regions and municipalities.*
- ***Legislative Decree 19th June 1999, No. 229, "Rules for the rationalization of the National Health Service, in accordance with Article 1 of the Law of 30th November 1998, No. 419"****. It defines and divides performances into three according to the entity's jurisdiction: health care activities of social relevance (ASL competence and to their charge), health and social activities with healthcare significance (responsibility of the municipalities) and health and social activities with high healthcare integration (responsibility of Local Health and Social Care Units-ULSS paid by the national health fund).*
- ***Law 8 November 2000, No. 328, "Outline Law for implementing the integrated system of interventions and social services"****. It determines the structure of the planning and the legitimacy of the principle of subsidiarity through the introduction of the national, regional and local plans, as connection tools for different institutional levels, subjects and areas of social and health care.*

The following are the most important regional laws of the Veneto Region:

- ***Regional Outline Law 15 December 1982, No. 55 "Standards for exercising duties in the field of social work"****. It integrates social services with the totality of existing health services in order to reach a coordinated operation throughout the territory (expansion of the welfare state). It represents a "milestone" of the Veneto Region's socio-sanitary integration and regulates the actions to be implemented in the social care sector. Services that require greater social care integration are delegated to the Local Health Authorities.*
- ***Regional Law 14 September 1994, No. 56 "Rules and principles for the reorganisation of the regional health service"****. It envisages the adoption of regional socio-health planning as an instrument to organise the social and health care services and establishes the local plan for planning health and social services throughout the territory.*

The institutional and organisational structure of the Social Services in Italy is as follows:

- The State has the role of regulation and coordination;
- The Region has the role of programming, coordination and verification;
- The Province gathers information and collaborates to programming;

- The Municipality, as the responsible body for the administrative issues at local level, collaborates to the regional programming, provides services, promotes the collaboration of different parties for the development of interventions of self-help and the collaboration between citizens.

The **National Fund for Social Policies** (FNPS), established by Law 449/1997 (Finance Act 1998), contains the resources that the state allocates annually with the Finance Law for the promotion and achievement of social policy objectives. The Outline law for implementing the integrated system of interventions and social services (Law 328/2000) has outlined a comprehensive system of Regional Social Plans and Area Social Plans describing, for each territory, an integrated network of social services and socio-health services funded through the FNPS. Some recent regulatory measures have reduced interventions financed from the Fund. In particular, resources for the Fund for Childhood and Adolescence - established by Law 285/1997 - initially allocated to FNPS, have now been determined by the Finance Act since 2008, as concerns the resources allocated for financing interventions in the 15 ranked Municipalities indicated by the establishing law. The remaining resources of the National Fund for childhood and adolescence flow into FNPS. As regards the amounts allocated to financing operations which constitute subjective rights (family allowances for family units with three minors, for maternity, facilities for disabled and thalassemia affected workers), the 2010 Finance Act decreed they must be financed according to specific item costs budgeted by the Ministry of Labour and Social Policy.

The FNPS resources which are allocated annually to the regions, autonomous provinces, municipalities and the Ministry of Labour and Social Policy in agreement with the State-Regions Conference, are assigned through an inter-ministerial decree by the Ministry of Labour and Social Policy and the Ministry of Economy and Finance.

The Stability Law for **2011** (Law 220/2010) has earmarked EUR 273.8 million for Social Policies, to be divided between the regions and the Ministry of Labour and Social Policy. With the Inter-ministerial Decree of 17th June 2011, **218 million euro** were allocated, of which 39.5 million euro to the Ministry of Labour and Social Policy. The Stability Law for **2012** (Law 183/2011) allocated **69 954 000** euro to FNPS. The Decree of 16th November 2012 has allocated financial resources actually relating to the Fund, amounting to **EUR 42 908 611**, allocating EUR 32 033 310 to the Ministry of Labour and Social Policy. Finally, the **Stability Law for 2013** (Law 228/2012), with Article 1, **paragraph 271, increases the FNPS allocation by 300 million euro for the year 2013.** Consequently, the budget chapter (3671) of the allocated Fund with the Ministry of Labour and Social Policies has **344 178 000** euro for 2013.

As for the “work force” used in the context of Social Services, the relevant professional categories are as follows:

- Social worker
- Psychologist / psychotherapist
- Child psychiatrist
- Educator / facilitator
- Other professionals on a project basis for specific interventions and always in accordance with the requirements and standards set by sector rules.

With regard to the regional operational reality, the jurisdiction relating to social services is by law allocated to the Municipalities (579). Municipalities may delegate duties and powers (as provided by law) to Local Health and Social Care Units (ULSS). The services within ULSS delivering social and social and health care are:

- Family counselling centres
- Protection services / teams

- Services for children and adolescents

Social workers and psychologists take on a role of primary importance in the family counselling clinics of the 21 Local Socio-Health Units of the Veneto Region: provide support during the implementation of promotional activities, including providing psychological support to individuals, couples and families.

Family counselling centres have spaces for teenagers / young people, which girls and boys (singles, couples or groups) can access freely and at no price for psychological and social counselling as well as for health services concerning emotional life and relationships, sexuality, contraception and prevention of risky behaviour.

The professionals organised in structured teams (gynaecologist, psychologist, midwife / nurse / health and social worker) have specific training to welcome young people and respond to their needs, ensuring confidentiality both for minors and adults. The *Spazi Adolescenti/Giovani* (Centers for Adolescents/ Youngs), in collaboration with other departments of the Local Health Units of the Veneto Region, with organisations and public and private local institutions (Municipalities, Schools, Vocational training courses, Sports and recreational centres of aggregation, Associations, etc.) implement health education projects for young people and adults (teachers, parents, educators, sports coaches, etc.). The projects offered mainly concern: relationships and socio-emotional education, sex education and the prevention of sexually transmitted diseases, the prevention of substance use.

The table below contains 2012 data concerning the staffing of public Family Counselling Centres in the Veneto Region with 108 public and 27 private/authorized offices:

JOB PROFILE	N° OF WORKERS
Office worker	23
Health assistant	15
Social worker	160
Legal consultant	4
Manager (Director of Social Services excluded)	5
Educator/Entertainer	51
Gynaecologist	93
Professional Nurse	53
Midwife	118
Pedagogue	2
Psychologist	173
Not determined	9
Total	706

Social workers and psychologists represent the majority of employees. In addition, the educator has an important role, especially in the context of promotion / prevention activities in support of individual patients and their families.

The social workers attend to individuals, families, groups, community and the different social groups contributing to their development. They nurture the autonomy, subjectivity, the capacity of taking responsibilities of the individuals. Moreover, they support the individuals in the use of their own and the society's resources to prevent and tackle the situations of need or distress and promote any initiative to reduce the risks of exclusion (art 6 of the Code of conduct of the social worker – 2009, La Direzione del sociale nel welfare regionale. Regione del Veneto).

As regards "Responsibility", this refers to the State and Region as subjects in charge of programming health promotion and prevention interventions.

As regards the “provision of services”, this refers to Provinces, Municipalities, local health authorities, and private social subjects.

The State defines the general objectives of the social policies and the minimum requirements of social assistance. The Department for social policies and social protection of the Ministry of Welfare, in agreement with the interested ministries (Health and Economy, first) defines the indications for programmes of social policies of the Government, coordinates the social interventions and verifies the activities of the Regions.

The Regions have the role of programming, coordination and orientation of the social policies, integrating them with the health, education, recreational and working policies. They are also responsible for the evaluation of the efficiency and effectiveness of the services offered.

The Provinces are responsible for the collection and distribution of data on available and required resources; for the analysis of the available services; for the promotion of training initiatives. Furthermore, the Provinces collaborate on the definition and implementation of the Area Plans

The Municipalities are the main body responsible for social assistance and have the obligation to pay the social services. They can directly manage these activities or delegate them to other entities, although ultimately they are responsible. They are also in charge of: programming, planning and implementing the local network of social services; providing financial subsidies and other support services; authorising, certifying and supervising the social services; evaluating the efficiency, effectiveness and the results of these services. Together with other entities (Province, Local health trusts and tertiary sector), the Municipalities negotiate, elaborate and approve the Area Plans.

The Organisations and other non-profit entities can offer and manage those services that are not offered by the public entities, addressing the population in need. The Regions have to establish the necessary requirements for the offered services and have to check the quality of the activities, also through the constitution of regional registries of organisations authorised to offer social support services.

3.7.4 The Education system for children and adolescents

The essential documents concerning the educational sector in Italy are:

The Italian Constitution of 1 January 1948 dedicates the following articles to the education sector:

- ***Art. 3*** *All citizens have equal social dignity and are equal before the law, without distinction of sex, race, language, religion, political opinion, personal and social conditions. It is the duty of the Republic to remove those obstacles of an economic and social nature which by constraining the freedom and equality of citizens, prevent the full development of the human person and the effective participation of all workers in the political, economic and social life of the Nation.*
- ***Art.9*** *The State promotes culture and scientific research and technology.*
- ***Art. 33*** *Education is free of charge. The State draws-up the general norms on education and creates public schools of all grades. Public and private entities have the right to establish a school or education institute, without any cost for the State. The law governing the rights and obligations of the private schools, applying for the statute of equal to state schools (paritarie schools) has to ensure them the maximum independence and guarantee to pupils the same treatment of pupils who attend State schools.*
  The law foresees a national examination for admission to various schools and grades or an exam for graduation and entrance into labour market. The universities and academies have the right to have an autonomous system in the limits imposed by the State.
- ***Art. 34****: Everybody can enrol in a school. The compulsory school shall last at least 8 years and is free of charge. The school is available for everybody independent of their economic background and the State can contribute with scholarships, family allowance and other benefits on the ground of a ranking.*
- ***Art. 117*** *regulates the responsibilities of the State and of the Regions in accordance also with the EU and International legislations. The State has the exclusive role of providing, among other regulations, also the norms ruling the education system. The Regions have the role of complementing the legislation where the State does not have the exclusive role.*

Main laws governing the education system:

- ***Law n°104/92 (articles 8-14 and 15)*** *recognises and safeguards the participation of disabled persons, especially in the fundamental areas such as the school (during the infancy and adolescence) and the labour market (during the adulthood). The rights of the disabled students are contemplated in the principle of an inclusive education to which the State contributes with measures at national level and to which the local entities and the National Health System contribute at local level.*
- ***Guidelines for the inclusion of students with disabilities (2009).***
- ***Law No. 170*** *of 8th October 2010 on specific learning disabilities, referred to as "LD".*
- ***Ministerial Circular No. 8 of 6th March 2013*** *- Practical Guidelines concerning the ministerial directive of December 27th, 2012 entitled "Instruments of intervention for pupils with special educational needs (SEN) and local organisation for school inclusion."*
- ***Law n°59*** *of 15 March 1997: The education institutes have autonomous regime of organisation, teaching, and research and Presidential Decree 275/99, Regulations for the Autonomy of educational institutions.*

- ***Law n° 62, art 1*** *of 10 March 2000 "The national education system, as foreseen by the Constitution, includes the public and private (paritarie) schools and institutes".*
- ***Law n°53/2003, art 2 lett. d****: "The education and training system includes pre-primary schools, a first cycle composed of primary and secondary schools of first grade and a second cycle composed of high schools and professional schools and institutes".*
- ***Ministerial Decree 139/07*** *on extension of the length of compulsory education and relative technical guidance document.*
- ***Decree n°139*** *of 22 August 2007 establishing that the compulsory education shall last 10 years as to obtain a certificate of completion of the secondary school of second grade or a professional qualification upon completion of at least 3 years of instruction and within the age of the student of 18 years"*
- ***Decree n°87*** *of 15 March 2010 regulating the new organisation of vocational institutes,* ***Decree n°88*** *of 15 March 2010 rearranging the technical institutes and* ***Decree n°89 of 15 March 2010*** *regulating the reorganisation of general upper secondary institutes*
- ***State-Regions Conference Agreement of 29th April 2010, of 27th July 2011 and 19th January 2012*** *concerning vocational education and training.*
- ***Agreement in Unified Conference of 16th December 2010****, concerning vocational education and training.*
- ***National Guidelines for the curriculum in pre-primary school and first cycle of education of 5th September 2012.***

In Italy, the education and training system is organised based on the subsidiarity and autonomy principles of the scholastic institutes (Presidential Decree 275/1999).

The State is responsible for the tasks and functions which concern the criteria and parameters for the general organisation of the education system, the legal status of school staff, the evaluation of the school system, the determination and allocation of financial resources debited to the State budget and the allocation of staff to schools (till Regions will have their own regulations and instruments to carry out this function themselves); planning of research institutions and interventions in the university system; issue of general regulations, evaluation and financing of both the university and High level arts and music education (Afam) institutions; foreign schools and cultural institutions in Italy.

The Regions, through their relevant education offices, carry out: the planning of the integrated training offer (a combination of education and vocational training), the planning of the school network on the basis of provincial plans, fixing of the school calendar, the contributions to non-State schools, the planning, management and offer of vocational training courses through accredited agencies. However, Regions always work in collaboration with the State (Ministry of education, university and research and Ministry of Labour and Social Policy) through the Regional School Offices (*Ufficio Scolastico Regionale - USR)* also through the State/Regions unified Conference.

At local level, **Provinces and Communes** are entrusted with the following specific functions, respectively for the upper secondary level and the lower levels of school education: establishment, aggregation, merging and closing down of schools, or sizing and rationalization of the school network.

Schools have important administrative and managing functions, as well as high responsibility tasks such as the definition of curricula, the widening of the educational offer, the organisation of teaching (school time and groups of pupils, etc.), within the general frame applied at national level (DPR 275/1999).

As far as higher education is concerned, both universities and High level arts and music education (Afam) institutions have statutory, regulatory, teaching and organisational autonomy (DM 509/1999, law 508/1999 and law 240/2010). (Retrieved from: *https://webgate.ec.europa.eu/fpfis/mwikis/eurydice/index.php/Italy:Organisation_and_Governance)*

With regard to the financial resources that are dedicated to the Education System addressing children and adolescents, the situation in 2011 in Italy was as follows:

Expenditure in education

TOTAL GOVERNMENT EXPENDITURE IN EDUCATION	%
As % of GDP	4.29
As % of total government expenditure	8.62

Source: UNESCO, UIS.Stat

Concerning human resources employed in this sector, in 2007, the situation was as in the table below:

Teachers in Italy per level of education

LEVEL OF EDUCATION	TOTAL NUMBER OF TEACHERS
ISCED 0	142 212
ISCED 1	273 113
ISCED 2	190 740
ISCED 3	260 017
ISCED 4	n/a

Source: UNESCO, UIS.Stat

Thanks to the autonomy given by DPR 275/99, even outside school hours, the education institutes organise educational and informative and prevention projects in collaboration with the local entities, that include also ULSS, the universities, local entities and associations or agencies, or with associations of voluntaries or private social organisations.

These projects are part of the Plan for the Educational Offer (*Piano dell'Offerta Formativa - POF*) which represents the fundamental cultural and planning identity of a school. The POF is drawn-up by the Teachers Assembly on the basis of the general directives given by the School Council (*Consiglio di circolo/istituto*) and taking into consideration the opinions of the bodies and of the parents' associations. As for the secondary school level, in particular, the POF is also prepared by the students whose participation and representation is regulated by Presidential Decree. No. 235, a regulation that makes changes and additions to the DPR June 24th, 1998, No. 249, concerning the Statute of female and male secondary school students. The school, in its autonomy, calls for representation by different members of the school community, including parents and students who sign the Joint Responsibility Agreement "at the moment of enrolment in the single educational institution" (art. 5 bis, paragraph 1).

3.7.5 Cooperation between sectors

The Law 285 of 28 August 1997 “Instructions for the promotion of the rights and opportunities for children and adolescents”:

1. regulates the creation of the National Fund for children and adolescents for the realisation of interventions at national, regional and local levels for the promotion of rights, of quality of life, of development, of empowerment of individuals and children and adolescents social skills, giving priority to their proper environment i.e., their own family, or foster or adoptive family, in accordance with the principles of the Convention on the rights of children,

2. transfers the emphasis from guardianship and intervention in difficult evident situations to the promotion of health and well-being of children,

3. introduces the term of “participative project” where potentially interested actors belonging to different sectors can collaborate on the creation of new initiatives, “forcing”, for the first time, the institutional (and non-institutional) parties to coordinate among themselves for the presentation of projects that will have then the advantage of being financed as they include wide partnerships.

Concerning Veneto Region, Area Plans have been established as the primary instrument to integrate and deliver the network of health and social services. These plans are fundamental planning instruments. They aim to coordinate public and private services within the same district in order to meet population needs and to guarantee high-quality services.

The same legislation established a new financial instrument, the Regional Fund for Social Policies that collects the national funds earmarked to the Region for its social services as well as the Veneto Region’s own funds for this purpose.

The Veneto Region prepares its Regional Development Plan on the basis of a model where all policies are compared and coordinated. The Regional Development Plan is a region-wide strategic plan that coordinates various policy areas including health and social care, education, environment, transport, etc. The Regional Health and Social Care Plan represents one of the characteristic elements of the Regional Development Plan. In particular, the Veneto model envisages a strong integration between health and social policies.

Policy interventions must address new needs that emerge from the region’s complex social pattern, delivering health and social services efficiently. Priority areas include: increasing birth rates; support for mothers; infant and family services; development of social services for the elderly; measures to help working women, minors and young people; prevention and recovery services for drug addicts; and supporting innovation (Toniolo, Mantoan & Maresco, 2012).

An example of effective collaboration between the three sectors under the national project “Gaining health”, is the project carried out during the 2011-12 school year by the Regional School Office of the Veneto Region, the Veneto Region and the Local Health and Social Care Unit No. 9 of Treviso, which provides for joint training of Veneto health operators and teachers belonging to an institute of the first cycle of the same Local Health and Social Care Unit.

About 60 operators from 16 Local Health and Social Care Units of the Region, located in six provinces, and more than 70 teachers from 18 schools of the first cycle belonging to the territory of each Local Health and Social Care Unit have been involved.

The purpose of the initiative was to spread education by competences, referring in particular to European key competences, in order to build curricula and teaching practices able to provide students with not just knowledge and skills, but also and mainly to train future autonomous, responsible, and resilient citizens.

With regard to cross-sectoral cooperation, the local experts identified the strengths and weaknesses listed below:

Strengths and weaknesses in cross-sectoral cooperation in Italy

STRENGTHS	WEAKNESSES
The existence of a legal framework increases the effectiveness of interventions targeting common goals	No common procedures for planning and programming as well as timelines of the three sectors; different terminology
Optimum use of limited available resources	The need for cross-sectoral training of professionals from different sectors on specific prevention skills, for the early diagnosis of mental disorders

3.7.6 Selected examples of good practice

GOOD PRACTICE IN MENTAL HEALTH PROMOTION

"Setting goals and problem solving. Self-help manual for the promotion of mental health, psychological well-being and emotional intelligence in the school", 2009

This is a national program based on the belief that, in order to improve the mental health of children and adolescents, and perhaps even their physical health, it is important to improve their ability to address and solve problems and achieve goals, so that they can cope with the difficulties of life with less stress and hence be able to take control of their life. The project sees the cooperation between the health care and education sectors.

The manual is applicable mainly in high schools focusing on the promotion of mental health in young students through a phase of achievement or improvement of the capacity to define realistic goals, to address and solve problems, to communicate effectively and assertively, to develop self-discipline, to negotiate and cooperate, to control impulses. The manual includes theoretical and practical contributions related to each individual capacity, as well as a number of operating modules mainly to be used in groups of two, three in order to have a greater impact on more students and stimulate their creativity and mood.

http://www.ccm-network.it/documenti_Ccm/prg_area5/2005-manuale-scuola-depressione.pdf

GOOD PRACTICE IN MENTAL DISORDERS PREVENTION

"Against school drop-out: From drop-out to drop-in", Lazio Region, 2012

School drop-out in secondary schools reaches high percentages (30%). The Lisbon strategy states that, by 2020, the percentage of early leavers from education and training should be less than 10%. International literature identifies three categories of risk factors for early school leaving: 1) Academic risk; 2) Socio-cultural risk; 3) Behavioral risk.

The project aims to identify students who are at risk of early school leaving and drop-out; analyze environmental and individual determinants; deliver training in order to identify and support the strategies adopted by the students "at risk" themselves to avoid school drop-out; improve self-knowledge at individual and social level; select innovative practical approaches to enhance motivation for school attendance; strengthen students' protective factors; identify factors that lead to successful/ unsuccessful interventions.

The activities covered were: 1. Baseline evaluation of subjects using FOCUS 13 questionnaire; 2. Teachers training; 3. Training on motivational aspects; 4. Process and final evaluation of the intervention; 5. Project Monitoring: data on recovery of students at risk of disease or school drop-out; model of good practices; promotion of positive attitudes towards the Educational Institution.

The main results of the assessment were expressed by the efficacy indicator, i.e. the number of students recovered and the number of the ones not recovered. During academic year 2011/2012, 28 students at risk for drop-out were identified. Among these, 19 students were recovered while 9 were not recovered.

Bollettino OPV Lazio - http://www.ordinepsicologilazio.it/binary/ordine_psicologi/h_notiziario_psicologi/2013.12.19_Notiziario_n._1_2013.1387450564.pdf

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3.8 MALTA

3.8.1 Overview

Malta, which comprises an archipelago of five islands (Malta, Gozo, Comino, Cominotto and Filfla) is situated in the Mediterranean Sea, 80 km south of Sicily, and 284 km east of Tunisia.

According to 2013 figures, it has 421 364 inhabitants. The capital is La Valletta, with 5 748 inhabitants, of which 760 are under 16 years.

The surface area of Malta is of 316 km^2, with a population density of 1 333 inhabitants per km^2.

The average age of population is 39.3 years (men) and 41.5 years (women), and life expectancy at birth is 80.1, 78.0 years for men and 82.2 years for women.

Gross domestic product per capita in 2012 was EUR 19 403.

The school-aged population in Malta is divided as follows:

Maltese school aged population

AGE GROUPS	TOTAL	MALES	FEMALES
0-4	20 061	10 347	9 714
5-9	19 419	9 971	9 448
10-14	22 248	11 355	10 893
15-19	26 182	13 509	12 673

Source: Malta Census – 2011 National Office of Statistics

With regard to the level of education of pupils, data as of 2012 was distributed as follows:

Maltese level of education

LEVEL OF EDUCATION	NUMBER OF STUDENTS
ISCED 0	9 127
ISCED 1	23 567
ISCED 2	13 911
ISCED 3	17 857
ISCED 4	2 327

Source: UNESCO, UIS.Stat

In the school year 2011 the situation concerning school attainment was as follows:

Educational attainment of population aged 25 years and older in Malta

LEVEL OF EDUCATION	% OF STUDENTS		
	Males-Females	**Males**	**Females**
ISCED 1	24.9	20.4	29.3
ISCED 2	40.9	41.5	40.3
ISCED 3	10.0	10.3	9.7
ISCED 4	8.4	12.0	5.0

Source: UNESCO, UIS.Stat

As regards the numbers of students dropping-out from schools in Malta, the rates to the last grade per level of education, were as follows:

Drop-out rates to the last grade per level of education in Malta

	% OF STUDENTS
Drop-out rate to the last grade of primary education (2011)	5.53651
Drop-out rate to the last grade of general lower-secondary education	18.55923*

Source: UNESCO, UIS.Stat
*data of 2010

In 2012, there were 215 early school leavers from primary school (UNESCO, 2012).

In addition, the following statistics on educational attainment and drop-out rates were obtained from Eurostat (2012):

- The percentage of population aged 18-24 years, classified as early leavers from education/training (ISCED 0, 1, 2 or 3c short) was 22.6%;
- The percentage of 18 year olds who are still in education was 58.2%;
- The percentage of population aged 20-24 years having completed at least upper secondary education (ISCED 3c, 3b or 3c long) was 73.6%;
- The percentage of population aged 30- 34 years who have attained tertiary education (ISCED 5 to 6) was 22.4%.

Concerning the mental health status of children and adolescents in this country, there is limited epidemiological data available in Malta.

The European Health Interview Survey (Eurostat, 2008, Directorate of Health Information & Research, Ministry of Health, HIS), gives some data on the prevalence of mental disorders in the Maltese population. However, as the study population consisted of 5 500 persons aged 15 years and over, data cannot be inferred specifically to this age group as the analysis was not age segregated.

A Master's in Public Health dissertation on the prevalence of depression in children aged 13 – 14 years indicated that about 22% of this age cohort had signs of depression (Sammut, 2007, MSc - Public Health thesis).

In the context of this JA, the existence of a mental health strategy exclusively targeting children and adolescents was analysed, in the different countries.

Malta reports that, at the moment of report writing, there is no formulated strategy on mental health for children and adolescents, though services for such client groups exist.

The current government is giving a priority to this sector and it is envisaged that in the near future such a strategy will be formulated involving all key stakeholders.

The Maltese partner which contributed to the thematic area of "mental health and school" in the present Joint Action is the **Ministry of Health of Malta (MHEC),** and its main areas of interest and activities are:

1. Enhancing value for money across the sector through the implementation of sound management structures that foster accountability for resource utilisation and outcomes.

2. The operational re-engineering of services to provide a seamless, personalised and holistic care to this client group.

In addition, the Ministry of Health is in charge of mental health promotion and prevention in children, adolescents and at the workplace, and of epidemiological research.

3.8.2 Mental Health services for children and adolescents

There is no specific policy in Malta concerning mental health services for children and adolescents. However, such service provision form part of the comprehensive mental health policy document – **"National Policy on Mental Health Service"** published in **1995.**

The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation, and the policy strives to create healthy environments in family, school, workplace and community. It also aims to offer a range of appropriate services to empower people to cope better with mental health issues. The national health policy **"Health Vision 2000"**, (Department of Health, Policy and Planning, 1996) also **identified mental health as one of the priority areas for resource allocation.**

With respect to this analysis, the most relevant components are presented below:

- *The Mental Health Act 2012: it is a comprehensive legislation that concerns all age groups. It regulates the provision of mental health services, care and rehabilitation whilst promoting and upholding the rights of persons suffering from a mental disorder.*

  The main objectives of the Act are to:

  1. Focus on the well-being of clients (client centred)

  2. Promote the rights of clients and their carers

  3. Promotes multidisciplinary care in a holistic and personalised modality

  4. Promotes effective treatment in the shortest possible time

  5. Promotes professional accountability

  6. Introduce checks and balances to minimise abuse of this client group

  7. Promotes socio-economic integration

  With respect to minors (<18 years), the length of involuntary treatment in hospital is up to four weeks which can be renewed if there are solid medical reasons for such an extension. The Act prohibits certain interventions, clinical trials or scientific research on minors.

  The Act allows the minor to give informed consent for treatment, if in the opinion of the responsible specialist the minor is mature enough to give such consent.

Mental Health services for children and adolescents include **inpatient and outpatient services.** The latter include the **Child Guidance Clinic and the Child Development Assessment Unit.** These services are part of the mental health services which in turn form part of an integrated healthcare system provided in the public sector.

Services required from other specialities are provided through a referral system.

Within the hospital sector, the child/adolescent services are also linked to the educational sector to ensure that schooling is maintained for the benefit of these patients.

Specific data concerning financing and workforce dedicated to mental health of children and adolescents are not available for this Country.

The planning, financing and implementation of any health promotion or disease prevention programme are the responsibility of the Directorate for Health Promotion within the Ministry for Health.

Due to **lack of resources**, this Directorate has not as yet implemented any sustainable programmes to promote mental well-being in this age group.

The **NGOs** working in the mental health sector, in particular the **Mental Health Association** and the **Richmond Foundation** have implemented ongoing health promotion programmes in primary and secondary schools to increase awareness on mental health issues and to address the stigma of mental health problems.

3.8.3 Social Services for children and adolescents

With regard to the current legislation and policies concerning the social services for children and adolescents in Malta, it is somewhat limited as such services are provided by administrative decisions. The most relevant elements are:

- *The Children and Young Persons (Care Orders) Act, which makes provision for the care of children and young persons in situations of neglect or abuse.*
  The Child Protection Services investigate referrals from various sources such as schools, police, medical doctors, other professionals and the general public. Social workers carry out investigations and assessments whenever there are allegations that a child is suffering, or is at risk of suffering, from significant harm resulting from physical, sexual, emotional abuse and/or neglect. The Office of the Commissioner for Children, set up in terms of the Commissioner for Children Act of 2003, promotes the welfare of children and the compliance with the UN Convention on the Rights of the Child, as ratified by Malta on the 26th of January 1990.
- *There is a "National Children's Policy" which is still in draft form. The aim of the policy is to promote children's well-being, rights and obligations, protection, active participation, inclusion, creativity and leisure.*
  The principles underlining the policy centre across the concept of having focused programmes and actions, through a holistic and integrated approach.

Services for children and youth are not the domain of the health sector, and **are provided by:**

- **Appogg: a state agency within the Foundation for Social Welfare Services (Ministry for the Family and Social Solidarity).** Appoġġ, as the National Agency for children, families and the community, safeguards and promotes the well-being of these persons through the development and provision of psycho-social welfare services. **The Children & Young Persons Support Services, within this Agency,** offer a range of services for children and adolescents and their families who are facing some kind of difficulties in their life.

These services aim at providing intensive work with children, young people and their families, to promote their well-being, protect their rights and enhance their potential. With the involvement and participation of children/young people themselves, workers in this field develop care plans, take action to promote and protect children's rights, support and ensure that the well-being of children and young people is always given top most priority. **Services offered include:**

1. Freephone Helpline.

2. "Kellimni" – a joint programme with NGOs. This is a one to one online support service to children and adolescents who are suffering from social exclusion, abuse, neglect and/or psychological problems.

3. Court services – assist the Family Court in situations related to care and custody of minors in cases of separation or divorce. They also provide supervised access visits to minors when required.

4. Youth in Focus – This programme delivers a comprehensive service to promote the physical, emotional, social and spiritual well-being of adolescents with emotional/behavioral problem and/or who have an addiction problem.

5. Looked after Children Services – This provides social work services to children living away from their natural family either in residential or foster care.

All services provided by the Foundation have effective liaison with the healthcare sector, other public organisations, church institutions and NGOs.

Data on financing and workforce with regard to social services for children and adolescents are not available at the moment of report writing.

The government agency, SEDQA, within the Foundation of Social Welfare Services, is responsible for the planning, financing and implementation of strategies to address substance abuse in children and adolescents. Its' services range from health promotion and prevention mainly aimed at school children and adolescents to treatment and rehabilitation of persons with substance abuse problems and their families, so as to help them live a stable life and to integrate better in society.

NGOs and Caritas (church institution) also provide promotion and prevention services on substance abuse to children and adolescents.

Caritas also provides treatment and rehabilitation services to persons suffering from such conditions and support to their families.

3.8.4 The Education system for children and adolescents

The essential documents concerning the educational sector in Malta are:

- *The Education Act: it defines, inter-alia, the rights and obligations of students, parents, the State and NGOs (foremost the Catholic Church) in the sphere of education (Chapter 327, 1988).*

Various policies have been published in this sector by the Ministry responsible for education, amongst which are:

1. National Curriculum Framework, 2012

2. Attainment of Core Competencies in Primary Education – National Policy & Strategy (2009)

3. Career Guidance – Policy for Schools (Debono et al., 2007)

4. Early Childhood Education and Care – A National Policy (Sollars et al., 2006).

These policies were published by the Directorate for Quality & Standards in Education. The main objectives of such policies is to improve the quality of educational services whilst empowering students to attain their educational potential.

The Maltese educational institutions - State, private, and religious - provide a comprehensive educational system which caters for all requirements.
Education is free of charge from kindergarten to the tertiary level in public and church institutions.
Education is compulsory from age 5 to 16, but kindergarten classes are provided from the age of 3.
More than 54% of students continue with their education and training after the age of 16.
There is a **National Minimum Curriculum** set for all schools and there are National Minimum Conditions

to establish standards of hygiene, safety, dimensions of classrooms, and amenities.
The public school system is made up of various Colleges.
Each College is made up of a number of schools providing education from kindergarten to secondary level.
On completion of the compulsory school cycle, the students are encouraged to choose from about 50 different vocational and academic courses in the post-secondary sectors. These courses range from academic (as preparation for entry to University) to technical, tourism, secretarial, health care, nautical, agricultural, hairdressing, and beauty therapy.
Students in most of the post-secondary sector, besides being given free tuition, are also given non-refundable grants, monthly stipends and scholarships during their course of study.
The University of Malta, which has a four-hundred-year history, has a long tradition of scholarship and research in most disciplines. It awards degrees in various disciplines including Architecture and Civil Engineering, Arts, Management, Accountancy, Economics, Dentistry, Education, Engineering, Medicine and Surgery, Health Sciences, Law, Science, and Theology. The University has a number of Foundations and Institutes that provide specialised courses such as in International Maritime Law, Diplomatic Studies, Mediterranean Studies, Gerontology, etc.

With regard to the financial resources that are dedicated to the Education System addressing children and adolescents, the situation in 2010 was as follows:

Expenditure in education

TOTAL GOVERNMENT EXPENDITURE IN EDUCATION	%
As % of GDP	6.91
As % of total government expenditure	16.06

Source: UNESCO, UIS.Stat

Concerning human resources employed in this sector, in 2012 the situation was as per the table below:

Teachers in Malta per level of education

LEVEL OF EDUCATION	TOTAL NUMBER OF TEACHERS
ISCED 0	720
ISCED 1	2 058
ISCED 2	1 757
ISCED 3	1 971
ISCED 4	146

Source: UNESCO, UIS.Stat

The educational sector is not directly responsible for any promotion/prevention programmes but it collaborates effectively with the department of health, public agencies and NGOs to enable the latter to carry out such programmes within the school environment.

The Directorate for Quality & Standards in Education within the Ministry for Education and Employment is responsible for the formulation of the **national educational curriculum.**

Within this curriculum there is the subject of **Personal Social and Emotional Development (PSD) which is taught by specialised teachers.** The main aim of this subject is to enable children and adolescents to gain life skills needed to cope with every day stressors and to make healthy life choices. Students have also the opportunity to discuss personal problems with such teachers or school counsellors.

3.8.5 Cooperation between sectors

In Malta **there is no special legislation or policy** defining cross-sector cooperation.

Despite the absence of a legal framework to foster collaboration between the social sectors, in practice it is present and effective both at Ministerial and departmental levels. This collaboration is further facilitated given the **geographical size and population density** of Malta, whereby **top management in all 3 sectors are known to each other on a personal basis.**

All major policy and strategy decisions are discussed in the Cabinet of Ministers and are taken collegially.

Major policy documents are drafted by working groups composed of relevant key stakeholders and published for public consultation before they are enacted.

The local experts identified the following strengths and weaknesses concerning the cross-sectoral cooperation:

Strengths and weaknesses in cross-sectoral cooperation in Malta

STRENGTHS	WEAKNESSES
Collaboration is effective and on-going without much bureaucratic structures	Not much programmes have been evaluated
Common synergy among the three sectors	Lack of resources

3.8.6 Selected examples of good practice

GOOD PRACTICE IN MENTAL HEALTH PROMOTION*

The Mental Health Association, an NGO, has an ongoing primary school project to raise awareness about mental health issues amongst children aged 8 – 11 years.

The project, which is funded by EUFAMI, involved the publishing of **three interactive books dealing with different real life family situations like dementia and depression.** The interactive books were incorporated in PSD sessions through group storytelling, role plays, discussions and sharing of experience.

The evaluation of this project indicates that the books raised the awareness on mental health issues not only among children but also on their parents and teachers.

They enhanced the capacity of staff to understand the difficulties encountered by certain children in their class.

*This Good Practice was not included in the "good practice review" from participating Countries, as it did not fit the inclusion criteria applied as per the shared procedure protocol, namely that the practice had to be concluded and evaluated at the moment of the research. However, being aware of the broader goal of the Joint Action on Mental Health and Well-being, this practice still ongoing has been included in the report.

GOOD PRACTICE IN MENTAL DISORDERS PREVENTION

"Tfal favur ambjent liberu" (children in favour of a healthier environment).

This is a **comprehensive programme formulated by SEDQA** (public agency against substance abuse) targeting children from Kinder 2 to Year 6 of primary school.

It consists of **workbooks and interactive CDs for children, to be used in the classroom by teachers or Sedqa facilitators.** Workbooks accompany a prevention programme delivered by Sedqa personnel to promote skills for healthy lifestyle and information-based activities.

The students are offered learning activities which help them become aware of substance abuse as well as challenges the misconceptions about addictions they receive through media and their peers. It helps students develop **decision-making skills, assertiveness and awareness about peer pressure and media influences.** Interactive discussions, activities and role plays help children examine what goes on around them in life and to build their behaviour on positive role models.

The evaluation of this programme indicated a positive outcome amongst children on substance abuse issues.

The programme was accepted to form part of the European Action on Drugs, whose aim is to increase awareness and commitment as regards to drugs and the risks related to drug abuse, and to promote dialogue, and exchanges of best practice around Europe.

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3.9 NORWAY

3.9.1 Overview

Norway is situated in the Western part of the Scandinavian Peninsula. According to National Statistics at 1 January 2014 it has 5 109 056 inhabitants: 2 567 434 males and 2 541 622 females.

The capital is Oslo with 634 463 inhabitants 1 January 2014. It is expected that the population in Norway will continue to grow throughout the rest of this century due to positive net birth rate and positive net immigration. The growth is particular high in and around the major cities and in general the population is becoming older.

The average age in the Norwegian population is calculated at 39.4 years. Life expectancy at birth is 79.32 years for men and 83.57 years for women. Natural increase 2013-2014 is positive, 1.1 per 1 000 inhabitants.

The surface area of Norway is of 305 470 km^2, of which 56 594 km^2 is land area with a population density of 17 inhabitants per km^2. It is the 2nd least densely populated country in Europe. This density varies greatly among different counties.

Gross domestic product per capita in 2013 was NOK 591 242 (The Statistics Norway, 2014).

In Norway education is compulsory for children and adolescents. This means that all children living in Norway are entitled to ten years of education at primary level. Primary education is split into primary school covering grades 1-7, and lower secondary school cover grades 8-10. Kindergarten is not mandatory but most children attend kindergarten from the age of one to two years old.

The Education Act states that all children, regardless of abilities and backgrounds, are entitled to receive appropriate training at their local school. The unitary school system means that pupils across the country are being trained by the same curriculum. Primary education is free of charge. The school-aged population is divided according to the table below:

Norwegian school aged population

AGE GROUPS	TOTAL	MALES	FEMALES
0-4	311 912	160 017	151 895
5-9	310 750	159 165	151 585
10-14	308 183	157 471	150 712
15-19	325 805	167 828	157 977

Source: WHO Standards of 2001 and Statistics Norway

Young people have finished primary education when they are approximately 16 years old and nearly all choose to continue their education at high school. Higher secondary education is also free of charge. With regard to the educational attainment of pupils in Norway, in 2012, the distribution of students by level of education is as follows:

Children and adolescents in Norway by level of education

LEVEL OF EDUCATION	NUMBER OF STUDENTS
ISCED 0	179 739
ISCED 1	423 351
ISCED 2	191 023
ISCED 3	241 523
ISCED 4	14 206

Source: UNESCO, UIS.Stat

Students generally move to higher education after completing and passing three years of higher secondary school (there are exceptions for gifted children). It is a fundamental goal that everyone should be able to get a higher education irrespective of their social background. The education attainment was as follows in the school year of 2011:

Educational attainment of population aged 25 years and older in Norway

LEVEL OF EDUCATION	% OF STUDENTS		
	Males-Females	**Males**	**Females**
ISCED 1	0.4	0.3	0.4
ISCED 2	23.0	21.8	24.2
ISCED 3	39.7	42.0	37.6
ISCED 4	2.9	3.9	1.9

Source: UNESCO, UIS.Stat

Concerning the drop-out from primary school, 907 children dropped out of primary school education last year (Norwegian Directorate for Education and Training, 2013).

High school drop-outs is a main challenge for mental health promotion and prevention in Norway. The Norwegian Teachers' Union notes that approximately one-third did not complete secondary education within the stipulated time last year (before their 25th birthday). The drop-out rate in Norway is by far the largest in vocational education programmes. Nearly three out of ten students who start high school courses in vocational education programmes end their studies without papers or diplomas. They also report that girls are more likely to complete than boys, and that Norwegian adolescents are doing better than young people from the minority or immigrant groups. In addition, the drop-out rate varies geographically. The rates for students dropping-out from schools in Norway in 2011 is presented in the table below.

Drop-out rates during/at the last grade per level of education in Norway

	% OF STUDENTS
Drop-out rate to the last grade of primary education	1.51155
Drop-out rate to the last grade of general lower-secondary education	1.66981

Source: UNESCO, UIS.Stat

Between 15 to 20 percent of children and adolescents in Norway have mental health problems (have reported "psychological distress") negatively affecting their level of functioning. Approximately half of these (8%) - about 70 000 children – have a mental disorder with severe symptoms that meet the requirements for a psychiatric diagnosis. Most of these children need treatment. The coverage of specialist mental health services for children and adolescents is 5%. The waiting time to see a specialist fluctuates, but is approximately + 50 days depending upon geography and the point in time.

The incidence of mental disorders is about the same for girls and boys until the age of six years with the most common being emotional disorders (anxiety and depression), externalizing behaviours (ADHD and antisocial behaviours) and language difficulties. From 6 to 12 years of age, boys account for two-thirds of those who qualify for a psychiatric diagnosis. The most common disorders among boys at these ages are concentration difficulties, neuro-developmental disorders, such as ADHD, and behaviour disorders. Of those who receive psychiatric treatment younger than 12 years of age, two out of three are boys. Of those who are receiving treatment after 12 years of age, two out of three are girls, with anxiety and depression being the dominant diagnosis (Mathiesen, Mikletun & Knudsen, 2009).

Both mental health problems and disorders are unevenly distributed among the population. Especially at risk are children and young people growing up in families with significant burdens that affects many areas of life or lasts a long time. According to reports from Statistics Norway (2013) approximately 8% of

all Norwegian children are living in families with a family income below the poverty line, amounting up to about 78 200 children according to the OECD scale. However, this is one of the lowest rates in Europe (Save the Children, 2014).

In the context of this JA, the existence of a mental health strategy exclusively targeting children and adolescents was analysed, in the different countries.

Several ministries and agencies in Norway have developed legislation, programmes and strategies targeting the mental health of children and adolescents.
The Public Health Act (2013) based on Health in All Policies, including mental health, places responsibility of surveillance, prevention and promotion on the municipality/local government (not the municipality health system).
The **Government´s strategy plan for the mental health of children and adolescents was presented in 2003 by the Ministry of Health a Care Services.** The strategy, called "Together on mental health", lists 100 interventions with the main goal to provide good mental health to children and adolescents. Many interventions target parents, schools and the mental health services. The strategy plan was implemented during the **Mental Health Action Plan 1999 - 2008** with one of the main aims to provide mental health services from the psychiatric health services covering 5% of children and adolescents younger than 18 years of age. From almost 10 years of preventive actions and implementations of new treatment, the opportunities are evaluated and the results discussed in several reports. At the moment of writing this report, the strategy is under revision.
The Child Welfare Act (1992) aims to ensure that children and young people who live in conditions that may be detrimental to their health and development receive the necessary assistance and care at the right time, and to ensure that children and young people grow up in a secure environment.
The Kindergarten Act (2005) aims to ensure that children under compulsory school age shall be provided with good opportunities for development and activity in close understanding and collaboration with the children's homes.
According to the **Education Act (1998)**, all pupils are entitled to a good physical and psychosocial environment promoting health, well-being and learning, where schools are required to promote a good psychosocial environment.
A national program in the educational sector: **"Better learning environment (2009-2014)"** aims at engaging schools to work systematically and continuously in order to promote the pupils health, well-being and learning.
Another national program has recently been launched: **"Mental health in the school arena"** (2013-2017). The project aims to acquire and analyse knowledge about the school´s handling of mental health issues and to increase the cooperation between schools and services for children and adolescents.

The Norwegian partner which contributed to the thematic area of "mental health and school" in the present Joint Action is the **Norwegian Institute of Public Health (NIPH).** The overall area of interest for the institute is to improve public health in the population, both targeting somatic and mental health, which is expressed in the vision 'Better Health for Everyone'.

The NIPH acts as a national competence institution for governmental authorities, the health service, the judiciary, prosecuting authorities, politicians, the media and the general public on issues related to forensic science, physical and mental health, prevention of communicable diseases and prevention of harmful environmental influences.

3.9.2 Mental Health services for children and adolescents

Components of promotion of mental health and prevention of mental disorders are integrated into national legislation and various policies. With respect to this analysis, the most relevant components are presented below:

- *"The National Mental Health Action Plan" has been the largest initiative until now (1999 - 2008). The program sought to improve mental health services through a major expansion of primary care services provided by local councils and a restructuring of specialised services. The total cost of the plan was around 4 billion Euros in 10 years (ca 5 mill. people). This plan has substantially increased the number of services for severe mental disorders in terms of specialized treatment both for children, adolescents and adults.*
- *"The Coordination reform" (2012) is an ongoing initiative and including changes in general health legislation and health policy in Norway. The aim is to establish more services closer to where people live and strengthen efforts in health prevention and promotion. The objectives are to increase the municipalities´ responsibility and financial support for health promotion, prevention and treatment. The reform also strives to increase cooperation between hospitals and municipalities.*
  The Public Health Act which is aimed to promote health and reduce social inequalities in health, including mental health, and The Health Care Services Prevention Act are the legal instruments for carrying out the coordination reform.
- *White papers on public health. In 2013 the Norwegian government presented a White Paper to the Parliament which set the direction for the development of Public Health in the coming years. The White Paper is a follow up of the new Public Health Act (see above). A new White Paper on public health is to be delivered to the Parliament every third year, the next one coming in 2015 has prioritised mental health and children and youth. Mental health is one of the priority areas stated in the government platform of the present Norwegian government.*

Mental health care for children and adolescents are an integrated part of the general health care system with no specific acts regarding mental health. The following general acts also regulate their opportunities and rights with equal attention to mental and physical health:

- *The Public Health Act*
- *The Health Personnel Act*
- *The Mental Care Act*
- *The Patients' Right Act*
- *The Norwegian Primary Health Services Act*
- *The Child Welfare Act*
- *The Kindergarten Act*

"Health stations" for infants, preschool children and their families, run by specialised health nurses follow the health –including mental health – of all children and mothers in Norway from pregnancy until the child starts school. Visits to the health stations are free of charge. The health stations are probably the most important mental health promoting and mental illness preventing health care service for pregnant women, preschool children and their families provided by the health care services. The employees at the health stations have attained confidence by the whole population regardless ethnicity

and religious faith. The coverage is 98 percent at 1-2 year of age and still high at 4 years of age. The collaboration between health stations and other sectors may be extensive when needed. However, as the health stations are run by the local municipalities and organisation, the frequency of health controls and collaboration between sectors may vary.

"School health care services" are focused on health promotion and prevention, regarding both mental and physical health and social relations. School health services are normally provided at the school, and are mandatory in all primary and secondary schools (covered by the Education Act or approved under the Private Education Act). It is often referred to as children and adolescents "occupational health". The service will include:

- having a consistent look and expertise in health, upbringing and life quality
- contributing to increased well-being and coping for children and adolescents, and facilitating a good psycho-social and physical work environment in schools
- supporting children and young people in a vulnerable phase
- helping prevent dropping out of high school

This requires a partnership between the children/adolescents, schools and parents. Studies show that where the service is regularly present over time, it is used by 50% of the adolescents for "drop-in" consultation (Norwegian Health Directorate, 2014).

Each Norwegian citizen in the country has a personal **medical general practitioner for primary health** care (fastlege) who, if needed, will most frequently refer the child to a specialised mental health service. Specialised mental health services cover 5% of the child population under 18 years of age.

Over the last two/three years the government has supported establishment **municipality psychologist services in the primary health care.** The government finances half of the cost of this appointment and the municipality finances the other half. The psychologist service includes systems directed work, such as collaboration with the municipality administration, supervision of professionals from other professions, and direct clinical services without referrals. Three models are currently being tested; psychologist located at the school often together with the pedagogical service; psychologist at the Health Station (see above), and psychologist working side by side with the general medical practitioner. In municipalities where The Family's House has been established offering integrated services from several sectors (e.g., open kindergarten, pedagogical-psychological service, health station, child protection service, physiotherapist, local mental health service) under the same roof, the municipality psychologist might have her/his office there.

Financial and human resources dedicated to Mental Health of children and adolescents are very difficult to assess since these services often are integrated parts of a larger system. However, there is no doubt that the services from medical general practitioners, public health care centres for mothers and children, school health services, child protection services, pedagogical services, municipality mental health service and municipality psychologists in primary care are considerably cheaper to run than specialised mental health services.

The Ministry of Health and Care Services has the main responsibility for the quality and dimensions of the health services for children and adolescence.

The subordinates **Norwegian Directorate of Health** and the **Norwegian Institute of Public Health** are responsible to provide research based knowledge and give professional advice to the ministry. The **Norwegian Directorate of Health** also contributes to planning, financing and monitoring of promotion and preventive actions in collaboration with the health and care services in the municipalities.
The 428 Norwegian municipalities are responsible for delivering health care services. They are responsible for preventive actions and promotion has been emphasized in the Coordination reform. The

reform also underlines that the four regional health enterprises (i.e., regional hospitals) and the local health authorities at the municipality level have common responsibility for the provision of specialist health care services, and should contribute to health promotion and prevention. The 19 counties have the responsibility to plan and monitor the municipalities' provision of local health - and mental health promotion and prevention measures.

According to the new Public Health Act, the municipalities (not the municipality health and care services) have a responsibility to monitor mental health actions, promote mental health, and prevent mental disorders. The activities are highly decentralised, i.e., the level and dynamics in the mental health promotion and mental illness prevention initiatives vary from one municipality to another.

3.9.3 Social Services for children and adolescents

The most relevant elements of the current legislation and policies concerning the social services for children and adolescents in Norway are included in the Norwegian Child Welfare Act.

- *Norwegian Child Welfare Act, of 17 July 1992, last amended on 1.1.2014. The Child Welfare Act aims to ensure that children and young persons who live in conditions that may be detrimental to their health and development receive the necessary assistance and care at the right time. The Act also aims to ensure that children and young people grow up in a secure environment. The most common used preventive activities are home-based programmes for parenting support and follow-up activities for children. The most common used treatment and care orders are foster care and institutions.*

  The Child Welfare Service in the municipality is responsible for child welfare. If a child is exposed to unhealthy conditions, the Child Welfare Service is required by the Act to immediately investigate how the child is doing and intervene, if necessary. According to the Act, the Child Welfare Service is required to review any report as soon as possible and, if necessary, carry out closer investigations within three months, at the latest. If intervention and implementation of measures is deemed necessary, this must be done within six weeks of completing investigations, at the latest. In the view of the legislators, it is important that the child gets help in time. On this basis, the municipality may impose fines if these deadlines are not met.

The Welfare Services for children and youth are separated from the health care system and mainly organised under the **Ministry of children, Equality and Social Inclusion and its agency, The Office for Children, Youth and Family Affairs (Bufetat).**
Bufetat is divided into **five underlying regional organisations and an overall executive body, the Norwegian Directorate for Children, Youth and Family Affairs (Bufdir).** Bufetat's five regions are responsible for state-funded child welfare and family counselling services. Their main task is to provide children, adolescents and families in need of help and support with appropriate, high-quality assistance on a nationwide basis.
At the local level, the main task of the child welfare service is to ensure that children and young people who are living in conditions which may harm their health and personal development receive the care and assistance they need in a timely manner. The child welfare service shall also contribute towards the provision of a safe environment in which children can grow up.
The health care system and the child welfare services are separate legal units, but an increasing number of municipalities (25 – 33%) have organised all services for families and children under one family service in the municipality, which includes child care centres, schools, social services, child protection services, physical and mental health services. Since the health care and the child welfare services are separate legal units, cooperation and information sharing between the sectors on individual cases requires

consent from the parent and child/adolescent (for children – their right to participate, increases with their age). The exception to this may be situations when compulsory measures towards individuals (parents, children/adolescents) are needed.

As of the year 2012, a total of 5.5 billion NOK was granted to measures within governmental responsibility areas, whereas gross expenses to municipal child welfare services counted approximately 9 billion NOK. In the same year, the state budget totalled 1,003 billion NOK. The proportion of Bufetat's (governmental responsibility) expenses for child protection in relation to total government expenditure in 2012 was therefore of 0.55 percent. The percentage Bufetat plus municipal expenditures for child welfare in relation to total government expenditure was of 1.45 percent.

Moreover, the child welfare services were granted earmarked subsidies of 205 million NOK and as a consequence the number of employees in the child welfare services has increased with 470 since 2012. There were a total of 8 180 man-labour-years within the municipal child welfare services (3 475) and the governmental sector (4 704).

The overall responsibility for child welfare lies with the **Ministry of Children, Equality and Social Inclusion of Norway.** Executive tasks are further divided between the **Ministry, the Norwegian Directorate for Children, Youth and Family Affairs (Bufdir), and the Office for Children, Youth and Family Affairs (Bufetat), the Norwegian Board of Health Supervision, the County social welfare boards and the County Governor.**

At the local level, the municipalities are responsible for:

- Establishing child welfare services,
- Delivering both measures of promotion, prevention and services addressing vulnerable children, adolescents and their families.

The Child Welfare Services' main task is to ensure that children and adolescents, who are living in conditions that may harm their health and personal development, receive the care and assistance they need. The Child Welfare Service shall also contribute towards the provision of a safe environment in which children can grow up. Bufetat is, at regional level, responsible to run and offer residential care to children in need for such treatment.

3.9.4 The Education system for children and adolescents

The essential legislation concerning the education sector in Norway is the Education Act and the Kindergarten Regulation.

- *The Education Act (1998 with amendments 2010, 2011, 2012 and 2013) relating to Primary and Secondary Education was last amended in 2013. Compulsory primary and lower secondary schooling in Norway lasts for ten years, and children start school the year they turn six. Primary and lower secondary education is founded on the principle of equity and education is adapted for all pupils in a school system based on the National Curriculum. All children and adolescents are to share a common foundation of knowledge, culture and values.*
- *The Kindergarten Act (Act no. 64 of June 2005 relating to Kindergartens last amended 2013). Kindergartens shall provide children under compulsory school age with good opportunities of activities and development in close understanding and collaboration with the children's homes.*

Early learning

The Norwegian Kindergarten Act guarantees all children in Norway a right to affordable, available and accessible child care centres/kindergartens from the time that the child has reached one year of age. Coverage: 1-2 years of age, 80%; 4 years of age, 98%.
To ensure high quality kindergartens the Kindergarten Act requires "sufficient staffing to conduct adequate educational activities". In practice the management at each kindergarten decides what is considered adequate staffing in their institution. However, the general requirement for adequate competence includes at least three years educational training. The goal is that 50 percent of the staff should have this qualification.
The **Kindergarten Regulation** states that there should be no more than 7.9 children per educational leader for children between 0 and 3 years, and 14 to 18 children per educational leader for children older than three years.
The government sets a maximum price. Half of the kindergartens are run by the municipalities, half are run privately. Attending kindergarten is not compulsory. In certain inner city centres in the larger cities core time in the kindergartens are free of charge in order to encourage those who have immigrated, low income families and others who are reluctant to use their local kindergarten.
Attending a child care centre from early on is regarded as a central part of language and culture learning, which is considered a prerequisite for migrant children to succeed in school, and later as young people and adults in the Norwegian society.

Primary and secondary education

The school reform called "The Knowledge Promotion" was introduced in 2006. It was based on objectives and quality framework for primary and secondary education and training laid down in the **National Curriculum for the Knowledge Promotion**. Adolescents, who have completed primary and lower secondary school, or the equivalent, now have a right to attend a three-year higher secondary education and training leading either to admission to higher education, to vocational qualifications or to provide basic skills. They are thereby entitled to a place on one of three alternative education programmes. The **county authorities** are in addition, legally obliged to follow up on young people between the ages 16 to 21 years who neither attend a course of education nor are employed. Pupils who have a right to special needs education have also the right to an extra two-year of upper secondary education or training if it is necessary for them to achieve their educational objectives.

All municipalities spent a total of 57 billion NOK in 2011 on public primary and lower secondary education according to figures from the Statistics Norway's Municipality State-Reporting (the Statistics Norway, KOSTRA). These expenses include operating expenses for mainstream schools, special schools, school premises and school transportation. The expenses for mainstream primary and lower secondary schools and special schools constitute about 80% of the expenses to the primary and lower secondary school sector. The biggest individual item in the primary and lower secondary school sector is payroll costs, which constitute 78% of the expenses.

Expenditure in education in 2010

TOTAL GOVERNMENT EXPENDITURE IN EDUCATION	%
As % of GDP	6.87 (in 2010)
As % of total government expenditure	15.31

Source: UNESCO, UIS. Stat

In 2011-2012, teachers in primary and lower secondary school performed 57.446 full-time equivalents (FTEs).

The Ministry of Education and Research is responsible for developing and carrying out national educational policy. The Ministry bears the overall responsibility for the goals in the Education Act with regulations, contents and financing of primary and secondary education and training. According to the Education Act, chapter 9a, all primary and secondary schools are required to provide a good physical and psychosocial environment conducive to health, well-being and learning. Further, and according to section 9a3, schools are obliged to make active and systematic efforts to promote a good psychosocial environment, where individual pupils can experience security and social belonging.

The County Governors act as links between the Ministry of Education and Research and the **Directorate for Education and Training**, this is the education sector on one hand and municipalities and counties on the other. The County Governors are responsible for supervision and for dealing with complaints related to regulations, participation in quality development, information, guidance and various administrative matters.

The municipalities are responsible for operating and administering primary and lower secondary schools, whereas the county authorities are responsible for upper secondary education and training. Legislation and regulations, including the National Curriculum, form a binding framework, but within this framework the municipal and county authorities, schools and teachers can influence the implementation of the education and training. Each school has a head teacher and various boards, councils and committees.

Pedagogical-Psychological Counselling Service (often abbreviated PPT or PP service) is a municipal or county advisory and guidance service that acts as an expert authority in matters of child, youth and adult education situation and the need for special educational measures.
An educational and psychological counsellor is a dedicated position in PPT that usually requires training in psychology, education or special education at the master's or professional level. There are also other technical positions in the PPT, such as a speech therapist and social worker.

3.9.5 Cooperation between sectors

There is no specific legal framework that foresees cooperation between the three sectors. Each sector has a legal responsibility to ensure cooperation, guidance and advice to other relevant sectors when necessary to fulfil its own duties and tasks. For instance, some legal frameworks include different kinds of cooperation tools, e.g., agreements to cooperate and the duty to prepare individual plans when coordinated measures are necessary.

At the national level, **the cooperation between the Norwegian Directorate of Health and the Norwegian Directorate of Education** was recently formalised. A cooperation forum was established that meets 4 times a year with a yearly meeting for the Directors. There are also forums where the Directors of all the Directorates on welfare issues can meet. A four year joint project is carried out in four municipalities "The schools as an arena for mental health for children and young people" as a result of this formalised cooperation.

The action plan against domestic violence (2012) is the result of a collaboration between the **Ministry of Justice- and Public Security, the Ministry of Children and Equality and Social Inclusion, the Ministry of Health and Care Services and the Ministry of Education.** Various national aid and treatment programmes for abusers as well as programmes to prevent domestic violence have been developed and established within the action plan.

Education and health authorities have provided financial support for the development and dissemination of school programmes through several initiatives. Because of these efforts, schools have access to a variety of programmes, many of which are evidence-based with good results from Norwegian efficacy and effectiveness studies. The programmes have different objectives, such as creating a good school environment, preventing and reducing bullying, reducing behaviour problems, promoting coping

skills, promoting social skills, providing knowledge about mental health, teaching problem solving and preventing anxiety and depression. There are universal, selective and indicated preventive programmes as well as more comprehensive school-wide programmes that operate on the universal, selective and indicated level.

The Norwegian website "UngSinn" ("YoungMind") is an information bank which provides practitioners and decision makers with information about evidence based interventions in the field of child and adolescent mental health. The site contains interventions that are available in Norway, which can be implemented in different types of services such as kindergartens, schools, child welfare services, healthcare services for children, or specialized mental health care services. "UngSinn" is managed by Regional Centre for Child and Youth - Mental Health and Child Welfare (RKBU-North) at UiT, The Artic University of Norway.

Norhealth is a Norwegian health information system which presents key statistics on health and the prevalence of diseases, risk- and protective factors in the Norwegian population. Data is extracted from central health records, health surveys, Statistics Norway and several other sources including, the Directorate of Health, the University of Bergen and the Norwegian Labour and Welfare Administration (NAV) and is presented at the national, regional and county level. The information is used to generate a Public Health Profile for each municipality and county in the country. Everyone can easily look up the current state of health in their local municipality or county as compared to the means for the county or country.

The local experts identified the following strengths and weaknesses concerning the cross-sectoral cooperation:

Strengths and weaknesses in cross-sectoral cooperation in Norway

STRENGTHS	WEAKNESSES
Mutual awareness within the sectors of collaboration directed to a common target group, and towards similar principal objectives	Decision-making and budgeting may be complex and bureaucratic due to the fact that there are different sectors involved and responsible
Cooperation at a national level, is also considered important because it sends positive signals and may inspire others, for instance at the local level	

3.9.6 Selected examples of good practice

GOOD PRACTICE IN MENTAL HEALTH PROMOTION

Mental health in early learning. The Kindergarten Act (2005) states that everyone who has passed one year of age has a right to a full time place in an affordable, available and accessible child care centre (Kindergarten). The municipality under auspices by the Norwegian Directorate for Education and Training is responsible that the local community has full coverage of places. The general requirements for adequate competence among the employee, the number of children per adult and other quality assurance indicators are defined by norms. There is strong evidence that high quality child care centres promote mental health, strengthens cognitive, emotional and social development, enhances school achievements, have the strongest positive effects on disadvantaged children, have substantial positive effects also on advantaged children, may compensate for difficult periods in family life, reduces social inequality in health more than any other public health initiative, have long term effects into adulthood and is an economically highly profitable investment to the society. However, the positive effects are obtained only in child care centers of high quality.

GOOD PRACTICE IN MENTAL DISORDERS PREVENTION

The Act of public health (2012) is a comprehensive legal framework based on "Health in all policies", which may serve as a best practice-example in mental illness prevention. The purpose of the Act, comprising all health challenges, including mental health, is to contribute to a society that promotes public health, including the reduction of social inequalities in health. Public health efforts should aim at promoting health, well-being, good environments and contribute to prevent mental and physical illness, injury or disease. Furthermore, the Act should ensure that all responsible entities, such as municipalities, counties and state health officials, are taking action and coordinate activities in public health and provide for continuous and systematic public health interventions. This framework is based on the approach that all responsible entities should consider public health in all other policies, locally, regionally and nationally. The law also constitutes the recognition that health matters in all policy-areas, and should therefore be considered in the planning and implementation of all other policies. The Act commits all municipalities to keep the necessary information and overview regarding the health status of the population and the positive and negative factors that can affect it. The municipality shall take appropriate measures to meet the local public health challenges. Examples of such measures, stated in the Act, are measures related to childhood and living conditions such as housing, education, employment and income, physical and social environments, physical activity, nutrition, injuries and accidents, tobacco use and alcohol and other substance abuse. Further the municipality is obliged to provide the local population with information, advice and guidance on what the individual and the population as such can do to promote health and prevent disease.

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3.10 SLOVAK REPUBLIC

3.10.1 Overview

Slovakia is situated on the crossroads between Central and South-Eastern Europe.

According to 2013 census, it has 5 410 836 inhabitants: 48.7% males and 51.3% females (Statistical office of the European Union, 2013).

The capital is Bratislava, with 373 671 inhabitants (Statistical office of the Slovak Republic, 2013).

The surface area of Slovakia is of 49 036 km^2 with a population density of 110.3 inhabitants per km^2 according to 2012 statistics (Statistical office of the European Union, 2013). Slovakia accounts eight counties, 2 890 towns/cities and 8 municipalities (Statistical office of the Slovak Republic, 2013).

The average age of population is 37.7 years (men) and 40.9 years (women) (Statistical office of the Slovak Republic, 2013) and life expectancy at birth according to 2011 statistics is 72.3 years for men and 79.8 years for women. Natural increase is positive, 0.1 per 100 inhabitants (OECD, 2013). Concerning ethnicity and religion, 86% are Slovaks, and Hungarians are the largest minority (Statistical office of the Slovak Republic, 2013). Gross domestic product per capita in PPS (purchasing power standards) 2012 was 76 EUR and per inhabitant 9 400 EUR (Statistical office of the European Union, 2013).

The school-aged population is divided as follows:

Slovak school aged population (at 31 December 2011)

AGE GROUPS	TOTAL	MALES	FEMALES
0-4	289 548	148 283	141 265
5-9	265 164	136 203	128 961
10-14	277 860	142 656	135 204
15-19	331 895	169 923	161 972

Source: The Institute of Information and Prognosesof Education, Bratislava 2014

In accordance with the Education Law in the Slovak Republic, compulsory school attendance is ten years and lasts until the end of the school year in which the pupil turns 16 years old. The age of compulsory school attendance starts at the age of 6 years. If the child who has attained the age of six is not adequately physically or mentally developed, the appropriate body of state administration postpones the start of compulsory school attendance for this child by one school year.

With regard to the educational attainment of pupils in Slovakia, in 2012, the distribution of students by level of education is as follows:

Children and adolescents by level of education

LEVEL OF EDUCATION	NUMBER OF STUDENTS
ISCED 0	149 082
ISCED 1	209 325
ISCED 2	266 391
ISCED 3	243 400
ISCED 4	2 171

Source: UNESCO, UIS.Stat

Compulsory school attendance starts in the year the child has already reached the 6th birthday. If a 6-year old child is not capable to attend primary school, the competent state administration education

authority will decide on including such child in the zero level (pre-school) of a primary school or on postponing the compulsory school attendance until the next school year. In case of children in special primary schools, the start of compulsory school attendance depends on their 'education maturity' and the compulsory school attendance ends when conditions for compulsory education have been fulfilled.

Compulsory school attendance is legally established in duration 10 years; ends in the 16th year of schoolchild. The state educational curricula defines the mandatory content of education and training.

Primary education is provided by ZŠ – "primary school" which has two stages: first stage (grades 1-4) and second stage (grades 5-9). After successful completion of ZŠ, the pupils continue fulfilling compulsory school attendance in the first grade of secondary school. Education at both ZŠ and secondary schools are free.

Students achieve primary education by successful completion of last year and obtain a report/certificate of a comprehensive program of educational training, whilst students with intellectual disabilities completing the last year of primary school obtain a report/certificate with endorsement/clause. Students obtain lower secondary education by successful completion of last year of a coherent part of the educational program of training.

In the school year 2012, the situation concerning school attainment was as follows:

Educational attainment of population aged 25 years and older in Slovakia

LEVEL OF EDUCATION	% OF STUDENTS		
	Males-Females	**Males**	**Females**
ISCED 1	0.4	0.3	0.6
ISCED 2	13.9	8.9	18.5
ISCED 3	68.2	74.3	62.6
ISCED 4	Not applicable		

Source: UNESCO, UIS.Stat

As regards the numbers of students dropping-out from schools in Slovakia, the rates in 2011 were as follows:

Drop-out rates to the last grade per level of education in Slovakia

	% OF STUDENTS
Drop-out rate to the last grade of primary education	2.04721
Drop-out rate to the last grade of general lower-secondary education	9.27486

Source: UNESCO, UIS.Stat

In 2012, there were 1 063 early school leavers from primary school (UNESCO, 2013).

Concerning the mental health status of children and adolescents in this country, the most comprehensive dataset on health related information available in Slovakia is collected and periodically published by the National Health Information Centre (NHIC, 2012).

The statistics of 2011 show:

- Number of examination by diagnosis, age and sex:

DIAGNOSIS ACCORDING TO ICD-10 AGED 0 – 18	MALES	FEMALES
F00 – F09 "Organic, including symptomatic mental disorders"	558	424
F10 – F19 "Mental and behavioural disorders due to psychoactive substance use"	2 163	634
F20 – F29 "Schizophrenia, schizotypal and delusional disorders"	1 992	1 703
F30 – F39 "Mood (affective) disorders"	1 857	3 015
F40 – F48 "Neurotic, stress-related and somatoform disorders"	4 816	6 224
F50 – F59 "Behavioural syndromes associated with physiological disturbances and physical factors"	489	1 388
F60 – F69 "Disorders of adult personality and behaviour"	494	311
F70 – F79 "Mental retardation"	7 150	4 180
F80 – F89 "Disorders of psychological development"	5 026	1 925
F90 – F98 "Behavioural and emotional disorders with onset usually occurring in childhood and adolescence"	32 699	14 855
F99 "Unspecified mental disorders"	54	45
Without detected mental disorder	450	199

- Hospitalized patients in psychiatric health care facilities by age, sex and diagnosis:

AGE GROUPS	MALES	FEMALES
0-4	58	10
5-9	237	63
10-14	694	365
15-19	705	580

Considering that the total number of children and young people in 2011 in Slovakia was of 1 091 056, the total number of hospitalised patients in psychiatric health care facilities in age group 0-19 represents approximately 0,32% of the total number of children and adolescents (0-18) in Slovakia (NHIC, 2012).

In the context of this JA, the existence of a mental health strategy exclusively targeting children and adolescents, was analysed in the different countries.
In the structure of the State Health Policy in Slovakia, the mental health area has an important place. Between the years 2004 and 2008, the Government developed and adopted:
- The National Mental Health Programme 2005 - 2015
- The National Programme of Care for Children and Adolescents 2008 - 2015
Both these programmes include planning as well prevention activities. In addition to the mentioned programmes, other programmes were developed focusing on addictions.
However, an individual strategy focused specifically on the children's mental health in the Slovak Republic has not yet been prepared.

The Slovak partner which contributed to the thematic area of "mental health and school" in the present Joint Action is the Ministry of Health of the Slovak Republic (SKMoH).

The Ministry of Health is the central authority of the state administration for health issues. According with the Statute of the Ministry of Health of the Slovak Republic, the Ministry of Health is responsible for:

a) drafting the principal directions and priorities for the development of public health policy and defining the concept of medical fields, specialisations,

b) establishing the system of medical equipment and defining their network.

In the area of health protection:

a) drafting the principal directions and priorities for the development of public health policy,

b) governing the protection and national programmes and health promotion, pursuing medical equipment, and expertly guides those governing other sectors and organisations.

3.10.2 Mental Health services for children and adolescents

Mental health care falls under the general system of health care and is specifically mentioned and regulated by general health care legislation, reflecting much of the International thinking about human rights in health care. With respect to this analysis, the most relevant components are presented below:

- *The Act on Health care specifies forms of outpatient and inpatient care. With respect to human rights, it improves protocols for informed consent, the right to information, choice of provider, access to documentation, right to dignity, confidentiality, refusal of care, and a separate anti-discrimination act, adopted in 2004, bans discrimination on the grounds of health status.*
- *In 2006, the Ministry of Health adopted the Regulation of a Conception of psychiatric care which is based on the work of a large group of psychiatrists. This organises mental health care but does not include mental health promotion.*
- *Dedicated mental health legislation which includes the health care for children and adolescents exists and was revised in 2009. These are continuously amended each year and the area of mental health is always discussed by expert groups, taking into account the current situation.*
- *There are also publicly available guidelines:*
  - *The regulation of a physician practice (issued by the Ministry of Health of Slovak Republic, 2011) to inform a parent or guardian of a child with disabilities and the importance of parent involvement in the educational, psychological and special pedagogical assistance and prevention, which provides special pedagogical centres*
  - *The guidelines created by Slovak Psychiatric Association - Methodological briefings.*

Mental health care is provided in a wide range of settings in hospitals and the community and is covered by public health insurance. Health establishments in Slovakia are separated according to activity on establishments of outpatient type, establishments of institutional type, pharmaceutical care and emergency health service. Health establishments of outpatient type provide services to patients during doctor's surgery hours which are approved by higher territorial units. Health establishments of institutional type and emergency health service provide services to patients 24/7.

Mental health services in Slovakia comprise:

- Mental health outpatient facilities – ambulatories provides a comprehensive evaluation and treatment with therapy;
- General hospitals (psychiatric units/departments for adult patients, departments for children and adolescents, psychogeriatric units);
- Mental hospitals (for adult patients or children and adolescents);
- Centres for treatment of drug addiction;
- Day treatment facilities.

In 2011, psychiatric services were provided in 35 mental health outpatient facilities reserved for children and adolescents only and 187 psychiatric beds in general hospitals (i.e., beds dedicated to mental health care in general hospital wards) and 1 (psychiatric hospital) and 1 private psychiatric hospital with 80 beds for children and adolescents (Centre of Statistics and Services, 2011).

Slovakia does not have a separate budget for mental health care. Financial allocations for mental health care are part of the overall health budget (in 2010 total health expenditure as percentage of GDP was 7.3); mental health care is financially integrated with other health care services. Mental health services are also part of social services and paid for by other sources. There are not available data about specific expenditures for mental health care for children and adolescents.

According to the Concept of Psychiatric Care, health workers in mental health care are: physicians – psychiatrists, nurses, graduate nurses, nurses specialised in psychiatry; other health workers: physiotherapists, psychologists specialised in clinical psychology, pedagogic therapists, social workers, and volunteer healthcare workers.

In Slovakia, there are no available data about psychologists and nurses in mental health care of children and adolescents.
In 2011, the number of mental health professionals that fall into the following categories/primary employment setting are:

HEALTH CARE WORKFORCE IN SELECTED CATEGORIES	NUMBER (FULL-TIME EQUIVALENTS)
Psychiatrists with work contracts in institutional medical facilities without spa treatment facilities. These do not include those with contracts in mental health outpatient facilities.	309
Psychiatrists with specialisation in child psychiatry	50
Registered psychologists, considered as health care professionals (this number does not include school psychologists, who are not obliged to register)	1 100 (approx 600 are specialised in clinical area)
Out of the taxes of municipalities and HTU, the following structures are funded	1 261

Source: NHIC, 2011

A broad range of prevention of mental illness and mental health promotion initiatives exist for all target groups and many of these are funded by the Government.

The organisation and performance of the public health system in Slovakia is provided by Act No. 355/2007 on Protection, Support and Development of Public Health which includes also prevention in mental health area. The executive public health bodies are:

- **Ministry of Health of the Slovak Republic** – defines priorities of state health policy in the sector of public health
- **Public Health Authority of the Slovak Republic** – manages, controls and coordinates the execution of state administration carried out by regional public health authorities

- **Regional Public Health Authorities** – 36 authorities covering 8 regions and 79 districts.

The Government Manifesto (2011) includes a section on Public healthcare and prevention. This declares an intention to strengthen and encourage health prevention practices, including supporting and financing existing nationwide programmes, including the National Mental Health Programme and the National Programme for Child and Adolescent Health, and to prepare other programmes focusing on senior citizens with no additional requirements for budgetary funds.

A new Mental health plan was approved or most recently revised and adopted by the Government in 2012. This Mental health plan includes timelines for the implementation of a variety tasks including prevention programmes and activities. In 2012, the Mental Health Board of the Ministry of Health, responsible for the implementation of the National Mental Health Programme, discussed this plan and in April 2013 carried-out an evaluation. The next evaluation will be done in 2014.

Individual specific tasks are carried out by other relevant departments and ministries and non-profit organisations such as the well-known **Slovak League for Mental health (LDZ); Civic Association "Let´s Open the Doors, Open your Hearts" (ODOS), Slovak association for psychotherapy, etc.**

3.10.3 Social Services for children and adolescents

With regard to the current legislation and policies concerning the social services for children and adolescents in Slovakia, the most relevant elements are:

- *Act No. 448/2008 Coll. on Social Services regulates the basic legal relations in the provision of social services, social services funding and supervision of social services provision.*
- *Act No. 305/2005 Coll. on the social security law protection of children and social care regulates the system of the public protection and ensures the interests of the child and on amends certain acts (the "Act on ASCPCSC"), which entered into force on 1st of September 2005.*
- *Act on ASCPCSC, Act No. 36/2005 Coll. on the family and other applicable laws regulates the authority for the social protection and social care (hereinafter called the "ASCPCSC authority") and proceeds by carrying out the measures for the social security law, protection of children and social care proceedings in accordance also with International conventions. The Act on ASCPCSC ensures the implementation of ASCPCSC measures to every child living on the territory of Slovakia. Those measures are carried out continuously by the ASCPCSC authority (state authority) to protect the life, health and the favourable development of the child.*

The social services are decentralized in Slovakia. They are provided and assured by the **municipality** (for example: low-threshold facilities for children and family) and at the **regional level** (for example: "Home on half way").

The social services for children and adolescents are not a part of the health care system. Services are provided by **public providers** (community and regional self-governments) and **private providers**, such as non-profit organisations, civic associations, individuals.

Social services for children are funded from the municipal budget and partly from the state budget (Ministry of Labour, Social Affairs and Family financial contribution provided for municipalities to selected social service facilities) as well as payments from clients.
We note, however, that in accordance with Act on ASCPCSC, the ASCPCSC measures of the financial type

are priority oriented to prevent the separation of the child from the family, to support remediation of the families where the children were separated for various reasons, to create an equivalent substitute environment for children who can´t grow up in their own families and to helping young adults leaving the foster home becoming independent. The Act on ASCPCSC defines also which of its measures are funded from: the state budget, by self-government, accredited bodies, eventually others.
The ASCPCSC provides social counselling and social work. Psychological counselling and help in the reconstruction of the biological family within the help to the victims of violence are provided mainly through the Department of Psychological Counselling Services.
In 2012, social care measures were provided by 113 employees of LSAF offices, i.e., specialised social curators for children for a total of 25 930 children, with an average of 229 children/curator.
The social care workers filed 15 881 reports on children social care issues to various institutions and conducted 28 746 investigations in the families and institutions (Ministry of Labour, Social Affair and Family, 2013).
In 2012 advisory and psychological services office account for 87 employees, providing 52 173 consultations for 8 983 cases, with an average of 5.8 consultations/case.

The **Act on ASCPCSC** regulates the area of primary, secondary and tertiary social prevention, including the perspective of matter scope of action of individual entities – government administration, higher territorial unit, municipality. At the same time, regulates the conditions under which the accredited (non-governmental) entity can act in the ASCPCSC field.

In the primary prevention, the ASCPCSC measures are aimed at the implementation of measures to prevent and remove the causes of socio-pathological phenomena. Primary prevention measures are the measures of a general scope and are addressed in particular to children and families (intact terrain). To implement these measures, given their nature, the NGOs are not required to be accredited.

In accordance with Act on ASCPCSC, the Offices of Labour, Social Affairs and Family are the first instance government entity within the LSAF SR department, that among other things:

- provide the execution of ASCPCSC measures (of preventive and curative nature) also for children maltreated, sexually abused, neglected or where is a reasonable suspicion of maltreatment, sexual abuse, neglect or those that have been a trafficking, or where was the combination of other reasons,
- mediate to children, families and adults the professional help of specialized institutions and the participation in programmes and activities organised by the municipality, higher territorial unit or accredited body.

The Central Office for Labour, Social Affairs and Family, a second-level government body within the LSAF SR department, manages, controls and methodologically guides the state administration execution in the field of social security law protection of children and social care, and the execution of counselling.

3.10.4 The Education system for children and adolescents

The essential documents concerning the educational sector in Slovakia are:

- *The Constitution of the Slovak Republic provides for every citizen's right to free education in state elementary schools and a possibility to establish types of schools other than the state schools.*
- *Act No. 245/2008 Coll. on education. It is a comprehensive law on education, which defines the state's education policy, lays down principles and goals of education, as well as basic assumptions for the development of educational standards, which are part of state educational programmes. The Act: introduces the free-of-charge access to pre-primary education for children one year prior to starting the compulsory education, sets forth the obligation to continuously improve the process of education according to the results achieved in the field of science, research and development, creates the conditions to check and assess the quality of education and the quality of educational system (through the National institute of certified measurements of education, State schools inspection, establishing entities, schools). The Act defines children and pupils with special education and training needs, to whom the provision for additional sources to support effective education is necessary. In this manner, the pupils will be provided with equal access to education, adequate development of abilities or personality as well as attain an adequate level of education and inclusion in the society.*
- *Act No. 317/2009 Coll. on of pedagogical staff and specialists establishes the qualification requirements for educational and professional staff.*
- *Act No. 282/2008 Coll. on support of working with youth.*
- *Act No 184/2009 Coll. on vocational education and training.*

Education, training and upbringing in schools is executed and carried out through educational programmes. In addition to the common curriculum for all schools, each school has the freedom to define some parts of its curriculum. Legally defined educational standards are a set of requirements for acquiring knowledge, skills and abilities that children and students should get for their continuing education.

The school-system in Slovakia consists of: kindergarten, elementary school, high school, middle school, conservatory school, schools for children and pupils with special educational needs, artistic school, language school. Schools are funded by government, church and the private sector.

With regard to the financial resources that are dedicated to the Education System addressing children and adolescents, the situation in Slovakia is as follows:

Expenditure in education

TOTAL GOVERNMENT EXPENDITURE IN EDUCATION	%
As % of GDP	4.1
As % of total government expenditure	10.6

Source: UNESCO, UIS.Stat

Funding of primary and secondary schools is based on a normative principle. Schools are funded according to the number of pupils and staff and to the economic demands of the educational process. The main laws that regulate the financing of the education sector in Slovakia are: the Act No. 597/2003

Coll., on financing primary schools, secondary schools and school facilities as amended, and the Government Regulation No. 630/2008 Coll. which establishes the details of the breakdown of funds from the state budget for schools and school facilities as amended.

The Ministry of Education, Science, Research and Development of the Slovak Republic finances the schools where the education is considered to be a systematic preparation for career established by Higher territorial units (hereinafter "HTU").

The Ministry of Interior of the Slovak Republic finances:
- schools where the education is considered to be a systematic preparation for career established by the municipality, ecclesiastical establishing entity, private establishing entity and district office in the county,
- kindergartens for children with special educational needs established by the district office at the county,
- educational facilities established by the district office at county level.

Out of the taxes of municipalities and HTU, the following structures are funded:
- the kindergartens, elementary art schools, language schools and school facilities established by municipalities and HTU from 1 January 2005,
- the kindergartens, elementary art schools, language schools and school facilities established by church and private establishing entities from 1 January 2007.

According to report on the situation of the school system and education in Slovakia, in 2012, the regional school system involves 61 947 teaching staff, 1 305 professional staff and 19 710 other employees financed under the transferred competencies and 24 624 teaching staff, 120 professional staff and 19 276 other employees financed under the original competencies (Ministry of education, science, research and sports of the Slovak Republic, 2013).

However, according to UNESCO statistics for Slovakia, the human resources employed in this sector, in 2012, were as in the table below:

Teachers in Slovakia per level of education

LEVEL OF EDUCATION	TOTAL NUMBER OF TEACHERS
ISCED 0	12 023
ISCED 1	14 011
ISCED 2	23 841
ISCED 3	21 094
ISCED 4	280

Source: UNESCO, UIS.Stat

Ministry of Education, Science, Research and Sport of the Slovak Republic establishes directly controlled budgetary and contributory organisations. The Research Institute for Child Psychology and Patho-psychology is involved in the area of prevention.

The Ministry of Education continuously provides recommendations for fulfilling the individual articles of the Convention on the Rights of the Child and the implementation of preventive measures, campaigns and activities in the area of child protection, prevention of bullying, truancy, human trafficking, drug prevention. These measures and professionally supervised activities are made available with the collaboration of the staff of the Center for pedagogical - psychological counselling and prevention.

3.10.5 Cooperation between sectors

The framework for cooperation between sectors in Slovakia is governed by:

- *The Act No. 575/2001 Coll. on competency as amended by Act No. 60/2013 Coll. on the organisation of activities of the government and central government. By this law, the government can establish its advisory bodies (councils). Government advisory bodies are executing the tasks of coordination, consultative or professional role.*
- *The Act No. 448/2008 Coll. on Social Services on amendments of certain laws.*
- *The Act No. 305/2005 Coll. on the social protection of children and social guardianship and amending of certain laws (hereinafter called the "Act on SPaSG"). The Act on SPaSG ensures the implementation of measures of the public protection and safeguard for each child located on the territory of Slovakia. These measures are carried out by government agency "Department of social protection of children and social guardianship" to protect the life, health and child development continuously favourable.*
- *Act No. 36/2005 Coll. on family and other applicable laws.*

In Slovakia, the cooperation between the sectors is based on government-approved conceptual and strategic documents. They are arising from interdepartmental working groups - guarantors for the implementing the action plan. (e.g., inter-ministerial working group for state youth policy).

In addition to the legal regulation, the collaboration between different sectors in area of the social protection of children and social guardianship is implemented through the National Action Plan for Children for 2013-2017 (hereinafter called "NAP for Children"), which responds to the recommendations of the UN Committee. Part of the NAP for Children measures includes legislative initiatives. NAP for Children for 2013-2017 was prepared under the responsibility of the Committee on Children and Youth Government Council for Human Rights, National Minorities and Gender Equality. The NAP for children as the implementation of cross-cutting tasks is the example of cooperation between sectors whose outputs have implications not only for practice, but also the on legislation.

In the process of creation of the National Programme for the Development of living conditions of persons with disabilities for the period 2014 - 2017 with a view to 2020, representatives of central government and public administration are involved in accordance with Art. 4 Paragraph (3) of UN Convention on the Rights of persons with disabilities and persons with disabilities through their representative organisations. The National Programme was prepared with the participation of several experts from different fields, to ensure that a wide range of areas will be covered and also to ensure the coherence and compatibility of all actions and tasks.

The local experts identified the following strengths and weaknesses concerning the cross-sectoral cooperation:

Strengths and weaknesses in cross-sectoral cooperation in Slovakia

STRENGTHS	WEAKNESSES
Existence of cooperation between the health, education and Labour, Social Affairs and Family departments supported by the Slovak government	Insufficient conceptual cooperation
Existence of an interdepartmental working groups addressing specific topics raised from resolved issues within the mental health care for children and youth	Insufficient financial coverage

3.10.6 Selected examples of good practice

GOOD PRACTICE IN MENTAL HEALTH PROMOTION

"School aged child with behavioral disorders in primary and secondary school" is a methodological and informative material, approved by the Ministry of Education, Science, Research and Sport of the Slovak Republic with effect from 1 September 2013.

This material is primarily intended for teaching and professional staff at primary and secondary schools. In general terms, the material defines the most common behavioral disorders, types, and informs about problems and manifestations of pupils with behavioral problems in the learning process and formulates basic recommendations for pedagogues and professional school employees to work with those students. The methodological material is also an informative and supportive material for parents of children with behavioral problems. It helps the specialist to take a suitable approach in education, re-education process and in application of correction methods in special treatment or education process. Training assistance can eliminate or reduce the impact of deficiencies affecting the performance of the student. The material describes the different types of behavioral disorders, problems, mainly due to deficit in upbringing. Furthermore, some disorders that may result in impaired mental health, chronic illness are described.

The interventions are offered both by teachers in an individual approach during education process or by professionals outside the ordinary/regular classes, in collaboration with other professionals (psychologist, special pedagogue, pedagogue for medical-treatment, and child psychiatrist) and institutions - particularly the school facilities for upbringing counseling and prevention, i.e. with the centers of pedagogical-psychological counseling and prevention, centers of special pedagogical counseling as well with child psychiatry outpatient/ambulatory facilities.

http://www.statpedu.sk/files/documents/vzdelavanie_so_zz/integracia/informa%C4%8Dno-metodick%C3%BD%20materi%C3%A1l%20%C5%BEiak%20s%20poruchami%20spr%C3%A1vania.pdf

GOOD PRACTICE IN MENTAL DISORDERS PREVENTION

Specialized guidelines of the Ministry of Health of the Slovak Republic on the procedure of informing the parent or child's legal representative of the child with diagnosed health disabilities and on the psychological and pedagogical counselling and prevention and upbringing (2011).

The Ministry of Health of the Slovak Republic in cooperation with pediatricians, child psychiatrists, psychologists, physiotherapists, representatives of associations of people with disabilities and children and special pedagogical counselling centres prepared a guideline to improve the process of informing parents or legal representatives of the child with health disabilities about the benefits of early delivery of the complex care in centers of special pedagogical counseling and educational counseling facilities. Further assistance can be then provided by non-profit organisations as not to miss a significant period in the growth and development of the child, during which specialists can be more effective.
The main objective of these guideline is to enhance the preventive and curative care, rehab, the genetic activity and collaboration of pediatricians with centers of early assistance and devices of special pedagogical counseling, including network security zoning in order to promote the earliest care intervention for a child with disabilities.

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3.11 GALICIA REGION (SPAIN)

3.11.1 Overview

Galicia is an autonomous community in northwest Spain, with the official status of an historic nationality. It comprises the provinces of A Coruña, Lugo, Ourense and Pontevedra.

According to 2013 census, Spain has 46 609 652 inhabitants: 22 941 196 males and 23 668 456 females (Instituto Nacional de Estadìstica, 2013). The capital is Madrid, with 3 207 247 inhabitants.

The surface area of Spain is of 504 645km^2, with a population density of 92.0 inhabitants per km^2. This density varies greatly among different counties. Spain is made up of 17 regions or autonomous communities (Comunidades Autónomas), 2 autonomous cities (Ciudades Autónomas), 50 provinces and 8 119 municipalities (Instituto Nacional de Estadìstica, 2014).

The average age of population is 40.83 years (men) and 43.43 years (women), and life expectancy at birth is 79.08 years for men and 84.92 years for women. Natural increase is negative, - 0.52 in 2013 (Instituto Nacional de Estadìstica, 2014).

At the moment of writing of the report, no information concerning ethnicity and religion could be retrieved.

Gross domestic product per capita in 2010 was USD 34 542.80.

Spanish school aged population

AGE GROUPS	TOTAL	MALES	FEMALES
0-4	2 480 195	1 280 210	1 199 185
5-9	2 389 845	1 229 079	1 160 766
10-14	2 199 332	1 131 355	1 067 977
15-19	2 203 001	1 134 415	1 068 586

Source: Instituto Nacional de Estadìstica, 2011

With regard to the educational attainment of pupils in Spain, in 2012, the distribution of students by level of education was as follows:

Children and adolescents by level of education

LEVEL OF EDUCATION	NUMBER OF STUDENTS
ISCED 0	1 919 879
ISCED 1	2 816 584
ISCED 2	2 039 727
ISCED 3	1 256 402
ISCED 4	Not applicable

Source: UNESCO, UIS.Stat

In the school year 2012 the situation concerning school attainment was as follows:

Educational attainment of population aged 25 years and older in Spain:

LEVEL OF EDUCATION	% OF STUDENTS		
	Males-Females	**Males**	**Females**
ISCED 1	19.3	18.1	20.4
ISCED 2	24.3	26.7	22.0
ISCED 3	18.6	19.1	18.2
ISCED 4	Magnitude nil or negligible		

Source: UNESCO, UIS.Stat

As regards the numbers of students dropping-out from schools in Spain, the rates in 2009 and 2011 were as follows:

Drop-out rates to the last grade per level of education in Spain

	% OF STUDENTS
Drop-out rate to the last grade of primary education	2.85256*
Drop-out rate to the last grade of general lower-secondary education	20.17265**

Source: UNESCO, UIS.Stat

*data of 2011, **data of 2009

In 2012, there were 13 583 early school leavers from primary school (UNESCO, 2012).

Concerning the mental health status of children and adolescents in this country, in 2006 a National Health Survey of the population between 4-15 years old was conducted and produced the Mental Health National System Assessment. This instrument showed that the 11.96% of the 4-15 years old population had poor mental health risk rates (10.9% girls and 12.9% boys) (Ministerio de Sanidad, Servicios Sociales e Igualdad, 2006).

A new National Health Survey was carried-out in 2011-2012, but there is not a new Mental Health National Health System Assessment as yet (Ministerio de Sanidad, Servicios Sociales e Igualdad, 2011).

As of the end of 2013, there is not a specific strategy on mental health for children and adolescents, but there are two documents about that:
1) Mental Health Strategy of the Spanish National Health System (2009-2013)
The Strategy includes five strategy lines that cover:

- Promotion of the mental health of Spain's population, prevention of mental illness and eradication of the stigma associated with persons who have mental disorders
- Providing Care for Mental Disorders
- Intra-institutional and Inter-institutional Coordination
- Healthcare Personnel Training
- Mental Health Research.

2) II Strategic Plan for Children and Adolescents (2013-2016)

The Strategic Plan lays down these remedies:

- Design a plan of Mental Health for Children and Adolescents for promotion of positive mental health, prevention of mental health problems in school and primary health services and strengthening of professional teams to deal with children mental health problems (both outpatient and inpatient).
- Improve and increase services and programmes aimed at mental and psychological health for children and adolescents, with special attention to those who are particularly vulnerable.

In addition, in the new legislation, it is expected the set-up of a specialization of Infant and Juvenile Psychiatry (Ministerio de Sanidad, Politica Social e Igualdad, 2011; Ministerio de Sanidad, Servicios Sociales e Igualdad, 2013).

The Spanish partner which contributed to the thematic area of "mental health and school" in the present Joint Action is the **Secretariat General of Social Policy of the Regional Government of Galicia – Spain** and its main areas of interest and activities are:

1. disabilities and ageing,

2. technology health and social determinants of health.

3.11.2 Mental Health services for children and adolescents

Concerning the legislation governing the mental health, in Galicia there is the **Regional Decree 389/1994**, of 15th December. This Regional Decree regulates the structure of the resources for a new model in Mental Health in Galicia. Mainly, the different levels are:

- Primary Care service,

- Mental Health Units: they help primary care services about mental health,

- Mental Health Day Care Hospitals,

- Psychiatric Units in hospitals.

Furthermore, this Decree enables the organisation of special units for children/youth, psychogeriatric, alcoholism, drugs, etc.

At regional level of Galicia, the available policy rule:

- Child and Youth mental health units in community social services,

- Short-term Hospitalization Units (The first one was created in 2012).

The Child and Youth mental health care is part of Galician Health Service (SERGAS) through specific medical teams of different psychiatric services in 6 of the 7 Medical Management Areas (Vigo, A Coruña, Santiago, Lugo, Ourense and Pontevedra). In Ferrol, the care is provided by an association (ASPANEPS-Parents of Children with Psychosocial Problems Association). The main access to this kind of mental health care are through the paediatric services or/and primary health services.
The Child and Youth mental health units are the basic services of community care.

The Mental Health care is financed by the Galician Health Service budget (mainly dedicated to human resources). In Ferrol, there is a collaboration agreement between SERGAS and ASPANEP.
Currently, Galicia has 8 Child and Youth mental health units. They include:

- 13 psychiatrists
- 12 clinical psychologists
- 9 administrative assistants
- 4 social workers
- 3 nurses

Moreover, there is a 7-bed short-term hospitalization unit in the University Hospital of Santiago de Compostela.

The Mental Health promotion and prevention are the responsibility of the **Galician Regional Ministry of Health,** in particular, of the **Directorate General of Innovation and Public Health Management**. Meanwhile, the Galician Regional Ministry of Health and SERGAS are responsible for implementing specific projects.

3.11.3 Social Services for children and adolescents

With regard to the current legislation and policies concerning the social services for children and adolescents, the most relevant elements at national and regional level are:

- State level legislation:
  - Civil Code.
  - Organic Law 1/1996, of 15th January, on legal protection for children.
  - Organic Law 5/2000, of 12th January, on criminal responsibility of minors
  - Act 54/2007, of 28th December, on International Adoptions.
  - Royal Decree 1774/2004, of 30th July, which develops Organic Law 5/2000.
- Regional level legislation:
  - Regional Act 2/2006, of 14th June, on Civil Law of Galicia.
  - Regional Act 13/2008, of 3rd December, on Social Services of Galicia.
  - Regional Act 3/2011, of 30th June, on family support and cohabitation of Galicia
  - Regional Decree 254/2011, of 23rd December, on registration, authorisation and inspection regime for social services of Galicia.
  - Regional Decree 329/2005, of 28th July, on centres for minors and child care centres.
  - Regional Decree 42/2000, of 7th January, which recasts regulations regarding family, childhood and adolescence.
- Plans:
  - II National Strategic Plan of Childhood and Adolescence (2013/2016). Ministry of Health, Social Services and Equality.

- III Plan against Sexual Exploitation of Children (2010/2013). Ministry of Health, Social Services and Equality.
- Plan for demographic revitalization of Galicia. Horizon 2020. (2013 – 2016) Regional Ministry of Labour and Welfare (Galicia).

The Galician system of social services is structured in a network with two levels of operation, each one with interdisciplinary human resources and equipment to develop the childhood support:

- **1st level of intervention:** Community social services. They are inclusive and develop preventive interventions for children and families comprehensive care. They are coordinated and follow protocols and services referral systems.
  This level includes two subtypes of services:
  - Basic community social services. These services are versatile and have a local dimension and they represent the normal access point to social services system. They include detection and diagnosis needs and actions of preventive nature.
  - Specific community social services. These services develop programmes and manage resources for specific target groups. Their activity is based on territorial equity and social return principles. They represent the previous step to the specialised social services. They have a higher level of local dimension. This is why it is necessary to have a coordination among councils.
- **2nd level of intervention:** Specialised social services. They are oriented towards a particular range of population or a specific problem as childhood support. These services assess, diagnose and take action. Furthermore they manage centres and specialized programmes.

Specifically for children, the Galician Childhood Support System has interdisciplinary teams (pedagogy, psychology, social work, social education and law fields) in the four provinces of Galicia. They are in charge of assessment and taking part in programmes to protect children's needs.

In 2013 the Regional budget dedicated an amount of €59 500 000 for childhood and family policy, while €19 000 000 were for the Galician Consortium of Equality and Welfare. This Consortium includes Galician Government (Xunta de Galicia), 272 councils and 4 council associations. It manages different social services, mainly nursery schools (0-3 years). Furthermore, there are human resources working in labour and welfare activities (staff of Technical Secretariat General).

Concerning the human resources, the organisation of Galician Family and Childhood care system has two different levels:

- Central services in Santiago de Compostela with a role of guidance and coordination,
- Province Offices with a role of assessment and implementation

Both levels have technical, legal and management staff. The first one involves interdisciplinary teams with psychologists, pedagogues, social educators and social workers. Legal staff involves legal advisers while management staff includes managers, administrative assistants, IT staff and other related fields.

Xunta de Galicia has 88 centres for minors (public and private- subsidised centres), 145 nursery schools (27 of Xunta de Galicia and 118 of Galician Consortium of Equality and Welfare), 7 family meeting points and 9 targeted intervention programmes.

	TECHNICAL STAFF	LEGAL AND MANAGEMENT STAFF
Central services	15	31
Province Offices (A Coruña, Lugo, Ourense e Pontevedra)	110	107
Protection Centres	444	190
Juveniles Criminal Justice Centres	133	29
Nursery schools	236	159
Family meeting points	26	No data

The **Galician Regional Ministry of Labour and Welfare** is responsible for planning, programming and development of projects and services for protection and social integration of families, especially their most vulnerable members:

- Promoting children's development in a family environment,
- Protection and care of minors in situation of lack of protection,
- Guardianship of abandoned minors and exercising functions of protection,
- Implementation judicial measures for juveniles offenders,
- Coordination of actions concerning minors.

The Galician Regional Ministry of Health is responsible for providing effective resources for early detection and specific care of children with chronic, mental, physical, intellectual or sensory medical conditions while the Galician Regional Ministry of Education is responsible for ensuring the child's right to special needs for prevention, detection and monitoring school absenteeism and drop-out.

The **Councils of Galicia** have to do next actions concerning minors:

- Detection of child's needs concerning health, education, economic, socio-occupational, family or others.
- Information and advice about resources for children and adolescents.
- Prevention and early intervention in minors risk situations.
- Collaboration with Xunta de Galicia for monitoring protection measures.

3.11.4 The Education system for children and adolescents

The essential documents concerning the educational sector in Galicia are:

- *Organic Law 2/2006, of 3 May, of Education regulating:*
  - *Definition and organisation of the curriculum forms*
  - *Territorial cooperation and collaboration between Administrations.*
  - *Organisation and stages of education: primary, secondary, vocational training and adult education.*
  - *Students with special needs.*
  - *Teaching profession.*
  - *Schools: typology, legal framework and the programming of networks of schools.*
  - *Evaluation of the education system.*
  - *Education inspection.*
  - *Financial resources.*
  - *Schedule for the application of the Law, to religious education, text books and teaching materials and the school calendar.*
- *Royal Decree 1513/2006, of 7 December establishing the competencies for Primary Education.*
- *Royal Decree 1631/2006, of 29 December establishing the competencies for Compulsory Secondary Education.*
- *Decree 130/2007, of 28th June establishing the Curriculum for Primary Education in the Autonomous Community of Galicia.*
- *Regional Decree 133/2007, of 5th July establishing the Curriculum for Compulsory Secondary Education in the Autonomous Community of Galicia.*
- *Regional Decree 229/2011, of 7th December regulating student diversity care in educational institutions of Autonomous Community of Galicia.*

The education system includes five levels:

- Pre-school education (2nd cycle) for 3-6 year old students – ISCED 0
- Primary education for 6-12 year old students – ISCED 1
- Compulsory Secondary Education for 12-16 year old students – ISCED 2 and 3
- Post-compulsory Education (vocational training/ Baccalaureate): 16-19 years (or older) students – ISCED 4
- University education: 19 or older students – ISCED 5

With regard to the financial resources that are dedicated to the Education System addressing children and adolescents, Galicia has a budget for 2014 of €2 147 897 354, while the human resources include 30 354 teachers (Consellería de Cultura, Educación e O.U., 2014).

Expenditure in education

TOTAL GOVERNMENT EXPENDITURE IN EDUCATION	%
As % of GDP	0.21
As % of total government expenditure	21.47

Source: UNESCO. UIS.Stat, Consellería de Cultura, Educación e O.U., 2014

Concerning human resources employed in this sector, in 2012, the situation was as in the table below:

Teachers in Spain per level of education

LEVEL OF EDUCATION	TOTAL NUMBER OF TEACHERS
ISCED 0	157 142
ISCED 1	223 517
ISCED 2	181 946
ISCED 3	108 455
ISCED 4	Not applicable

Source: UNESCO. UIS.Stat

Responsibility for coordination of promotion and prevention activities is divided on two levels:

- Spain (state level) is responsible for rule primary/basic legislation to create a common framework.
- Regions (regional level) are responsible for the rest of the planning and financing.

The delivery of the services belongs to the Regions and to the education centers (nursery schools, primary schools, secondary schools).

3.11.5 Cooperation between sectors

Concerning the cooperation between sectors, the Galician Legal Framework includes:

- Regional Act 13/2008, of 3rd December, on Social Services of Galicia: articles 1, 4, 36, 64, 65, 4th additional provision and 5th additional provision.
- Integrated action plan for people with disabilities in Galicia (2010-2013): area of activity 9, aim 1, objectives 1, 2 and 3.
- Regional Decree 183/2013 of 5th of December 2013 concerning the establishment and implementation of the Galician Early Care Network al. This Regional Decree constitutes the legal framework for cooperation between the 3 sectors. But a Regional Act is necessary as to develop the Regional Decree.

This framework establishes and regulates:

- The target group of the Early Care Galician Network: children from 0 to 6 years old resident in Galicia with developmental disorder or at risk.
- The list of services, human resources and equipment of the network.
- The competencies of each department involved in early care: health, social services and education.

- The procedure to have access to services, which has to be coordinated among the three departments.
- The strategic and technical collegiate bodies.

These aspects need a further development through specific normative act.

As concerns the organisation, the Early Care Galician Network is not developed yet. As of the end of 2013, the organisation of the early care is formed by two types of teams:

- Interdepartmental and interdisciplinary early care teams. They are formed by medical staff and social services staff. They are located in hospitals. They work in coordination with the education sector.
- Interdisciplinary early care teams. They are formed by social services staff. They are located in social services centers, normally community social services centers which depend on city councils. They work in coordination with the health and the education sectors.

The local experts identified the following strengths and weaknesses concerning the cross-sectoral cooperation:

Strengths and weaknesses in cross-sectoral cooperation in Galicia

STRENGTHS	WEAKNESSES
Achievement of legal framework which establishes an early care network, involving health, social and education sectors. The Regional Decree regulates the establishment of strategic and technical collegiate bodies among the three sectors.	Difficulty to know the magnitude of the problem about the Early Care as there are not suitable resources (mainly, specific software) to obtain information. Without data, it is very difficult to design procedures for dealing with the needs of Early Care (treatment, cooperation, etc.).
Existence of a previous work that constitutes an important base. All the teams have enough experience in mental health field and work in coordination with the other sectors	Not enough resources to improve the network

3.11.6 Selected examples of good practice

GOOD PRACTICE IN MENTAL HEALTH PROMOTION

Nise Project (2010)

The aim of this project is to raise the awareness of mental health, to provide information and health training and education to families and people with mental disorders and to improve the processing of information about this kind of illnesses. Thus far, 280 activities (conferences, workshops for patients and families, film series about mental illness, painting exhibitions, theatre plays) have been organised and 29 844 persons participated.

GOOD PRACTICE IN MENTAL DISORDERS PREVENTION

Suicidal Behaviour Intensive Intervention Programme (2008). It is a care programme for Ourense Medical Area, aiming to reduce the suicidal behaviours in Ourense. It is supplemented by specific training for primary health professionals to detect patients at risk.

* This Region was not part of the activities of this thematic Work Package at the moment of performance of "good practice review" from participating Countries, as it did not fit the inclusion criteria applied as per the shared procedure protocol, namely that the practice had to be concluded and evaluated at the moment of the research.

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3.12 BOTKYRKA MUNICIPALITY (SWEDEN)

3.12.1 Overview

Sweden is situated in the middle part of the Scandinavian Peninsula, between Norway and Finland.

According to statistics, at 31st December 2012, Sweden has a total population of 9 555 893 inhabitants: 4 765 905 males and 4 789 988 females (Statistic Sweden, 2014).

The capital is Stockholm, with 2 054 343 inhabitants.

Botkyrka municipality has a surface area of 194.2km^2, with a total population of 86 274: 43 740 men and 42 534 women, and a population density of 444 inhabitants/km^2.

The surface area of Sweden is of 450 300 km^2, of which 410 340 km^2 is land area with a population density of 22.85 inhabitants per km^2. Sweden consists of 21 counties, 108 towns/cities with a population of over 10 000 and 290 municipalities.

The average age of population is 40.2 years (men) and 42.2 years (women), and life expectancy at birth is 81.4 years for men and 84.6 years for women. Natural increase is 1 020 per 1 000 inhabitants (0.2%).

Concerning ethnicity and religion, 68% are of the population are members of the Church of Sweden (Lutheran) and an estimated 2% of the population are Catholics. An estimated 13% of the population practice other religions including Islam.

Gross domestic product per capita in 2013 was 43 800 EUR.

The school-aged population, as per WHO age groups standardisation of 2001, is divided as follows:

Swedish school aged population

AGE GROUPS	TOTAL	MALES	FEMALES
0-4	573 583	294 723	278 860
5-9	543 993	279 307	264 686
10-14	494 283	253 966	240 317
15-19 (15-17)	564 627 (317 485)	290 616 (163 241)	274 011 (154 244)

Source: Statistic Sweden, 2014

With regard to the educational attainment of pupils in Sweden, in 2012, the distribution of students by level of education is as follows:

Children and adolescents by level of education

LEVEL OF EDUCATION	NUMBER OF STUDENTS
ISCED 0	419 238
ISCED 1	602 295
ISCED 2	302 381
ISCED 3	373 401
ISCED 4	24 340

Source: UNESCO, UIS.Stat

In the school year 2012 the situation concerning school attainment is as follows:

Educational attainment of population aged 25 years and older in Sweden

LEVEL OF EDUCATION	% OF STUDENTS		
	Males-Females	**Males**	**Females**
ISCED 1	11.5	11.0	11.9
ISCED 2	9.2	10.3	8.1
ISCED 3	43.1	45.2	41.0
ISCED 4	5.3	6.4	4.2

Source: UNESCO, UIS.Stat

OECD data from 2012 shows high educational attainment in Sweden: 87% of 25-64 year olds obtained at least upper secondary education with a further 34% attaining tertiary education (vocational and university programmes). Only 4% of 25-64 year olds obtained pre-primary or primary levels of education only (OECD, 2014).

In the scholastic year 2012/2013, 87.6% of pupils who completed their compulsory education were eligible to continue studying at upper secondary school level.

In 2012, 76.7% of pupils graduated from upper secondary level education within 4 years from commencement. Of these, 86.7% were eligible to study at university level (SIRIS, 2012).

As regards the numbers of students dropping-out from schools in Sweden, the rates in 2010 were as follows:

Drop-out rates to the last grade per level of education in Sweden

	% OF STUDENTS
Drop-out rate to the last grade of primary education	4.42096
Drop-out rate to the last grade of general lower-secondary education	1.10648

Source: UNESCO, UIS.Stat

In 2011, there were 4 528 early school leavers from primary school (UNESCO, 2010).

Concerning the mental health status of children and adolescents in this country, a report published in 2013 on children and adolescent's mental ill health has shown rising trends since 1990s, and in recent year shown signs of stagnating. Depression, anxiety and substance abuse are most common among the adolescents. However, there is an increased negative self-reported psychological well-being, indicating warning signs for increased suicide attempts, and other forms of harm and accidents.

A comprehensive study on the population's living conditions (ULF, 2007) includes data on 3-15 year olds (from parental descriptions) and 10-18 year olds, showing higher prevalence of psychosomatic disorders among girls. 27% of girls and 14% of boys perceived stress to occur frequently in their week, with 15% of the girls and 7% of the boys indicating a daily felt stress. Psychological well-being is worse over the teenage years than younger years, and more prevalent among girls. Among 10-18 year olds, boys more commonly present a positive self-image than girls. 21% of the boys and 14% of girls identify themselves with statements describing positive psychological well-being. In contrast, 1% of girls and 6% of boys identify themselves with statements describing negative psychological well-being (Socialstyrelsen, 2013).

In the context of this JA, the existence of a mental health strategy exclusively targeting children and adolescents, in the different countries was analysed.

In May 2011, the Swedish Government adopted an **action plan for the continued work on mental illness.** During the period 2012-2016, a total of SEK 870 million is being allocated annually **to prevent mental illness and improve health and social care for those already affected (children and adults).** The Swedish Agency for Health and Care Services Analysis has been tasked with following up and evaluating the action plan and the effects of this initiative. It is to present its final report in 2017.

The SALAR - Swedish Association of Local Authorities and Regions has an action plan for mental health during the period 2012-2016 (ratified on 25 May 2012 by the SKL steering committee "Handlingsplan för psykisk hälsa 2012-2016"). The long-term goal is **for children and young people between 0-25 years to have good mental health and good school results.**

The Swedish partner which contributed to the thematic area of "mental health and school" in the present Joint Action is the Social Services of Botkyrka Municipality and its main areas of interest and activities are:

- Provision of early intervention and preventive services for children and youth with a focus on their social and psychological development. This type of intervention calls for close collaboration with other agencies such as child health care centres, schools, child psychiatric services and of course families and children themselves. Direct services include open play groups, parenting groups and advice and support
- Intervention when receiving reports that a child is in need of support or protection as a result of issues such as neglect on the part of the parents, abuse or because of their own behaviour or emotional status. The focus is then on providing interventions to support or protect the child: in the form of family treatment/intervention, structured cognitive-based programmes such as ART, placement in foster care or a wide variety of other measures.

Secondary areas of interest are:

- monitoring the social factors which affect children and youth - e.g., alcohol and drug use, criminal behaviour and finding the applicable and effective intervention
- Support children experiencing difficulties in their educational achievement.

In Sweden it is generally very difficult to specify areas of interest in ranking order, as a holistic approach is adopted and it is recognised that there are many factors which can affect the child and their ability to reach their potential. These areas include family relations, poverty, education and local environment conditions.

3.12.2 Mental Health services for children and adolescents

Components of promotion of mental health and prevention of mental disorders are integrated in national legislation and various policies. With respect to this analysis, the most relevant components are presented below:

- *The Health and Medical Services Act (1982:763) covers all types of health areas including mental health services for children and adolescents.*
  The Government's policy calls for health and medical care to be run efficiently and with good results for patients so that it enjoys a high level of confidence. Health and medical care is to promote health by working to prevent ill health. Other objectives include ensuring that health and medical care is knowledge-based, accessible, allows self-determination, is followed-up in an open and comparable way and uses knowledge and experience to systematically improve health and medical care.
  Priorities for 2013 include accessibility and freedom of choice, improved health with the help of online services and positive mental health development.
- *National public health policy which was passed in 2003, then updated in 2008. The updated policy focuses particularly on children with a special focus on initiatives aimed at strengthening and supporting parents in parenthood and increasing suicide prevention efforts.*

Mental health services for children are expected to be provided by the general health care system in the form of local health centres and GPs who are the "first line" of health care. In many areas there are also integrated health and social services in the form of family centres (familjecentraler) However, there is a generally accepted view that school health care, social services, child health care centres and other services for children and adolescents have a significant role in preventing and detecting the onset of child mental health issues. In certain areas of Sweden there are currently on-going trials to increase services for early intervention by health care services in the area of mental health for children. Financial subvention is provided to health care to develop services aimed at early intervention allowing the employment of certain child care professionals, e.g., child psychologists.

Counties in Sweden have specialised child psychiatric units that are accessible for self-referral from parents, referrals from schools and social services. These units provide outpatient contact and are often connected to regional units with access to limited 24 hour emergency care. In addition to the specialised psychiatric units, larger counties such as Stockholm have other specialised units for specific target groups, such as adolescents with suicidal behaviour, children who are victims of sexual abuse and adolescent refugees.

No data on financing and workforce of Mental Health Services for children and adolescents were provided at the moment of the analysis.

The responsibility for planning, financing and monitoring promotion and prevention of mental health for children is shared by the **municipalities** and the **County Councils** in their respective organisations. The **National Board of Health and Welfare** is the authority with responsibility for monitoring the work of municipalities and county councils.

The implementation of promotion and prevention is also carried out by **municipalities** and the **County Councils**. There are a limited number of **NGOs** who deliver promotion and prevention and their activities are often publically funded.

3.12.3 Social Services for children and adolescents

With regard to the current legislation and policies concerning the social services for children and adolescents in Sweden, the most relevant elements are:

- *Current legislation has undergone changes in the last few years in order to match the Government's strategy to strengthen the rights of the child. This strategy was approved by the parliament in 2010 and includes nine principles including:*
  - *All legislation concerning children must be designed in accordance with the Convention on the Rights of the Child.*
  - *The child's physical and mental integrity must be respected in all circumstances.*
  - *Children must have the right to express their views in all matters that concern them.*
  - *Children must receive information about their rights and what they mean in practice.*
  - *Parents must receive information about the rights of the child and be offered parenting support.*
  - *Decision-makers and relevant professional groups must have knowledge of child rights and put this knowledge into practice in their relevant professional activities.*
- ***The Social Services Act (Socialtjänstlagen 2001:453) and Care of Young Persons (Special Provisions) Act (LVU 1990:52)** are the most important current legislation. These two acts govern the work of social services in the area of social care for children and young people. If social services become aware that a child is coming to harm or is at risk then they must investigate the child's situation and assess the need for measures. Social services can offer services and measures, and in some cases, intervene irrespective of whether consent has been given by parents or if the child is over 18 years of age (compulsory legislative measures). Examples of measures are a contact-person or contact-family to support and help the child. Other examples are individually adapted and goal-oriented programmes. Children and young people may be placed in foster homes or homes for care or residence. The main area of responsibility of social services is to provide care and service, information, advice, support, financial assistance and other non-specified assistance to families and individual children that are assessed as having need.*
- ***The Act on Support and Services for Persons with certain Functional Impairments (LSS).** This covers the needs of children with learning difficulties, autism or an autism-like condition. Under this act, provision can be provided for personal assistance, companion services, contact persons, relief service, short-term care and even foster care.*

Social services are provided by the **municipality** and are not part of the health care system. Each municipality has autonomy in deciding how its services are organised but naturally all municipalities are subject to the legislative requirements.
The organisation typically consists of services for children, adolescents and families, alongside other services for adults such as social assistance, alcohol and drug treatment/rehabilitation, services for the elderly and community housing and daily activities for mentally ill.
The **services for children and adolescents** typically consist of early intervention and preventive services, child protection and support measures.
Cooperation with the health services is normally regulated by a formal agreement and can cover specialised services such as alcohol/drug advice and treatment and also Young People's clinics (*Ungdomsmottagningar*) for young people up to 23 years of age. Staffed by midwives, counsellors and doctors, these clinics provide counselling on sexual issues, teenage issues, pregnancy testing and contraceptives.
Specialised Children's and Adolescents' Psychiatry services are offered within the health care system provided by County Councils.

No data on financing and workforce of Social Services for children and adolescents were provided at the moment of the analysis.

State legislated social services follow the Social Services Act issued by the **Swedish Government**. Social services are planned and delivered through the **municipalities**, responsible and legally accountable for providing support and assistance to their population. Since 1st June 2013 a new government agency, the Health and Social Care Inspectorate, took over responsibility for supervising health and medical care and also social services.

Municipalities are financed by a combination of local taxes and state funding. Delivery of promotion and prevention initiatives can take place within various channels such as **school, recreation centres and youth centres,** all off which will be regulated and monitored primarily by municipalities.

Municipalities also collaborate with other institutions within the country and state, such as the **County Council, employment services** and national insurance services to develop, deliver, monitoring promotion and prevention initiatives.

3.12.4 The Education system for children and adolescents

The essential documents concerning the educational sector in Sweden are:

- ***The Education Act (Skollagen 2010:800)*** *provides the legal framework for schools and preschools. It regulates the rights and obligations of children, students and their guardians, and states that all children and youth shall have equal access to education regardless of gender, ethnicity, place of residence, or social or economic factors. Special support shall be given to pupils who have difficulties completing their education successfully. This act also presents the accountabilities of the school and principal. The Education Act further refers to other legislation relating to the activities governed by the Act:*
  - *Work Environment Act (SFS 1977:1160),*
  - *Discrimination Act (SFS 2008:567),*
  - *International agreements on the Convention on the rights of the Child and human rights.*

The Education Act further describes and regulates the organisation of the "student health" agenda (Elevhälsan), which includes prevention and promotion initiatives, and the availability and access to resources such as school doctor, nurse, counsellor, and psychologist. The Act also states that "student health" is to support student development to achieve educational goals.

The Swedish education system consists of compulsory and non-compulsory education. Most Swedish schools are public, run by municipalities (with increasing numbers of independent schools). Attendance at school is compulsory for all children aged 7-16 (starting date can be flexible 7 years old +/-1 year).

Non-compulsory elements of the education system for children include the pre-school and pre-school class.

Municipalities are obliged to provide preschool or family day-care homes to children aged one year and up when parents are working, pursuing studies, and unemployed or on parental leave. All children are further offered a place in a pre-school class, designed to stimulate child's development and learning by combining the pedagogical methods of the pre-school and the compulsory school.

Compulsory school is mandatory and free of charge, and regulated by the Education Act to achieve a consistent level of standards. After completion of compulsory education, all young people in Sweden are entitled to three years of schooling at upper secondary level.

Expenditure in education

TOTAL GOVERNMENT EXPENDITURE IN EDUCATION	%
As % of GDP	6.98
As % of total government expenditure	13.35

Source: UNESCO. UIS.Stat

Concerning human resources employed in this sector, in 2012, the situation was as in the table below:

Teachers in Sweden per level of education

LEVEL OF EDUCATION	TOTAL NUMBER OF TEACHERS
ISCED 0	36 218*
ISCED 1	62 442
ISCED 2	31 830
ISCED 3	39 127
ISCED 4	70 957

Source: UNESCO. UIS.Stat

*data of 2007

Municipalities remain responsible for the overall monitoring of adherence to the Education Act of all theirs schools, including follow through on delivery of "student health". Although municipalities provide required resource-support to initiatives within schools, each **school principal** has autonomy over the planning, implementation and monitoring of promotion and prevention activities. This includes any collaborations with relevant NGOs or other institutions.

3.12.5 Cooperation between sectors

Social services legislation gives social services a mandatory role in cooperation with schools and health services. Similar expectations are found in the health care and education legislation.

In Sweden the cooperation between sectors can be organised in many different ways as a result of the autonomy of municipalities. In 2008, for the first time, Sweden's municipalities and county councils have united to address the efforts to take in promotion of mental health and prevention of mental ill health among children and adolescents. The new document, a position paper by SALAR, identifies 16 determinants for approach that will form a holistic action plan. It includes health promotion, early intervention for at-risk groups and the proper care and assistance to those affected by mental illness. This position paper underlines the importance of cooperation between the three sectors (SALAR, 2009).

Most regions in Sweden have an agreement for organised cooperation for children and adolescents who need services from schools, social services and the health services. These formal regional agreements are the basis for local agreements within the schools, health service and social services in each municipality.

In Botkyrka municipality, there is a local agreement with the schools, health services and social services which calls for cooperation in planning for services for each individual child. There is also a specific cooperation which focuses on schools and social services, "*Kraftsamling*" which is a structured form of collaboration at all levels: politicians, management and line-workers.

The local experts identified the following strengths and weaknesses concerning the cross-sectoral cooperation:

Strengths and weaknesses in cross-sectoral cooperation in Sweden

STRENGTHS	WEAKNESSES
Focus on the specific needs in a particular area	Unclear roles within the health services in particular and the effect of privatisation.
Establishment of a sustainable system for collaboration between the different sectors	Uncoordinated budgets in the different sectors

3.12.6 Selected examples of good practice

GOOD PRACTICE IN MENTAL HEALTH PROMOTION

A range of different programmes and initiatives (>100) exists to prevent mental illness (especially those of aggressive and life-threatening nature) and promote mental health in children. At this time, none of them have been evaluated in randomised trials with six months follow-up. Many further lack economic analysis to evaluate cost-effectiveness. Without this impact analysis, a conclusive best practice is difficult to identify.

www.sbu.se/upload/Publikationer/Content0/1/Program_forebygga_psykisk_ohalsa_hos_barn.pdf

GOOD PRACTICE IN MENTAL DISORDERS PREVENTION*

In June 2011, SALAR and the government (Ministry of Health and Social Affairs) came to an agreement on a three-year work "Psynk project" coordinating all public and NGO initiatives for children and young people experiencing or at risk of mental illness. Currently some 50 municipalities are involved in the project at different levels and in different themes (a range of relevant intervention themes are provided to improve applicability and acceptance across all municipalities). Offices working on the project ensure that the knowledge generated has a national and International distribution, collating evidence based practice and practice based evidence available to all.

www.skl.se/psynk

* This Municipality was not part of the activities of this thematic Work Package at the moment of performance of "good practice review" from participating Countries, as it did not fit the inclusion criteria applied as per the shared procedure protocol, namely that the practice had to be concluded and evaluated at the moment of the research.

However, being aware of the broader goal of the Joint Action on Mental Health and Well-being, this practice still ongoing has been included in the report.

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4. MAIN FINDINGS AND DISCUSSION

4.1 Mental health of children and adolescents: information, interventions and evaluation

The mental health status of children and adolescents

The countries involved in this investigation were asked to provide information on the mental health and well-being status of their children and adolescents. From the country profiles presented in this report, a substantial variety in the presentation of data (e.g., regarding the age ranges considered, most recent data available, participation in cross-national studies, etc.) can be observed. Where available, data at national level is presented (instead of regional or municipality level) in order to allow comparisons. This is mainly due to the adoption of different methodologies, time frames and disorders classifications in different European countries and regions. In addition not all the countries have national web-based health information systems containing epidemiological data (an example of good practice is the Norwegian "Norhealth"), nor databases of effective mental health promotion interventions. Moreover, in general, the participation in cross-national studies, which would imply the adoption of shared and standardised protocols and thus result in an increased data comparability, is still lacking homogeneity across Europe.

Nevertheless, the report documents the most recent available information regarding the status of the mental health of the children and adolescents in each country according to the system in that country. Some of the most significant findings are highlighted here below.

Data from 2011 from **Croatia** inform us that mental health and behavioural disorders accounted for 4.8% of all hospitalisation in 10-19 age group, but the most surprising data for this country is about addiction: the mean age for the first consumption of heroin is 16 years and of cannabinoids is 16.3.

According to data from the WHO collaborative study HBSC 2005/2006, close to 13% of 13-15 years old schoolchildren in **Estonia** reported suicidal thoughts, and in 2013, the suicide rate in Estonian youth (age group 15-19) was 8.0%. The prevalence of depression in adolescents in the same year was 11% and anxiety was identified in 32% of schoolchildren.

Symptoms of anxiety and depression resulted to be increased among **Icelandic** adolescents in the years from 1998 to 2008, and in **Finland**, according to parents' interviews of 8-year old children, the prevalence of general anxiety is 5.2% and 6.2% for depression.

The PRISMA study, conducted in **Italy** in 2007, found that 8.2% of pre-adolescents (10-14 years old) met criteria for at least one mental disorder at the time of the investigation. With regard to risk behaviours, Italy reported data relatively in line with the av erage of ESPAD countries.

This is similar to data from UK's last national child and adolescent psychiatric morbidity survey (Green et al., 2005) that found prevalence of different mental disorder in 5-16 year olds as follows:

- Any mental disorder: 9.6%
- Conduct disorder: 5.9%
- Emotional disorder (anxiety or depression): 3.5%
- Hyperkinetic disorder: 1.5%
- Any conduct, emotional or hyperkinetic disorder: 8.7%
- Less common disorder (including autism, tics, eating disorders and selective mutism): 1%

- 7% of 11-16 year olds had self-harmed although this was much higher in those with emotional disorder (28%) and conduct disorder (21%).

Malta reports a paucity of epidemiological data on children and adolescents mental health, due to the fact that these samples are not age segregated.

Norway reported fluctuations associated with age: according to data collected in a study published in 2009, of those who were receiving psychiatric treatment younger than 12 years of age, two out of three were boys, while of those who were receiving treatment after 12 years of age, two out of three were girls, with anxiety and depression being the dominant diagnosis.

The **Slovak Republic** provided data which are collected and periodically published by the National Health Information Centre (NHIC). The statistics of 2011 show that the disease category accounting for the highest prevalence corresponds to "Behavioural and emotional disorders with onset usually occurring in childhood and adolescence".

Interventions and approaches

The situational analysis identified a variety of different intervention approaches in mental health promotion and mental and behavioural disorder prevention which can be seen as being dependent on different organisational set ups at national level in terms of policy framework and allocation of responsibility.

Variation in child and adolescent mental health policy between participating EU countries

Different types of mental health policy exist across the small sample of EU countries. For example, some countries have mental health policies targeting specifically children and adolescents (e.g., Croatia) whereas others have mental health policies targeting all age groups, with a specific section dedicated to children and adolescents (e.g., England, Finland and Italy). Some countries have specific legislation for mental health but it deals with the issue in general and not in relation to sub-population (e.g., Slovak Republic). In other countries the issue is dealt with under the relevant health legislation (e.g., Estonia, Sweden). In some countries such as **Norway**, the responsibility for children and youth are under a separate Ministry (Ministry of children, Equality and Social Inclusion). However, this Ministry deals mainly with social services whereas public health is the responsibility of the municipality. Some countries (England) have incorporated a life course approach in their mental health strategy in recognition of the fact that the majority of lifetime mental disorders arise before adulthood. In **Iceland**, there is not a mental health policy but the National Curriculum Guide for pre-primary, primary and secondary schools defines "health and welfare" as one of the six fundamental pillars of education. In many countries, grassroots organisations work in partnership with government agencies in the implementation of promotion and prevention activities (e.g., Estonia, Finland, Iceland, Italy).

So a common feature in terms of policy framework would appear to be the fact that the majority of the countries who participated in this project do not have a specific mental health policy targeting children and adolescents. Similarly, the analysis highlights that most countries were unable to quantify the resources dedicated to promoting the mental health and well-being of children and adolescents. These resources are usually incorporated into the broader category of Mental Health or of Public Health in general.

Furthermore, some financing measures in the education and social sector may have long-term mental health promoting effects and reduce social inequalities among children but may not necessarily be categorized as investment into the promotion into the mental health and well-being of children and the prevention of mental disorder. For example, in **Norway, Sweden, Iceland and Finland**, the municipalities

subsidise day-care and preschool to ensure affordable, available and accessible arenas for early learning (e.g., centered child care/kindergartens) which take the whole child's development into its objective.

All the participating countries and regions reported difficulties in retrieving data on workforce and financing specifically dedicated to children and adolescents in the health, education and social sectors. This is critical since expenditure is a crucial determinant of successful implementation, population coverage, outcomes and collaboration. Data on Governments' expenditures on mental health as a percentage of total government expenditures and data on human resources employed in the area of mental health for the general population is available (WHO, Global Health Observatory Data Repository).

Information on funding and resource allocation, per sector, is key to a better understanding of the cost savings that can be made in terms of investing in mental health promotion and mental disorder prevention. Only **England** (Guidance for the commissioning of public mental health services. Joint Commissioning Panel for Mental Health - Campion & Fitch, 2013) demonstrated to carry out systematic evaluation of the economic advantage which can originate from public opportune mental health promotion interventions.

Lack of availability of information regarding coverage and expenditure on public mental health interventions highlights lack of clarity about individual sector activity, coverage and outcomes. Obtaining this information would facilitate a strengthening of inter-sectoral collaboration, which, as examined in paragraph 4.4, was generally found to be lacking in the countries that participated in the activities.

In terms of coverage of interventions, the detail of this information was not available. However, the majority of good practices included in the dataset follow a universal approach. No targeted interventions in favour of specific risk groups (such as LGBTQ or other vulnerable groups) were reported.

With regard to types of interventions, many examples of intervention in schools were identified, particularly in those countries where there is increasing emphasis on a Health in All Policies approach, which sees a strong collaboration with the education sector for developing mental health initiatives for children and adolescents in early learning and school (this topic is dealt with in more detail in paragraph 4.2).

In those examples of a health promoting school concept, the Whole School Approach seems to be increasingly favoured by many European countries: in the context of the present study, **Iceland and Norway** explicitly made reference to this holistic approach in some good practices.

Finally, the use of web-based/technology based interventions (E-mental health) as a potential tool for the prevention of mental health disorders and the mental health promotion of children and adolescents were found to be of increasing relevance in literature. However, IT interventions aiming at mental health and well-being promotion carried out in the school setting seem to be still a minority in most of the involved countries. This said, the number of studies and actions on this subject aiming at developing, implementing and evaluating internet and media use for the purpose of mental health promotion, also thanks to the funding opportunities from EC (e.g., SUPREME and ProYouth), is increasing. The great potential of eHealth for the improvement of the quality of care, also in terms of access to services, reduced risk of stigma and reduction of expenses, surely deserves further enquiry.

Evaluation

Scientific literature and International organizations in the field of health strongly underline the relevance of an accurate evaluation as a crucial step for improving interventions' effectiveness. The Director General of WHO wrote that "Clearly, the ultimate value of evaluations depends on their findings and recommendations being acted upon. An evaluation must be relevant, credible and impartial. It must have stakeholder involvement in order that the recommendations may be accepted and are implementable" (WHO, 2013b).

In the context of this project, when considering the different interventions for mental health and well-being promotion carried out, it is important to note that measures of mental health and its determinants vary between actions, also in terms of outcomes presentation, which are frequently expressed in terms of self-evaluation. In addition, in most of the participating countries, follow up resulted to be executed only in the short term or not made at all.

Specifically, the presence/absence of an assessment procedure was investigated in relation to the programmes identified in the partner countries. As per the table below, only 73 (46%) of the 157 programmes included in the dataset were assessed. The partner countries reported missing data about evaluation results for 24% of the relevant programmes and policies aiming at children's and adolescents' mental well-being promotion and mental and behavioural disorders prevention.

An exception is represented by **Norway** where evaluation of interventions in the area of mental health on large samples (e.g., 20.000 students or 45.000), use of RCT and quasi experimental designs and adequate follow-up (2-3 years), pre-post evaluation and qualitative methods are used.

Table 2: Number of programmes that have been assessed

	COUNTRIES								
	Croatia	Estonia	Finland	Iceland	Italy	Malta	Norway	Slovakia	Total
Yes	11	0	9	14	10	0	26	3	73
No	0	11	4	11	9	6	5	0	46

Although the findings related to evaluation are generally disappointing, it should be noted that some countries have been working to select evidence based interventions, setting up databases where RCTs showing consistent effects represent the highest level of evidence (see for example "YoungMind" from Norway, focused only on mental health or "Pro.Sa." in Italy which includes a wide range of health promotion projects targeting children and adolescents).

4.2 Mental health and schools: an elective setting for early intervention

The importance of the early stages of development

The importance of starting prevention of disorders and promotion of mental health and well-being from the early stages of development emerged from the papers and good practices included in the literature review, and also from the internal debate among the partners of this thematic area. In particular, the major influence on mental health and cognitive functioning of the early years of life is acknowledged, as during the first stages of life development mental, social, and physical functioning is at its peak. The educational environment (from pre-primary level of instruction) is the context where most of the protective and risk factors intertwine and play a major role. In this sense, and with reference to the potential of the school setting, it appeared clear how school and peer education may foster opportunities for collaboration among children, parents, care-givers, teachers, school staff and staff of school medical services, according to a whole school approach (WSA).

At European level, many large scale, agency-led, whole school programmes and initiatives were identified, such as Health Promoting Schools, Social and Emotional Aspects of Learning, and the Good and Healthy School (further information on these initiatives are included as example of good practices in the Policy Recommendations document, see Appendix 2).

However, from the information provided by the participating countries on the different kind of school administration approaches, it can be observed that, in general, a mental health promotion culture is not yet systematically formalised at an institutional level.

Mental Health promotion as part of the school curricula

The integration into school curricula of specific subjects such as the development of mental health, management of emotional, behaviour and relationship skills is still lacking, even though some countries would seem to moving in this direction, such as **Estonia**. The first chapter of the "Basic Schools and Upper Secondary Schools Act" includes, among the fundamental values of general education schools the following: "General education schools support the mental, physical, ethical, social and emotional development of students. Conditions for the balanced development of the abilities and self-realisation of students and for the materialisation of their research-based worldview are created". In **Malta**, the national curricula foresees that all school children between the ages of 11 to 15 years have a minimum of one hour per week on personal social development. They are empowered to build the skills needed to be responsible citizens within society, integrate positively within their social peer groups and cope with everyday life situations and stress factors.

Also, bullying and cyberbullying, which nowadays constitute one of the most worrisome risk factors for the mental health of children and adolescents, are not yet tackled formally by school administrations.

According to the results of the separate International literature review that was conducted in connection with the JA, and that analysed 17 RCT interventions to prevent bullying and cyberbullying at schools, these programmes were found to effective in the short term, while the long term duration of positive effects still has to be demonstrated (Cantone et al., 2015) (See Appendix 1).

Among the programmes selected by participating countries on this topic, Iceland and Norway proposed the "Olweus project", which embraces a multilevel approach (whole school level, classroom level and individual level) to contrast bullying by influencing the whole school climate.

Also of note at the International level, is the International Union for Health Promotion and Education (IUHPE) which works worldwide with the objective to strengthen and encourage teacher training in health promotion.

Screening as a potential tool for prevention

A consultation on the issue of systematic screening to be conducted in the European schools as a useful tool to identify and prevent mental health problems was launched among the partner countries and external experts. Screening for mental and behavioural disorders has been introduced to some extent into some countries that participated in the work done on this thematic area (e.g., Croatia, Finland, Italy, Iceland) but with varying approaches. In Finland for example, screening takes place in public health clinics as part of general check-ups. In Croatia, screening is carried out in some counties in schools but by medical personnel. Other countries (e.g., Germany and Luxembourg) are implementing widespread routine screenings in schools. Other countries, such as England, have data which enables estimation of prevalence of different types of child and adolescent mental disorder even by locality (Green et al., 2005; Campion & Fitch, 2013).

There are conflicting views as to the benefits of introducing screening as part of regular check-ups in schools. Literature suggests that screening could provide an added-value in early identification and hence treatment of mental health problems (Kaess et al., 2013; Williams, 2013). On the other hand, experts participating in this project and consulted on this subject were more tentative in their support raising questions about this practice in terms of both efficacy and the possible adverse effects on students. Where there are concerns, there are a wide range of measures that can be used. For example, in England, the Department for Education (2014) recommends use of the Strengths and Difficulties Questionnaire which has versions for pupils, staff and parents.

Certainly this is an area which requires further investigation, especially with regard to evaluation of the screening, the choice of the most appropriate screening tools, the skills and training required for implementing the screening and the procedures for the follow-up referral and treatment.

Drop-out and early school leaving

In the context of this analysis, the relationship between education and mental health and well-being of an individual was also considered in broader terms.

Education affects the life choices of an individual and therefore it is considered a human right. It enhances the skills of an individual such as seeking information (including on health issues) or dealing with social stressors. Moreover, education increases the opportunity of an individual to have an income and an occupation.

At macro level, education contributes to the economic growth of a country. In recent years, the majority of Member States have made slow progress towards achieving the European target to reduce early secondary school leaving rates to below 10% by 2020 (Europe 2020 Strategy). As per the figures included in the country reports, there are still disparities among countries on the early school leaving rates: drop-out rate to the last grade of primary education ranges from 5.54% in Malta to 0.48% in Italy and drop-out rate to the last grade of general lower secondary education varies from 20.17% in Spain to 0.08% in Finland (see table 3 below).

Table 3: Cumulative drop-out rate to the last grade of primary/general lower secondary education

COUNTRY OR TERRITORY	REFERENCE YEAR	CUMULATIVE DROP-OUT RATE TO THE LAST GRADE OF PRIMARY EDUCATION	REFERENCE YEAR	CUMULATIVE DROP-OUT RATE TO THE LAST GRADE OF LOWER-SECONDARY GENERAL EDUCATION
Croatia	2011	0.56046	2011	0.75028
Estonia	2011	3.02146	2011	0.42659
Finland	2011	0.44827	2011	0.07606
Iceland	2010	2.90968	2010	1.19656
Italy	2010	0.48225	2010	1.00607
Malta	2011	5.53651	2010	18.55923
Norway	2011	1.51155	2011	1.66981
Slovakia	2011	2.04721	2011	9.27486
Spain	2011	2.85256	2009	20.17265
Sweden	2010	4.42096	2010	1.10648
United Kingdom		Not available		Not available
European average	(2010 est.) 2011	(4.43423) 4.62073	n/a	n/a

Data extracted on 16 May 2014 09:33 UTC (GMT) from UIS/ISU (UNESCO Institute of Statistics)

In general, the term drop-out (early school leaver) refers to a new entrant who will not reach the last grade of primary or the general lower secondary education.

At EU level, the early school leavers (ESL) are those young people who leave education and training with only lower secondary education or less, and who are no longer in education and training. In statistical terms, European ESL rates are measured as the percentage of 18-24 year olds with only lower secondary education or less, and no longer in education or training.

On the other hand, the educational attainment of an individual is defined as the ISCED level corresponding to the highest educational programme completed successfully (UNESCO, 2012).

Data on the educational attainment of the population aged 25 years and older for all the countries cited in this report are presented in the table below:

Table 4: Educational attainment of the population aged 25 years and older/latest year available

COUNTRY OR TERRITORY	REF YEAR	PRIMARY (ISCED 1) (%)			LOWER SECONDARY (ISCED 2) (%)			UPPER SECONDARY (ISCED 3) (%)			POST-SECONDARY NON-TERTIARY (ISCED 4) (%)		
		MF	M	F	MF	M	F	MF	M	F	MF	M	F
Croatia	2011	7.7	4.9	10.3	18.5	14.6	21.9	52.3	60.8	44.8	.	.	.
Estonia(a)	2012	12.7	14.7	11.1	12.7	14.7	11.1	51.2	56.9	46.4	51.2	56.9	46.4
Finland	2011	28,8	29.1	28.5	28.8	29,1	28.5	38.6	41.6	35.8	38.6	41.6	35.8
Iceland	2005	4.0	3.2	4.7	33.4	28.4	38.5	28.3	34.6	22.0	2.0	3.3	0.6
Italy	2012	18.7	15.9	21.3	28.4	32.2	25.0	33.7	35.5	32.1	0.8	0.7	0.9
Malta	2012	24.9	20.4	29.3	40.9	41.5	40.3	10.0	10.3	9.7	8.4	12.0	5.0
Norway	2011	0.4	0.3	0.4	23.0	21.8	24.2	39.7	42.0	37.6	2.9	3.9	1.9
Slovakia	2012	0.4	0,3	0.6	13.9	8.9	18.5	68.2	74.3	62.6	.	.	.
Spain	2012	19.3	18.1	20.4	24.3	26.7	22.0	18.6	19.1	18.2	-	-	-
Sweden	2012	11.5	11.0	11.9	9.2	10.3	8.1	43.1	45.2	41.0	5.3	6.4	4.2
United Kingdom	2013	-	-	-	21.5	20.2	22.7	30.0	32.9	27.3	.	.	.

Data extracted on 16 May 2014 09:39 UTC (GMT) from UIS/ISU (UNESCO Institute of Statistics)
Legend:
- : Magnitude nil or negligible
. : Not applicable

(a): Data for population 25 to 74 years

Literature suggests that some health patterns increase the risk of drop-out from school and one such problem is poor mental health (Breslau, 2010). If these problems remain untreated, they can affect the future behaviour and learning abilities of children and adolescents. Therefore, school provides for an excellent opportunity for social integration as on average, pupils spend more than a quarter of a day in school and thus the education system, in broader terms, represents an elective setting for the promotion of the mental health of children and adolescents.

4.3 Different training approaches and opportunities for school staff on mental health

Human resources and training

From the situational analysis, teachers and school staff in general resulted to be the professionals who more frequently deliver mental well-being promotion and mental and behavioural disorders prevention through the practical implementation of projects in school settings and the creation of a "health promotion culture".

In terms of qualifications, the general professional competencies, including the relational and emotional skills necessary to become a teacher, vary across the participating countries.

Concerning the minimum qualification requirement for teachers, some countries require higher education and pedagogical and subject-related training (Estonia). Others (Finland) breakdown the requirements by school level: teachers in basic and general upper secondary education are required to hold a Master's degree, teachers in vocational education and training have to hold a higher education degree, whereas teachers (and guidance staff) within day-care centres generally have Bachelor's degrees. In the Norwegian early learning system, the required competencies for staff is of at least three years educational training, with the goal of having at least half of the personnel of a specific institution with this level of education.

Mental health of teachers and school staff

Since the teachers are the main professional categories providing promotion and prevention initiatives in the school setting, some countries have put a higher importance on the status of their mental health. This is in line with recent evidence that has shown the importance of strengthening the mental health of teachers and school staff (Chang & Davis, 2009). For example, UK has put in place a consultation service and training sessions for teachers and school staff that helps them to reduce their stress and also to enable them to support children in a more effective way.

At the International level, programmes such as Mindfulness or Cultivating Awareness and Resilience in Education aim to develop guidelines for teachers so as to improve their well-being, their relationship with students, the climate in the classroom as well as to be able to provide effective support to their students.

Other key stakeholders

The findings also highlighted how teachers interact with a number of different stakeholders in the school environment such as parents and care-givers, health care professionals, social workers belonging to NGOs, youth organisations, clerical institutions in the implementation of health promotion /disorder prevention projects and programmes.

For example, in Croatia, there is a legal framework (National Strategy) for cooperation between sectors when it comes to training for prevention of behavioural disorders of children and adolescents, involving not only the social, health and education sectors, but also the police, judicial institutions, professional institutions, etc.

In Malta, on the other hand, the education sector has no direct responsibility for any promotion and/or prevention initiative but collaborates with other sectors (such as health, NGOs, public agencies) who carry out such programmes within the school setting.

4.4 Mental health: part of a wider national network

As highlighted in Chapter 1.4 of the present report, the necessity to consider the health (mental health included) in a broader framework is recognised at International level: all sectors have a responsibility for the good mental and physical health of children and adolescents. Given the small number of programmes and policies and of good practice included in the sample for analysis, any generalisations would be inappropriate.

As resulted from the analysis of the existence of cooperation among the health, social and education sectors, 25% of the policy and programmes reviewed did not have any inter-sectoral collaboration element, and for 10% no information in this regard was available (See Table 5 below).

Table 5: Programmes and policies: cooperation between health-care, social sector and education

	COUNTRIES								
	Croatia	Estonia	Finland	Iceland	Italy	Malta	Norway	Slovakia	Total
Yes	11	7	22	14	24	7	15	3	103
No	0	4	6	11	1	0	16	0	38

Of the countries included in the survey, Finland has the highest number of programmes and policies with an inter-sectoral cooperation involving all three sectors. The investigation into the type of cooperation between sectors also revealed that cases of co-operation between the education and health sectors were more frequent than the education and social sectors (See Table 6 below). In some cases, countries reported missing data on types of cooperation between sectors (Iceland, Malta and Norway).

Table 6: Programmes and policies: different cooperation between health-care, social sector and education

	COUNTRIES							
	Croatia	Estonia	Finland	Iceland	Italy	Malta	Norway	Slovakia
Educational and social	0	1	1	0	2	5	0	0
Educational and health-care	1	6	0	4	5	0	5	0
Social and health-care	0	0	0	0	1	0	0	0
Educational, social and health-care	10	0	21	9	16	0	7	3

In those cases where initiatives in the area of mental health of children and adolescents do foresee the collaboration of the health, social and education sectors, these are generally conducted informally or outside of a policy or legislative framework and can be attributed largely to the will of local or pre-existing networks (Estonia, Malta). Iceland and Finland are the exceptions with legal frameworks that provide for cooperation among the three sectors for the promotion of the health and well-being of children and adolescents. **Sweden** also has legislation which gives social services a mandatory role in cooperation with schools and health services.

In England, 'No health without mental health' is a cross government mental health strategy, signed up to by a range of government departments.

In Sweden, the 2010 Social Services Act and the Health and Medical Services Act clarify the responsibility of the different organisations when dealing with people offering a coordinated individual plan.

This said, some countries do foresee inter-disciplinary approaches as part of their policies and programmes in general (Croatia, Italy), although while process indicators are defined to monitor this collaboration, there are no outcome indicators to assess the results of the collaboration. A Health in All Policies (HiAP) approach is also being supported in many countries to varying degrees (Norway, Italy) in line also with the recommendations from the Commission (Finnish Ministry of Social Affairs and Health, 2006; Council of the European Union, 2008).

A parallel analysis of the inter-sectoral collaboration was carried out among the good practice reported by partner countries. This analysis looked into what types of collaboration whether at national, regional and local levels.

The cooperation between the three sectors, namely health care, social and education is reported in Table 7. Specifically, good practice in which a collaboration between at least two of the three sectors was developed, are registered in the "yes" row. In Croatia, Finland and Italy, all the identified good practice are based on cooperation between at least two of the three sectors. Only one missing data on cooperation between sectors was reported (Slovakia).

A percentage of 21% (11) of the total of good practice collected shows a negative result with respect to the inter-sectoral collaboration.

Table 7: Good practice: cooperation between health-care, social sector and education

	COUNTRIES								
	Croatia	Estonia	Finland	Iceland	Italy	Malta	Norway	Slovakia	Total
Yes	8	0	16	3	7	0	5	2	41
No	0	1	0	4	0	0	5	1	11

In order to have a more in depth understanding of the different options of cooperation between the health sector, the social sector and the education with regard to the selected good practice, a breakdown of the combined cooperation between two or three sectors is provided in the table below (Table 8). Once again, Finland is the country reporting the highest number of good practice based on a cross-sectoral cooperation involving all the three sectors.

Table 8: Good practice: different cooperation between health-care, social sector and educationE

	COUNTRIES							
	Croatia	Estonia	Finland	Iceland	Italy	Malta	Norway	Slovakia
Educational and social	3	0	0	0	1	0	0	0
Educational and health care	4	0	1	3	6	0	3	0
Social and health-care	0	0	0	0	0	0	0	0
Educational, social and health-care	1	0	15	0	0	0	2	2

Observing the data distribution, it can be noted that in Croatia, Iceland, Italy and Norway a certain number of good practice demonstrates a collaboration only between the health sector and education.

The above findings demonstrate how the issue of inter-sectoral collaboration remains a challenge for many countries. This and other gaps are discussed in the following chapter and form the basis of the recommendations for policy makers.

5. CONCLUSIONS AND RECOMMENDATIONS

To recap, the purpose of this work was to carry out an in-depth analysis of the situation concerning the mental health in schools of children and adolescents in the participating countries, with a view to drawing up recommendations for action for Policy Makers at Regional, National and European level.

For each country, an overview of the mental health status of children and adolescents was provided. An in-depth analysis of the following areas was then carried-out: mental health services, social services, education systems and cooperation among sectors. Examples of good practice for each country were also identified according to common criteria.

The chosen topics for analysis reflected a consideration of the risk and protective factors that can influence the mental health and well-being of children and adolescents, underlining the importance of the basic relevance of the contexts in which they live.

In particular, the core role of the school, as the setting where the child learns, creates relationships, plays and experiments the fundamental developmental phases, was examined. There was a particular focus on early school leaving in terms of the size of the problem, the consequences of it and measures to address it as part of a broader consideration of the intrinsic relationship between mental health, education and economic growth. The way the education sector interacts with other relevant sectors (in particular the health and social sector) was also analysed.

The difficulties encountered when collecting data from the different countries to be analysed and to be presented in a homogeneous manner, represented one of the main challenges in the preparation of the present report. On the other hand, the variety of situations and of good practices available in the different countries constituted the most precious resource with an added value at European level.

From the literature, the school is confirmed as the elective setting for the promotion of the mental health and well-being of children and adolescents (NICE, 2009; ProMenPol, 2009; Durlak, Weissberg, et al., 2011). However, while there are many examples of good practice of school-based interventions, the search at country level highlights how a mental health promotion culture within schools is generally not yet systematically formalized at an institutional level.

Moreover, within those examples of good practice of school-based interventions, there are many variations in terms of approaches. For example, there are differences regarding the qualifications of teachers and their professional development, particularly with regard to mental health issues. There are differences in the staffing structure with diverse professional categories represented in schools (e.g., Teachers, Psychologists, School Nurse, Special needs assistants….). Also, the education systems themselves vary greatly and hence intervention opportunities are aligned to the structural divisions according to age group (e.g., pre-school, elementary, middle school, high school). While this review identified many examples of school-based intervention programmes in elementary, middle and high schools, some countries (e.g., Norway and Iceland), in line with recent literature, are placing a stronger emphasis on the early learning environment in terms of representing a key intervention period. Prevention and treatment in schools is also handled differently across countries. For example, in some countries, the school has a central role with screening for mental disorders being conducted within schools in collaboration with the health sector (e.g., Luxembourg). In other countries, it is the public health sector which takes the lead for mental disorder screening sometimes on the basis of input from the schools (e.g., Italy).

In terms of strategy, again the information from country profiles highlighted a range of approaches across the different countries. A commonality across countries was the fact that nearly all countries reported that the area of mental health of children and adolescents is addressed as part of overall national plans dealing with mental health or public health and targeting the overall population as

opposed to have a specific strategy for children and adolescents. Partial exceptions are: Croatia, Norway (that is currently revising its strategy) and the Italian National Mental Health Action Plan, which has a specific section dedicated to children and adolescents that defines the objectives, actions and indicators to be used to verify the results. The relative merits of having a mental health strategy dedicated specifically to children and adolescents was the subject of much discussion during this project. From the literature, it seems that it is rare to find countries that have a clearly defined mental health policy pertaining uniquely to children and adolescents (Shatkin & Belfer, 2004) whereas this has been recommended at an International level as being essential for defining resources, services, capacity, and prevention and promotion strategies (WHO, 2005).

Certainly, specific attention needs to be afforded to this category as a group with very specific needs, whether in a dedicated strategy for the mental health of children and adolescents or as an explicit component of a broader mental health strategy.

With such a diverse landscape, in terms of policy, educational systems and organizational frameworks, it is not possible, nor is it advisable, to be overly prescriptive in terms of recommendations to Member States about how best to promote the mental health and well-being of children and adolescents.

This said, from the country analysis and the literature review, certain themes can be said to be relevant for this subject irrespective of national or regional contexts.

Firstly, every child is an individual who has a right to grow up happy and healthy, to lead a fulfilling life, to develop individual competencies and to have access to equal opportunities. Consulting children and adolescents as the main stakeholder when devising mental health promotion and mental disorder prevention strategies, is therefore of utmost importance. Furthermore, in terms of promotion and prevention interventions, the review identified more good practice examples of universal programmes (e.g., promoting psychosocial well-being, positive development, healthy lifestyle behaviors and/or academic performance) in the different countries. However, in recognition of each child as an individual, and in order to support the higher risk groups (e.g., Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) or children and adolescents who are bullied or living in poverty conditions) or those with emerging problems, it is important that there is a good balance between both universal initiatives and targeted approaches.

Next, information or lack thereof represents one of the main barriers to addressing mental health problems. This gap concerns the epidemiological status of the mental health of children and adolescents, the burden of mental health illness among children and adolescents, interventions that have proven to be effective and their relative costs and the estimated cost savings of said interventions according to the relevant sector. Indeed, in this data collection, differences in methodologies, time frames and disorders classifications meant a comparative analysis on the mental health and well-being status of children and adolescents across the participating countries was not possible. Moreover, none of the participating countries was able to provide complete specific data on workforce and financing dedicated to children and adolescents mental health care services. For example England could retrieve data on workforce for child and adolescent psychiatry and Veneto Region of Italy could provide data on mental health professionals dedicated to children and adolescents. Although the last cross governmental mental health strategy in England included estimated economic savings from a range of public mental health interventions to promote mental wellbeing, prevent mental disorder and treat mental disorder produced, this has resulted in little further investment. Robust evaluation of the effectiveness of interventions in general is also an issue due to the wide variability of experimental designs and lack of common standardized measures in outcome evaluation (Cantone et al., 2015).

There are a number of possible explanations for this paucity of information. It could be a consequence of complex organization and shared responsibility among a number of different sectors which was reported in many of the participating countries. It could also be attributed in part to the issue of stigma surrounding mental health which still persists across society and which leads to a lack of attention on the subject. Whatever the reason, strategic planning cannot take place without a solid information base.

As mentioned in the previous paragraph, the responsibility for the mental health and well-being of children and adolescents falls under different sectors, namely the health, education and social sector but also other sectors such as the judiciary. The findings highlighted that while inter-sectoral collaboration was recognized as being key to the success of mental health promotion and mental disorder prevention initiatives, the approaches in the different country varied greatly. Many of the examples of good practice of inter-sectoral collaboration that were identified in the review process were isolated examples operating outside a formal policy framework, a practical response by institutions set up to respond to a genuine organizational need. Inter-sectoral collaboration is called for at multiple levels and implies a consolidated framework with shared budgeting and clear definition of responsibility, which, where necessary, should be enshrined in legislation.

Another central consideration was the importance of a whole school approach, in which interventions involve students, teachers, school environment and community (Weare, 2000; Fitzpatrick et al., 2013). The analysis highlighted how teachers in particular find themselves at the forefront not only of mental health promotion but also of prevention of mental disorders, early recognition and treatment and do not necessarily feel prepared for this role. It is essential therefore that greater attention is afforded to training and support for teachers not only in terms of dealing with mental health issues among children and adolescents but also in terms of addressing their own mental health to best engage with their pupils. Similarly, families and carers have a critical role and the school provides the ideal point of contact for interaction not only with teachers but also the other relevant stakeholders.

Finally, the role of the internet was a recurrent theme, both in terms of its potential as a mental health promoting and disease prevention channel, but also as a tool that is beyond the control of parents and caregivers and that can have very negative impact on children and adolescents (e.g., cyberbullying) especially the most vulnerable.

A separate document has been prepared which provides a summary of the main findings of this report, and which includes also the rationale behind each recommendation and as well as examples of good practice. This document can be found in Appendix 2 to this report. It has been prepared as a stand-alone document with clear and concise messages to be addressed primarily to policy makers operating in the area of mental health promotion and mental disorder prevention among children and adolescents.

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APPENDIX 1: INTERNATIONAL LITERATURE REVIEW (CARTA ET AL., 2015)

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An Overview of International Literature on School Interventions to Promote Mental Health and Well-being in Children and Adolescents

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Abstract: *Introduction*: Mental disorders are the largest cause of the burden of disease in the world. Most of the burden affecting adult life has its onset during childhood and adolescence. The European Pact for Mental Health and Wellbeing calls for immediate action and investments in the mental health of children and adolescents. Schools may be the ideal location for promoting health and delivering healthcare services, since schools are a location where young people usually spend their daytime and socialize, schools are easily accessible to families, can provide non-stigmatizing health actions, and form links with the community. *Aims and Goals of this Special Issue*: This issue is developed within the framework of the Joint Action on Mental Health promoted by the European Commission. This special issue presents a set of systematic reviews on the evidence of the international literature on school interventions for the promotion of the mental health and wellbeing of children and adolescents. It is focused on five topical main areas: promoting general health and wellbeing; programs targeting specific mental disorders and conditions and integration of adolescents with mental health problems; Bullying; Sport; Alcohol and Drugs. An additional paper on the results of the largest epidemiological study conducted in some European countries on the prevalence and relative risk factors of mental disorders in school-age completes the issue. *Conclusion:* These reviews are a first contribution to address future European research and interventions, in particular about the multiple ways through which European policies could support the schooling and wellbeing of children and adolescents.

Keywords: Adolescent, children, Europe, intervention, mental health, school, well-being.

INTRODUCTION

Evidence is accumulating on the broad impact that the wellbeing experienced during childhood and adolescence may have across the life course of an individual in terms of physical and mental health. Indeed, most of the burden affecting the adult life of individuals has its onset during childhood and adolescence; in fact over 50% of mental disorders have their onset before adulthood [1, 2]. Mental disorders, including depression, bipolar disorder, anxiety disorders, psychoses within the spectrum of schizophrenia, intellectual disabilities and developmental disorders with their onset during childhood and adolescence, are widespread in the general population. According to current estimates, up to 30% of the European population suffer from a mental disorder during their lifetime [3, 4]. Even larger are the estimates of the subthreshold mental disorders, which do not reach the criteria for a full diagnosis but nevertheless impact on the quality of life and the wellbeing of those affected by them.

Mental disorders are increasingly recognized as the determinant of poor quality of life and health. Current estimates recognize mental disorders as the largest and growing cause of the burden of disease [5]. The burden attributable to mental health disorders and self-inflicted injuries is currently estimated as being higher than the burden of cardiovascular diseases and cancer [6].

Mental disorders negatively affect the entire life course of individuals, being the cause of substantial psychological, cognitive, social and occupational impairments and disabilities. Active and undertreated mental disorders are the cause of poorer educational outcomes, involve higher rates of self-injuries and suicide, cause an increased involvement in unhealthy risk behaviors such as smoking, alcohol or drug abuse, poor diet, physical inactivity, which in turn result in an increased risk of physical illness and premature death [7]. The economic impact of mental disorders is huge for the individuals, their families and the society, because of increased health care utilization, lost productivity, unemployment, and of the costs attributable to increased antisocial behavior and crime [7].

Interventions aimed at improving the mental health and wellbeing of children and adolescents may have a broad impact on their developmental trajectories, resulting in a substantial reduction of the impairment and disability attributable to physical illness and mental disorders in adulthood, a decrease in suicide rates, and a diminution of mental health care utilization [7]. Additional benefits deriving from improved mental health of children and adolescents include improved educational outcomes, healthier lifestyle, e.g. a

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Enhancing the Emotional and Social Skills of the Youth to Promote their Wellbeing and Positive Development: A Systematic Review of Universal School-based Randomized Controlled Trials

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Abstract: *Background*: The acquisition of social and emotional skills is associated with positive youth development, character education, healthy lifestyle behaviours, reduction in depression and anxiety, conduct disorders, violence, bullying, conflict, and anger. School-based interventions aimed to enhance these skills go beyond a problem-focused approach to embrace a more positive view of health; they could also improve the youth's wellbeing. *Aim*: To describe the main features and to establish the effectiveness of universal school-based RCTs for children and the youth, aimed to promote their psychosocial wellbeing, positive development, healthy lifestyle behaviours and/or academic performance by improving their emotional and social skills. *Methods*: Systematic review by searching for relevant papers in PubMed/Medline with the following key words: "mental health" OR "wellbeing" OR "health promotion" OR "emotional learning" OR "social learning" OR "emotional and social learning" OR "positive youth development" OR "life skills" OR "life skills training" AND "school". Interval was set from January 2000 to April 2014. *Results*: 1,984 papers were identified through the search. Out of them 22 RCTs were included. While most interventions were characterized by a whole-school approach and SAFE practices, few studies only used standardized measures to assess outcomes, or had collected follow-up data after ≥ 6 months. The results of all these trials were examined and discussed. *Conclusion*: Universal school-based RCTs to enhance emotional and social skills showed controversial findings, due to some methodological issues mainly. Nevertheless they show promising outcomes that are relatively far-reaching for children and youth wellbeing and therefore are important in the real world.

Keywords: Children wellbeing, emotional skills, health promotion, positive development, randomised controlled trials, school, social skills.

BACKGROUND

The WHO [1] defines mental health as "a state of wellbeing in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". Wellbeing itself is one of the aims of the WHO strategy "Health 2020", which states that mental health promotion involves building peoples' resilience against various stressors in their lives [1-6]. Resilience is defined as the universal capacity that allows a person, group or community to respond proactively to new situations and to prevent, minimize or overcome the damaging effects of adversities [1, 2, 7].

Research shows that mental health promotion is most effective when it takes place early in a persons' life: therefore school is a favourable implementation setting for these programmes [1-4, 8-10]. The WHO [4] states that "there is ample evidence that school based programs in elementary, middle and high schools can positively influence mental health and reduce risk factors, emotional and behavioural problems through socio-emotional learning and ecological interventions".

Furthermore, recent evidences about school-based interventions promoting mental health and wellbeing point out the need to go beyond a problem-focused approach and embrace a more positive view of mental health [9, 11-16]. This shift involves the acknowledgment that childrens' and youths' wellbeing and mental health are not only influenced by the absence of problems and risk-need concerns, but are also impacted by individual skills and by those positive factors in their social settings that contribute to positive growth and development [10, 12].

From this perspective, extensive research in school, community, and clinical settings has led several authors to offer recommendations for effective school-based interventions on emotional and social skills to promote positive youth development, mental health and wellbeing [9, 12, 17, 18]. These interventions include a whole school approach, in which multi-component interventions involve students, teachers, the school environment and the community by par-

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Integrating Children with Psychiatric Disorders in the Classroom: A Systematic Review

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Abstract: *Background*: The school setting may be the optimal context for early screening of and intervention on child mental health problems, because of its large reach and intertwinement with various participants (child, teacher, parent, other community services). But this setting also exposes children to the risk of stigma, peer rejection and social exclusion. This systematic literature review investigates the efficacy of mental health interventions addressed to children and adolescents in school settings, and it evaluates which programs explicitly take into account social inclusion indicators. *Method*: Only randomized controlled trials conducted on clinical populations of students and carried out in school settings were selected: 27 studies overall. Most studies applied group Cognitive Behavioural Therapy or Interpersonal Psychotherapy. *Results*: Findings were suggestive of the effectiveness of school-based intervention programs in reducing symptoms of most mental disorders. Some evidence was found about the idea that effective studies on clinical populations may promote the social inclusion of children with an ongoing mental disorder and avoid the risk of being highly stigmatized. *Conclusion*: School programs are still needed that implement standardized models with verifiable and evidence-based practices involving the whole school community.

Keywords: Educational context, mental health, school.

INTRODUCTION

Schools are considered the ideal setting for the implementation of mental health treatment interventions, for several reasons.

Since the vast majority of children attends school and spends a considerable amount of time in school, the school is not only a setting for the early detection of children at risk of mental health disorders, but it also creates numerous possibilities to target these children with early interventions. Furthermore, the school provides a complex, far-reaching network of community, parents, teachers and peers who, when involved, have a large potential of influencing child development.

School-based screening or treatment programs for common mental disorders can raise complex issues as well. One often feared risk is the potential over-diagnosing of students with the risk of stigmatizing them with a life-long label, damaging their social interactions and peer acceptance. Indeed, stigma and discrimination behaviour towards mental health disorders have been observed in even the youngest school children [1, 2].

To avoid the risk of stigmatization, there is some agreement that school-based screening and intervention programs should not merely address clinical or cognition-based problems, but also include experiential social activities, engage students' feelings and behaviour thus facilitating their interaction with others, and develop their social skills [3, 4]. Within the worldwide call to eliminate and prevent mental health stigma and its antecedents [5], programs aimed at facilitating integration of children with psychiatric problems in the community were developed and tested.

Social competence is an important aspect in youth development and can be defined as the ability to form and maintain positive relationships and pro-social styles of interaction, and the ability to read social situations and to interpret them correctly. The absence of pro-social strategies often leads to dislike by peers, hence social exclusion. For children with a mental disease, peer-rejection at school can prompt or exacerbate antisocial development, while acceptance by peers could buffer the effects of dysfunctional behaviors [6, 7]. Interventions effectiveness could therefore benefit from the inclusion of strategies that strengthen social competence and stimulate peer acceptance in the school setting and in the community [6, 8, 9], and vouch for a functional network and community.

To create efficient functional networks and communities, school-based mental health activity and intervention programs increasingly involve families and school personnel in treatment. There is some evidence that positive interaction of families and school staff helps to achieve an overall functional school climate. Providers and families who work col-

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58 *Clinical Practice & Epidemiology in Mental Health*, 2015, *11*, (Suppl 1: M4) 58-76

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Interventions on Bullying and Cyberbullying in Schools: A Systematic Review

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Abstract: *Background*: bullying (and cyberbullying) is a widespread phenomenon among young people and it is used to describe interpersonal relationships characterized by an imbalance of power. In this relationships often show aggressive behavior and intentional "harm doing" repeated over time. The prevalence of bullying among youth has been reported to vary widely among countries (5.1%-41.4%) and this behavior seems generally higher among student boys than girls. Several school interventions have been developed to reduce bullying, but reported inconsistent results possibly related to limitations in the study design or to other methodological shortcomings. *Aims*: evaluating randomized-controlled trials (RTCs) conducted between 2000 and 2013 to assess the effectiveness of school interventions on bullying and cyberbullying. *Methods*: a systematic search of the scientific literature was conducted on Pubmed/Medline and Ebsco online databases. We also contacted experts in the field of preventive bullying research. *Results*: 17 studies met the inclusion criteria. The majority of studies did not show positive effects in the long term; the interventions focused on the whole school were more effective in reducing bullying than interventions delivered through classroom curricula or social skills training alone. *Conclusion*: while there is evidence that programs aimed at reducing bullying can be effective in the short term, their long-term effectiveness has not been established, and there are important differences in the results based on gender, age and socio-economic status of participants. Internal inconsistency in the findings of some studies, together with the wide variability of experimental designs and lack of common standardized measures in outcome evaluation, are important limitations in this field of research.

Keywords: Bullying, cyber bullying, randomized controlled trials, school.

INTRODUCTION

Bullying is a significant problem in schools [1]. It is defined as intentional aggressive behaviour by a single person or a group against a peer who cannot easily defend himself/herself. Its nature is repetitive over time, lasting weeks and, at times, even months or years. Bullying can take on the following forms: physical (punching or kicking, seizing or damaging other people's belongings); verbal (ridiculing, insulting, repeatedly mocking someone, making racist remarks); relational (leaving one or more peers out of aggregation groups) and indirect (spreading rumours or gossip about a student) [2].

In recent years, as a result of the widespread use of smart phones and Internet access among youth, another phenomenon has surfaced: cyberbullying. Cyberbullying is characterized by the use of electronic forms of contact (e.g., phone calls, text messages, picture/video clips, e-mails, chat rooms, instant messaging, websites) [3], that allow the perpetrator to remain anonymous and intensify feelings of discomfort in the victim [4]. Cyberbullying can take on the following forms: flaming (online fights using electronic messages with angry and vulgar language); harassment (repeatedly sending mean, insulting messages); cyberstalking (repeated, intense harassment and denigration that includes threats or creates significant fear); denigration (spreading rumours online; sending or posting gossip about a person to damage his/her reputation or friendships); impersonation (pretending to be someone else and sending or posting material to get that person in trouble or danger, or damage that person's reputation or friendships); outing (sharing someone's secrets or embarrassing information or images online); trickery (tricking someone into revealing secrets or embarrassing information, then sharing it online); and exclusion (intentionally and cruelly excluding someone from an online group) [5].

Three main roles have been identified within the bullying cycle: the bully, the victim, and bystanders [6]. Usually the bully is the strongest among peers and has a strong need for power. In fact, the main purpose of bullying behaviours is to undermine the social status of the victim and his/her sense of personal security, while at the same time raising the bully's self-esteem and social status. As a consequence, bullying

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Physical Activity Interventions in Schools for Improving Lifestyle in European Countries

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Abstract: *Background*: In the last decades, children's and adolescents' obesity and overweight have increased in European Countries. Unhealthy eating habits and sedentary lifestyle have been recognized to determine such an epidemic. Schools represent an ideal setting to modify harmful behaviors, and physical activity could be regarded as a potential way to avoid the metabolic risks related to obesity. *Methods*: A systematic review of the literature was carried out to summarize the evidence of school-based interventions aimed to promote, enhance and implement physical activity in European schools. Only randomized controlled trials were included, carried out in Europe from January 2000 to April 2014, universally delivered and targeting pupils aged between 3 and 18 years old. *Results*: Forty-seven studies were retrieved based either on multicomponent interventions or solely physical activity programs. Most aimed to prevent obesity and cardiovascular risks among youths. While few studies showed a decrease in BMI, positive results were achieved on other outcomes, such as metabolic parameters and physical fitness. *Conclusion*: Physical activity in schools should be regarded as a simple, non-expensive and enjoyable way to reach all the children and adolescents with adequate doses of moderate to vigorous physical activity.

Keywords: European countries, obesity prevention, physical activity, school-based intervention.

BACKGROUND

The optimal dose of moderate-to-vigorous physical activity (MVPA) recommended by guidelines to ensure children's healthy growth and to avoid the risk of metabolic and cardiovascular diseases is 60 minutes/day 5 days/week [1]. Furthermore, sport participation has been associated to psychological and social health benefits for youths, like increase self-esteem, low depression and anxiety, and even suicide behavior protection [2]. School-based interventions are worldwide aimed to promote children's wellbeing [3], and to avoid the risk of mental disorders and the stigmatization of those affected [4].

According to the latest report of the World Health Organization (WHO), one of three/four children and adolescents in Europe is overweight or obese [5]. Eating unhealthy foods, a decrease in physical activity, and a global increase in sedentary activities were suggested to be causes for the rise of the youths' obesity epidemic in European Countries.

While not in every European Country do children have meals at school, all European pupils have on average two hours per week of compulsory physical education in their academic curriculum. Moreover, schools generally have gyms, but also schoolyards, and even classrooms, which might be used to exercise. Thus, schools should be regarded as an ideal place to modify unhealthy habits, and a natural setting to learn, promote and enhance physical activity.

METHODS

We carried out a systematic review of the literature to summarize the evidence of the effectiveness of school-based physical activity interventions from trials carried out in European Countries since 2000.

A search for relevant papers was performed on PubMed, Google Scholar and Scopus using the following keywords: *school* or *school-based* or *schoolchildren*, and *physical activ-*

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The School Children Mental Health in Europe (SCMHE) Project: Design and First Results

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Abstract: *Background*: The School Children Mental Health in Europe (SCMHE) project aims to build up a set of indicators to collect and monitor children's mental health in an efficient and comparable methodology across the EU countries. It concerns primary schools children aged 6 to 11 years a range where few data are available whereas school interventions are promising. *Methods*: Three informants were used: parents, teachers and children. In selecting instruments language, instruments were selected according to the easiness to translate them: SDQ (Strengths and Difficulties Questionnaire) for parents and teachers and DI (Dominic Interactive). A two-step procedure was used: schools randomization then six children by class in each grade. *Results*: 9084 children from seven countries (Italy, Netherlands, Germany, Romania, Bulgaria, Lithuania, and Turkey) completed the Dominic Interactive in their own language. 6563 teachers and 6031 parents completed their questionnaire, and a total of 5574 interviews have been completed by the 3 informants. The participation rate of the children with parents in the participating schools was about 66.4%. As expected teachers report more externalised problems and less internalised problems than parents. Children report more internalised problems than parents and teachers. Boys have consistently more externalised problems than girls and this is the reverse for internalised problems. Combining the diverse informants and impairment levels children with problems requiring some sort of mental health care were about 9.9%: 76% did not see any mental health professional: 78.7% In Eastern countries 63.1% in Western Europe.

Keyword: Children, dominique interactive, epidemiological survey, Europe, mental health, strengths and difficulties questionnaire.

1. INTRODUCTION

Promoting children and adolescents' mental health and wellbeing is supported by the literature reviews from the previous chapters. School is there presented as a major setting for interventions. In order to evaluate and monitor these interventions, data collection on child mental health most commune problems is required.

Numerous studies have examined the epidemiology of child and adolescent internalized and externalized disorders in school-age youths [1] (Roberts, Attkisson, & Rosenblatt, 1998). Table **1** presents the results of a meta-analysis of data on the prevalence of internalized and externalized disorders in young people from more than 50 community surveys from around the world, published in the past 15 years (updated from Costello, Mustillo *et al.*, 2004; In IOM; 2009 [2]).

In this meta analysis sample size, number of prior months that subjects were asked about in reporting their symptoms and age of participants were controlled. It was observed a mean estimate for any diagnosis of 17% (standard error, SE, 1.3%). Anxiety disorders were common (8%), followed by depressive disorders (5.2 %) and ADHD (4.5%). However, this recent comprehensive review indicated that only a small proportion of these youth actually have sufficiently severe distress or impairment to warrant intervention. Moreover, the prevalence divergences, in part due to different ways to include impairment into the diagnoses, was pointed out as a major obstacle.

Several studies have noted that boys are more likely to present behavioral and externalized disorders while girls have emotional problems (Breton *et al.*, 1999; Fergusson *et al.*, 1993; Goodman *et al.*, 1998; Meltzer *et al.*, 2003; Simonoff *et al.*, 1997) [3-7]. Boys are more likely vulnerable to disorders with early onset, such as disruptive behavior disorders, and ADHD (Rutter, Caspi, and Moffit, 2003) [8]. Otherwise, after puberty, Depression and anxiety increase markedly in girls but not in boys (Rutter, Caspi, and Moffitt, 2003) [8].

Most of children with externalized disorders are likely to suffer from a later internalized disorders, such as anxiety or

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Concluding Remarks

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Mental disorders are highly prevalent in Europe and are a major burden on society. Age, gender and various social factors can influence the incidence of mental disorders; however no group is immune. Mental disorders can alter the lives of children as well as adults, causing enormous suffering and disability.

In fact, there is increasing evidence on the frequent onset of mental disorders during childhood, as well as on the significant impact these disorders can have on the physical and mental disorders in later periods of the life course.

There is also increasing data proving that positive mental health and well-being is a key factor for social cohesion, economic progress and sustainable development in the EU. Mental health is a human right and a key resource for the success of the EU as a knowledge-based society and the accomplishment of the objectives of the Lisbon strategy.

Significant efforts were made by EU and MS to tackle these challenges, which resulted in the creation of indicators and data bases, development of guidelines and other tools for the improvement of mental health interventions, and creation of networks supporting research, care and policy development. Yet, despite all these efforts, a lot remains to be done. A significant proportion of the general European population, including children and adolescents, has unmet need for mental health care. In promotion and prevention there is also a huge gap: the majority of the populations don't benefit from the interventions that have proved to be effective in these domains.

There is evidence showing that poor implementation of recommended mental health actions in the past is associated to lack of commitment of policy makers and other stakeholders, insufficient resources allocated to mental health, resistance to innovation, and insufficient integration of mental health in other policies. These and other barriers to be identified must be addressed in order to make possible the realization of the Europe 2020- strategy for smart, sustainable and inclusive growth, which requires actions to prevent and treat mental disorders, and to promote positive mental health in the population.

It was in this context that the European Pact for Mental Health and Well-being, launched in June 2008, agreed that "there is a need for a decisive political step to make mental health and well-being a key priority" and that "the mental health and well-being of citizens and groups, including all age groups, different genders, ethnic origins and socio-economic groups, needs to be promoted based on targeted interventions that take into account and are sensitive to the diversity of the European population".

To attain these objectives, a Joint Action on Mental Health and Well-being, including working group on mental health and wellbeing of children and adolescents in the school setting was created in 2012. This working group has reviewed the available knowledge and resources resulting from other mental health projects in Europe, has analyzed previous initiatives in order to better identify the ingredients that should be taken into consideration to improve the effectiveness and sustainability of future initiatives, and has been developing recommendations for action at EU and MS level to improve the effectiveness of mental health policies implementation.

This report, presenting an important part of this work, confirms that children and adolescents mental health is indeed an important public health issue in Europe. It also offers an excellent review of the available evidence on the effectiveness of prevention and promotion programs, confirming that school-based programs can have a major role in the improvement of mental health and well-being of children and adolescents. The promising findings found on the effectiveness of programs aimed at promoting general health and wellbeing in the school, programs designed to promote the integration of adolescents with specific problems, and interventions to prevent major problems such as bullying, obesity and alcohol and drugs consumption among children and adolescents, show that, despite the increasing attention most countries have dedicated to this issue, much more can be done in the future. The information gathered in this Report has important policy implications and certainly will be an excellent inspiration for the framework for action that European countries will adopt in the future.

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APPENDIX 2: POLICY RECOMMENDATIONS MENTAL HEALTH AND SCHOOLS

The Policy Recommendations consist of four recommendations that reflect the points that resulted to be most relevant with reference to the promotion of mental health and well-being of children and adolescents in the school context.

Each recommendation is followed by four specific actions supported by examples of good practice, which were made available by participating countries or retrieved from European and International literature.

Joint Action on Mental Health and Well-being

POLICY RECOMMENDATIONS

Mental Health and Schools

This document is not intended to be comprehensive in terms of recommendations and actions to be taken.

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BACKGROUND AND RATIONALE

- The burden of mental disorders and self-inflicted injury among the 407 million population of high income European countries is 30% compared to cancer (17.1%) or cardiovascular disease (16.0%) as measured by Disability Adjusted Life Years (DALY's) (WHO, 2014). However, even this is a significant underestimate since it does not include several mental disorders which affect a further 75.6 million people across the European Union (Wittchen et al., 2011);
- Half of lifetime mental illness has arisen by the age of 14 (Kim-Cohen et al., 2003; Kessler et al., 2005);
- Children with co-morbid depression and conduct disorders have higher adult service use and costs than the general population or those with depression alone (Knapp et al., 2002);
- Mental and behavioural disorders during childhood and adolescence lead to higher rates of adult mental disorders including common mental disorders, schizophrenia and mania, substance misuse, suicidal behaviour and personality disorders (Fergusson et al., 2005; Colman et al., 2009; Odgers et al., 2007; NICE, 2009; NICE, 2013);
- Cost savings can be made following investments to promote children's and adolescents' mental well-being, prevent and treat mental and behavioural disorders (Czabała, Charzyńska, et al., 2011) (McDaid & Park, 2011) (Knapp, McDaid, & Parsonage, 2011) (EAHC, 2013). Investing in education at an earlier age could help prevent early school-leaving. The Juncker investment plan (2014) foresees additional investment in several areas including for the education sector;
- Benefits of mental well-being 'outside health' include improved educational outcomes, healthier lifestyle and reduced health risk behaviour such as smoking, increased productivity at work, fewer missed days off work, higher income, improved social relationships, reduced anti-social behaviour and crime (NICE, 2009; Mills et al., 2007);
- It is proven that, particularly in adolescence, lifestyles such as sedentary behaviour and lengthy screen time may represent risk factors for mental health (Maras et al., 2015). There is evidence that regular physical exercise and moderate use of electronic media may favour good mental health (Lees & Hopkins, 2013; Ray & Jat, 2010). In this regard, literature also reports that electronic media use is negatively related with sleep duration and positively with sleep difficulties, which in turn is related to depressive symptoms (Lemola et al., 2015);
- Pupils spend more than six hours per day in school, totalling more than 180 days per year (OECD, 2014), therefore school, together with the child care services, provides an excellent opportunity for:
  - promotion of positive mental health and well-being among children and adolescents;
  - prevention of mental and behavioural problems, early recognition of mental disorders and appropriate referral;
- There is a growing evidence base for the effectiveness of mental health promotion in schools, in terms of both promoting positive mental health for all and treating those who suffer from poor mental health (Shucksmith et al., 2007);
- Opportunities for involvement in school life, positive reinforcement from academic achievement, identity with a school or need for educational attainment are protective factors that can affect the mental health of a child or adolescent. On the other side, risk factors are: academic failure, failure of schools to provide an appropriate environment to support attendance and learning, inadequate/ inappropriate provision of education (WHO, 2005);
- The European Pact for Mental Health and Well-being (2008) provided a framework for the exchange and cooperation between Member States (MSs) and stakeholders for promoting better mental health

in the European population and saw the organisation of 5 Thematic conferences in the following years, one of which was “Mental Health in Youth and Education”, 29-30 September 2009 (Stockholm)”. The Compass, an online resource developed by the EC in parallel to the thematic conferences, contains information on the 5 priority issues of the European Pact for Mental Health and Well-being;

- The Conclusions of the Vilnius Conference (October 2013) recommend to Member States and the Commission to address mental health as a priority of EU-education policy activities on early child education and care and on school education, by including mental health in future work to strengthen ‘whole school’-approaches and by considering to invite a study on “Mental health, educational attainment, school failure and early school-leaving in the EU”;
- According to the Eurostat figures for 2012, a majority of EU Member States have made progress on the Europe 2020 education target to reduce the rate of early school leaving to below 10%. The share of young people leaving school early now stands at 12.6% on average in the EU, down from 13.4% in 2011, making early school leaving still a challenge. However, there are still wide disparities between Member States, as only 12 countries have already achieved the target;
- Numerous initiatives and tools focusing on mental health of children and adolescents have been co-funded under the EU Public Health Programmes in recent years. Most of these projects were implemented in schools, the elective setting for the prevention and/or promotion of the mental health of children and adolescents (e.g., CAMHEE, SEYLE, SCMHE, SUPREME);
- The EU Council of Ministers recognises the importance of an integrated approach to the promotion of mental health, and specifically recommends to the Member States, among others, to: “Build innovative partnerships between the health and other relevant sectors (e.g., social, education, employment) to analyse policy impact on mental health, to address mental health problems of vulnerable groups and the links between poverty and mental health problems, to address suicide prevention, to promote mental health and well-being and to prevent mental health disorders in different settings, such as workplaces and educational settings” (2011);
- Finally, on 20 February 2013, the European Commission issued a recommendation on “Investing in children: breaking the cycle of disadvantage” for tackling poverty and social exclusion of young people in Europe so as to encourage Member States to organise and implement policies to address child poverty and social exclusion, promoting children’s well-being. The Commission also calls for enhanced coordination between the key actors involved in developing and implementing policy initiatives to combat child poverty and social exclusion, including states, local communities and civil societies.

MAIN FINDINGS

- Despite the availability of data on the burden of mental health and behavioural disorders for the general population, data on mental health among children and adolescents retrieved in the review phase are not homogeneous, due either to lack of data or different age ranges considered in national statistics. This is in line with the International literature, which highlights that defining the burden of disease due to mental health problems of children and adolescents still remains an unmet target. According to WHO (2014) suicide is the second leading cause of death in the age range 15-29 years worldwide, and data of 2004 report that neuropsychiatric disorders for 10 to 24 year olds ranked as the first cause of Years Lived with Disability (YLDs), with a prevalence of 45%;
- Early school leaving: as highlighted by the situation analysis in the European countries involved in the preparation of this document, percentages on school drop-out show that further efforts need to be made to address this issue: referring to data of 2011, the percentages for the drop-out rate to the last grade of general lower-secondary education vary from 0,07% (Finland) to 18,6% (Malta);
- Teachers and Educational psychologists in the frontline: as documented in literature and confirmed by the situation analysis carried out in the European countries involved in the preparation of this document, teachers and educational psychologists are the professional categories who are primarily responsible for delivering promotion of mental well-being and prevention through the practical implementation of projects in education settings. However, they may not always be fully equipped, for example in terms of appropriate training and support, to cope with this responsibility, particularly when it comes to the detection of early signs of mental and behavioral disorders for prompt referral purposes;
- Identification of mental and behavioural disorders: the situation is fragmented in Europe, as screening for mental and behavioural disorders has been introduced to some extent in some countries but with varying approaches;
- Cross - Budgeting: despite the broad impacts and costs of mental and behavioural disorders across sectors, there is generally an absence of a shared budget or joined up commissioning between sectors when it comes to mental health and well-being of children and adolescents which complicates service provision and case management;
- Expenses for treatment: in Europe a large amount of money is spent on the treatment of child and adolescent mental and behavioural disorders, while the majority of the European countries involved in the preparation of this document tend to rarely fund the promotion of mental well-being and prevention of mental disorders among children and adolescents, also through the promotion of mental well-being of teachers and other professionals who are in close contact with them, despite the economic savings even in the short term;
- Costs estimation: International literature and analysis of the situation in the European countries involved in the preparation of this document show that data on Governments' expenditures on mental health as a percentage of total government expenditures and data on human resources employed in the area of mental health is available (WHO, 2011), while data on workforce and financing specifically dedicated to the mental health of children and adolescents from the health, education and social sector is not available;
- Data comparability and compatibility is still too complicated as measures of mental health and its determinants vary between countries; outcomes are frequently expressed in terms of self-evaluation; follow-up is executed only in the short term or does not exist at all;
- Economic evaluation and evaluation of the results of programmes and policies aimed at the promotion of mental well-being, prevention and treatment of mental and behavioural disorders

among children and adolescents need to be strengthened; in general, a lack of standardized measures in the evaluation of the outcomes can be observed;

- Inter-sectoral collaboration between the health, education, social and other relevant sectors with regard to the mental health of children and adolescents is generally lacking in the European countries contributing to this document, despite its broad range of impacts; where in place, often this is not formalised in a policy or legislative framework.

OVERARCHING PRINCIPLES

- Identify children and adolescents as a priority target group of every countries' national Mental Health strategy;
- Consider that, although school represents the elective setting for mental health promotion and mental disease prevention activities, some minorities, such as Roma children, migrant children, street children do not benefit from such interventions;
- Tackle mental health and well-being of children and adolescents through ad hoc integrated strategies aiming to ensure children lead fulfilling lives, develop individual competencies and have access to equal opportunities;
- Ensure that the children rights approach is incorporated when devising any programmes in accordance with the relevant legislative provisions, namely the Treaty on the European Union, the Charter of Fundamental Rights of the European Union and the UN Convention on the Rights of the Child to ensure the respect of fundamental rights which constitutes per se a protective factor for mental health and well-being;
- Recognise the impact of stigma surrounding mental health problems, which constitutes one of the main barriers for an effective promotion of the mental health and well-being of children and adolescents both inside and outside of the school setting, not only in terms of preventing people from seeking help and accessing to care but also with regard to availability and prioritizing of appropriate services;
- Acknowledge the central role of professionals (school staff above all) in the promotion of mental well-being of children and adolescents and as such guarantee that these professionals will receive the necessary support (e.g., in terms of appropriate training) to fulfil this responsibility;
- Make sure that there is a good balance between universal initiatives, which address the whole population, and targeted approaches, aimed at supporting the higher risk groups or children and adolescents with emerging problems;
- Recognise the critical role of families and carers in the promotion of mental health and well-being among children and adolescents, in the prevention of mental disorders, early recognition and treatment;
- Ensure sustained and shared financing by the different sectors so as to ensure continuity, complementarity, efficient use of resources and long-term planning;
- Set and maintain an adequate system of data collection and data analysis as evidence base for setting strategies and plans aiming at the promotion of mental health and well-being of children and adolescents;
- Ensure systematic evaluation based on standardized measures and procedures as a basic component of programmes and policies aimed at the promotion of mental well-being, prevention and treatment of mental and behavioural disorders among children and adolescents;

- Always consider the role of the social media, not only in terms of its potential as a mental health promoting and disease prevention channel, but also as a new arena for children, which can be beyond the control of parents and other care givers;
- Acknowledge the importance of an operative collaboration among the sectors involved in mental health promotion including, among others the health, the social and the education sector so as to maximize efficacy of intervention.

POLICY RECOMMENDATIONS

1. Strengthen information and research on mental health and well-being among children and adolescents.

a. Establish a solid information base so as to have a detailed epidemiological frame of the mental health among children and adolescents and evidence on interventions.

Strategic planning has to rely on an evidence base in order to allow the definition of mental health priorities according to the level of well-being and prevalence of mental and behavioural disorders among children and adolescents (Conclusions of the Vilnius conference, 2013), including higher risk groups, such as Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) or children and adolescents who are bullied or living in poverty conditions.

Examples of good practice[5]

Norwegian Health Information System - Norhealth *(www.norgeshelsa.no) is an interactive web-based health information system, also available in English, developed to create a knowledge base for health promotion and prevention strategies in Norway. It monitors health and health related conditions, including risk- and protective factors, over time, targeting politicians, decision makers, media, students and health professionals. Norhealth has currently 40 health indicators, which correspond roughly to the European Community Health Indicators (ECHI) short list. Data is presented at the national and regional level and by age group and gender. Future developments include linking fact sheets to figures in Norhealth, writing annual health reports, translating fact sheets to English, improving user friendliness, adding more health indicators and monitoring social inequalities in health.*

YoungMind *is a database of* ***Norwegian*** *evidence based interventions for the promotion of mental health of children and adolescents. Interventions can be implemented in different types of services such as kindergartens, schools, child welfare services, healthcare services for children, or specialized mental health care services. A review of the research related to the effectiveness of the intervention is included. Based on the current level of evidence, the interventions are classified in one of four levels of evidence, where high quality research (e.g., RCT studies) showing consistent effects, represent the highest levels of evidence (level 4). The main aim of YoungMind is to simplify access to information, but also to encourage more research on the effectiveness of interventions in Norway.*

5 For the identification of good practice, preliminary review was conducted by all the countries involved in the work on "Mental health and schools" according to CDC definition (2010). Following a second analysis, the most fitting examples for each of the specific actions listed under the PRs were selected. Only evaluated initiatives were included. Where available European projects were given priority and only practices from 2000 onwards were considered.

*A relevant example of research reinforcing epidemiological and statistical capacity is the **European School Survey Project on Alcohol and other Drugs (ESPAD,** www.espad.org), which involves more than forty European countries and which is the largest cross-national research project on adolescent substance use in the world.*

***ADOCARE** (www.adocare.eu) is a European cross-sectoral consortium linking psychiatrists specialised in adolescence, psychologists, experts, researchers, stakeholders, policy-makers, care givers, care users, educators, parents and youth with the purpose of promoting and sustaining the creation of adapted and innovative care structures for adolescents with mental health problems.*

Among its objectives, ADOCARE aims to collect information on the state of mental health and mental health problems among adolescents and on existing care facilities and good practices for adolescents with mental health problems in the Member States.

*The **School for Health in Europe Network (SHE**, www.schools-for-health.eu/she-network) encourages research, provides a link to national expertise, and manages a data base of existing national and EU studies and organisations which can support Member States with relevant information.*

b. Provide information on coverage and outcomes of interventions, including for groups at higher risk as well as on the size, impact, cost and potential economic savings of appropriate interventions.

Identification of up to date information about costs-impact ratio of interventions and systematic estimation of the potential savings resulting from opportune mental health promotion interventions enable a more efficient allocation of resources and consequently reduce the public mental health intervention gap concerning children's and adolescents' mental health (Campion & Fitch, 2012).

Examples of good practice

*The **UK Joint Commissioning Panel for Mental Health (JCP-MH**, www.jcpmh.info) is a new collaboration co-chaired by the Royal College of General Practitioners and the Royal College of Psychiatrists. It brings together leading organisations and individuals with an interest in commissioning for mental health and learning disabilities.*

The JCP-MH, part of the government mental health strategy "No Health without Mental Health", aims at integrating scientific evidence, service user and carer experience and viewpoints, and innovative service evaluations in order to produce the best possible advice on commissioning, the design and delivery of high quality mental health, learning disabilities, and public mental health and well-being services. The JCP-MH methodology includes 7 stages: 1. Assess local need; 2. Assess local assets/resources; 3. Assess current service provision (information on quality, effectiveness and cost of current services); 4. Intervention analysis (estimation of the combination and level of coverage of intervention); 5. Intervention plan; 6. Procurement of interventions; 7. Evaluation of the impact of interventions.

*The **"Mental health promotion and mental illness prevention: the economic case"** (2011) analyses the costs and the economic payoffs of a range of interventions in the area of mental health promotion, prevention and early intervention. It was created to support the NHS and other commissioners in assessing the case for investment. This work was carried out by a group of researchers of the London School of Economics and Political Science together with the Centre for Mental Health and the Institute of Psychiatry at King's College London, upon the request of the UK Department of Health (www.eprints.lse.ac.uk/32311/1/Knapp_et_al__MHPP_The_Economic_Case.pdf).*

*The **Europopp – MH publication** (2013) provides an analysis of the European mental health systems and of the benefits to be expected from investments into mental health (www.ec.europa.eu/health/mental_health/docs/europopp_full_en.pdf).*

c. Carry out a mapping and analysis of existing screening tools for early identification, from the first developmental stages, of mental health disorders and poor well-being among children and school populations.

Considering the recent findings on the effectiveness of screening to reduce the burden of disease from depression in children and adolescents (Williams, 2013), obtaining a comprehensive understanding of the different practices in place in Europe concerning screening for mental health, including an evaluation of the efficacy or adverse effects of each practice, will allow to identify the best tools to be used in the school context (Kaess et al., 2013).

Note:

Screening for mental and behavioural disorders has been introduced to some extent into some countries that participated in the project (e.g., Finland, Croatia, Italy, Iceland) but with varying approaches. In Finland for example, screening takes place in public health clinics as part of general check-ups. In Croatia, screening is carried out in some counties in schools but by medical personnel. Other countries (e.g., Germany and Luxembourg) are implementing widespread routine screenings in schools.

There are conflicting views as to the benefits of introducing screening as part of regular check-ups in schools. Literature suggests that screening could provide an added-value in early identification and hence treatment of mental health problems (Kaess et al 2013; Williams 2013). On the other hand, experts participating in this debate and consulted on this subject were more tentative in their support raising questions about this practice in terms of both efficacy and the possible adverse effects on students.

Certainly this is an area which requires further investigation, especially with regard to evaluation of the screening, the choice of the most appropriate screening tools, the skills and training required for implementing the screening and the procedures for the follow-up referral and treatment.

Example of good practice

*In **Iceland, the Compulsory School Act No. 91/2008 (primary and lower secondary)** establishes the municipalities' responsibility for providing specialist services within primary and lower secondary schools, preventive measures in the form of screening and check-ups, and assessment of psychological or social difficulties. Parents can request a developmental or psychological assessment for their child on the basis of this act which is free of charge (art. 40).*

d. Examine the potential to increase the access to information and to services through the use of web-based technologies (e-mental health) for the promotion of mental well-being and the prevention of mental and behavioural disorders.

Negligence of mental health disorders is mainly due to stigma which, according to research results, is one of the main factors preventing people from seeking help and making them avoid face to face therapies (Klein, Mitchell et al., 2009). Internet use is increasing, especially among youth. The great potential of eHealth for the improvement of the quality of care, also in terms of access to services and reduction of expenses, has been recognised (Lal & Adair, 2014; Thonnet et al., 2010) and a number of

studies focusing on development of Internet-based mental health interventions is available (Ritterband, Andersson et al., 2006), but their efficacy and cost-effectiveness should be carefully assessed.

Example of good practice

The European project ***Suicide Prevention through Internet and Media Based Mental Health Promotion (SUPREME)*** *(www.supreme-project.org/) aimed at developing, implementing and evaluating an Internet and media-based, culturally adapted, peer facilitated Mental Health promotion and Suicide Prevention intervention. The project provided a highly interactive website (http://www.supremebook.org/) targeting adolescents and young adults in the age group 14-24 years, and a set of published guidelines, aimed at print and online media that targets young audiences.*

ProYouth *(www.proyouth.eu/home) is an European web-based initiative for health promotion and prevention of eating disorders. Its main objectives are:*

1. Provide information and training on mental health, health promotion and eating disorders;

2. Help youth to early identify their behavioural problems and risk behaviours;

3. Advise on what adolescents can do to be of help to themselves and to their peers;

4. Provide peer support through the web, so as to limit eating disorders and related problems;

5. Promote youth access to appropriate healthcare (e.g., counselling and treatment), so as to shorten the period from the onset of the disease and access to care.

Headspace *(www.headspace.org.au/) is the Australian National Youth Mental Health Foundation targeting young people from 12 to 25 years-old and providing services related to general health, mental health and counselling, services related to education, employment, alcohol and other drug services. It provides information and services for parents and carers and professionals who work with young people. Headspace offers also a confidential, free, anonymous secure space where users can chat, email or speak with qualified youth mental health professionals.*

2. Promote schools as a setting where health promotion and prevention of mental and behavioural disorders and early identification can reach all children and young people.

a. Recognise the role of early childhood education, school and peer education as having a core function for creating opportunities for collaboration among children, parents, care-givers, teachers, school staff and staff of school medical services, according to a whole school approach – WSA.

The importance of the school as an elective setting for socialisation and health promotion activities is widely recognised (WHO, 1998) and the WSA (Weare, 2000) contemplates all the actors which play a relevant role in this. The early years of life have a major influence on mental health and cognitive functioning, as during the first stages of life, development in mental, social, and physical functioning is at its peak. Recent studies (Zachrisson & Dearing, 2014) on the early learning environment have pointed to the health promoting effects and mental disorders preventing effects, particularly among underprivileged children.

Examples of good practice

*In **Iceland, School Management Training (SMT**, www.pmto.is) is a whole-school and **Positive Behaviour Support (PBS)** based programme where Parent Management Training – Oregon model (PMTO) (a treatment programme for parents of children with behavioural problems) is considered a part of the implementation process. SMT schools work according to certain values or standards that the schools set for themselves, e.g., respect, responsibility and consideration.*

Expectations regarding student and staff behaviour and communication within the school are extracted from these values. The focus is on positive communication, direct instructions and encouragement. Unacceptable behaviour among students is defined and stopped systematically in accordance with the disciplinary process of the school. The focus is on solution-based approaches to resolving problems that arise and co-operation with parents. Within the school there is a SMT team which is responsible for providing knowledge and training to staff, students and parents, and evaluates the performance of the project.

*At European level, examples of large scale, agency-led, whole school programmes are: **Health Promoting Schools** (Schools for Health in Europe, 2010, www.schools-for-health.eu/she-network/health-promoting-schools), Healthy Schools (Healthy Schools, 2011, www.healthyschools.org), **Social and Emotional Aspects of Learning (DES**, 2010 – www.nationalstrategies.standards.dcsf.gov.uk/inclusion/behaviourattendanceandseal), and the **Good and Healthy School** (Paulus, 2009).*

*Outside Europe, examples of good practices are **Mindmatters** (2009, www.mindmatters.edu.au) and **Kidsmatter** (2009 www.kidsmatter.edu.au), both of which are implemented in Australia.*

*In **Ireland** the Social Personal and Health Education Support Service (www.sphe.ie/Default.aspx), part of the curriculum, supports the personal development, health and well-being of adolescents and helps to create and maintain supportive relationships. SPHE works in terms of developing skills for self-fulfilment and living in communities, promoting self-esteem and self-confidence, developing a framework for responsible decision-making, providing opportunities for reflection and discussion and promoting physical, mental and emotional health and well-being.*

b. Mandate school administrations to develop and formalise a mental health promoting culture in their statute, so as to systematically address risk factors such as bullying and cyber-bullying.

The provision of knowledge, education for health and life skills supports personal and social development (WHO, Ottawa Charter, 1986), increasing the options available to people to exercise more control over their own health and well-being and over their environments. Opportunities to promote the health and well-being of children and adolescents should permeate all aspects of school life. Therefore, schools must embed in their national education curricula the teaching of mental health development, encouraging a health promoting culture to combat stigma through the combined implementation of universal and focused programmes on the management of emotional, behaviour and relationship skills.

Examples of good practice

WHO and UNESCO *have jointly issued a manual (www.who.int/school_youth_health/media/en/sch_local_action_en.pdf?ua=1) meant as a practical, "how-to" guide for school administrators, teachers and community leaders. It offers school leaders the organising ideas and very practical activities to identify health issues in their school and community and take steps, through the school, to improve health and learning.*

Within this conceptual frame, examples of programmes implemented across Europe are:

In ***Italy****, the project* ***United we stand: together against bullying*** *(www.ordinepsicologilazio.it/psicologi/progetti/insieme-contro-il-bullismo) has the following objectives:*

- *In the short term: 1. Offer psychological support in cases of bullying; 2. Provide advice for primary prevention in risk cases.*
- *In the mid-term: 1. Promote empowerment among adolescents, mutual respect and group participation, stimulate positive ego, contribute to improving relationships in classrooms, 2. Inform the teachers and parents of the socio-psychological characteristics of the phenomenon and of the juridical-legal aspects of violence among minors.*
- *In the long term: 1. Prevent and fight against episodes of bullying, through the promotion of respect, non-violence and legality, 2. Promote the acquisition of instruments by the teachers for the development of didactic, theoretical/practical modalities for tackling difficulties in cases of aggressive behaviours.*

The ***Finnish KiVa*** *school (www.kivaprogram.net) is a research-based anti-bullying program that has been developed in by the University of Turku and funded by the Ministry of Education and Culture. It has spread at national level: 90% of all comprehensive schools in the country are registered KiVa schools implementing the program. The KiVa program involves both universal and indicated actions to prevent bullying and to tackle cases of reported bullying. Efforts are made to influence the group norms and to build capacity in all children to behave in constructive ways, to take responsibility for not encouraging bullying, and to support the victims. KiVa reduces anxiety and depression and has a positive impact on students' perception of their peer climate. In addition, positive effects on school liking, academic motivation and achievement have been reported. It addresses multiple forms of victimization, including verbal, physical and cyberbullying. The effectiveness of KiVa demonstrated a significant reduction of both self- and peer-reported bullying and victimization.*

c. Actively consult children and adolescents and their families when developing any programmes to ensure their best interests are taken into account, particularly in the definition of objectives and quality criteria.

Needs assessment is a crucial phase for the proper planning and implementation of an intervention, and a careful definition of the parties to be consulted is to be made. In order to create a health promoting environment, the perspectives of all the relevant actors of the "whole school community" should be carefully integrated (Weare & Markham, 2005). Therefore children, adolescents and their carers should always be actively involved.

Examples of good practice

*In **Estonia**, the **Network of Health Promoting Schools** (www.vana.tai.ee/?id=4902) has been coordinated by several institutions: first by the Ministry of Social Affairs and by the Management Board (members of Ministry of Science and Education and HP schools), and since 2003, by the National Institute for Health Development (NIHD). The network foresees the establishment of "health councils" in the schools which, on a voluntary basis, include also students. The training comprises the teaching of general skills such as problem-solution, decision-making, cognitive skills to resist the influence of the media and other people, skills for developing self-control and self-esteem, skills for effective copying with stress and anxiety and general skills for establishing oneself.*

The council consists of the following people:

- *representative of the school administration (the principal or head teacher);*
- *teacher of human studies;*
- *representative(s) of students (recommendable member/members of the student self-government);*
- *health specialist (s) (school's doctor or nurse);*
- *teachers of physical training, biology or any other similar subject;*
- *representative(s) of parents (at comprehensive schools, recommended a member of the board of governors);*
- *teacher of extra-curricular activities;*
- *school's psychologist, social worker or teacher of social pedagogy;*
- *representative of the local municipality.*

Thus, the decisions of the health council reach all students, teachers and parents. Cooperation between the school's health council, student self-government body, the board of governors, the school's administration and the local municipality creates the synergy necessary for successful implementation of health promotion activities in school setting.

*In **Belgium** (FR) the government has decided to finance specific training for pupils who are elected by their peers to be class delegates. They can act as mediators to tackle problems inside their own class group, between different class groups, their peers and the staff of the school such as educators, teachers, and headmasters.*

d. Put in place evidence based interventions to combat early school leaving, since education is a protective factor for mental health and well-being of children and adolescents.

Education has a clear impact on the mental health of individuals by offering access to health information, helping them acquire social support and mitigating the effect of social stressors (Ross & Wu, 1995). School based interventions which can reduce the drop-out rates should therefore be of particular interest. Research from the US identifies the school based types of interventions that have the potential in reducing drop-out rates (Freudenberg & Ruglis, 2007), as those which address school climate, substance abuse prevention and treatment, violence prevention, mental health, HIV and sexual health.

Examples of good practice

Zippy's friends *(www.partnershipforchildren.org.uk/zippy-s-friends.html),* ***a project implemented in different European Countries****, is a 12-lesson universal prevention curriculum that aims to enhance children's coping skills and ability to cope with difficult situations and adversity in daily life. The curriculum is intended for 5-7 year old children in preschool and elementary school. Research indicates that the program has significant positive effects on children's coping and social skills.*

In Spain, one of the most comprehensive and successful campaigns was ***"When I grow up I want to be…"*** *(www.gitanos.org/campannas/de_mayor_quiero_ser.html.en) which targeted Spanish Roma community. Its purpose was to make Roma youth and their families, as well as the educational community, aware of the importance of pursuing studies to reach a profession, using photos which reflect the Roma children's dreams for the future and what they want to be when they grow up. The project intended to prevent early school leaving, as the majority of young Spanish Roma drop out of school before completing compulsory secondary education.*

At policy level, in the ***Netherlands****, a special unit within the Ministry of Education manages the national programme for reducing early school leaving. Six "account managers" have been assigned responsibility for early school leaving across a number of regions. They negotiate agreements with the regional representatives, monitor progress and also provide assistance and support for their regional, local and school level actors. In addition, they also facilitate the exchange of experiences with other regions or schools and hold regular meetings with key people from within the region.*

3. Enhance training for all school staff on mental health.

a. Review current practices in terms of initial and continuing professional development and carry out a consultation to define the training needs, tailored to the local context, for all school staff interacting with children and adolescents.

The content of the training to promote mental health and well-being of children and adolescents should always be in line with International literature and standards, and at the same time take into account the specific background and societal values of the local community. Therefore an accurate analysis of what is already in place in each school, in order to identify the gaps to be filled through school staff training, is always necessary (DES, 2013).

Examples of good practice

*In **Norway**, the Learning environment and pedagogical analysis (**LP-model,** www.lpmodellen.wordpress.com/english/) aims at developing a good learning environment for all. The LP-model provides a working method in which the teachers collaborate in groups, according to specific principles. The LP-model is a system analysis for the analysis of educational challenges, the improvement of learning and the proper tailoring of training in school. The purpose is to obtain an explicit understanding of the factors that trigger, influence and maintain students' actions and behaviour. The model relies on a number of working principles that show how to proceed in order to reach a solution. Teachers are responsible for identifying what needs to be done in order to develop a good learning environment. The identified measures should aim at reducing the importance of the factors that trigger and maintain problems in school. The LP-model does not follow a traditional strategy in which only a specific method or a particular intervention is tested in school: the measures that teachers should implement are developed locally, based on an analysis of the challenges and conditions in each class/group or school, in line with the results of research in this field.*

*At International level, the **International Union for Health Promotion and Education (IUHPE,** www.iuhpe.org/index.php/en/) is a worldwide, independent and professional association of individuals and organisations committed to improving the health and well-being of people through education, community action and the development of healthy public policy.*

IUHPE recognises the importance of schools as key settings for both health education and health promotion. To pursue this objective, it joins International forces to strengthen and advocate for teacher education in health promotion.

Among the different activities, a Working group on research exists, aiming to:

- *describe the different International practices in term of teacher education (TE) in HE/HP.*
- *identify and map the different models underlying TE in HE/HP.*
- *analyse the determining factors of the activity of teacher educators in HE/HP.*

b. Involve in the training also representatives of other sectors, such as social, criminal justice and youth organisations, and allocate appropriate resources.

Mental health is influenced by a broad range of determinants pertaining to different sectors (WHO, 2003). The integrated involvement of all relevant sectors is crucial to exploit the full potential of a mental health promotion intervention (Stahl et al., 2006). Inter-professional training can improve the quality of inter-sectoral daily work (Hean et al., 2011) and ultimately have an impact on the mental health of children and adolescents. In order to put this into practice, European governments should ensure political commitment, coherent planning and foresee adequate funding.

Empirical evidence of the benefits of collaboration in school mental health for youth is emerging (Mellin, 2011), two examples of good practices are provided below:

Examples of good practice

*The **Croatian National Strategy for Prevention of Behavioural Disorders in Children and Youth 2009-2012** (www.mladi-eu.hr/wp-content/uploads/2012/11/068_Nacionalna-strategija-prevencije-poremecaja-u-ponasanju-2009-2012.pdf) is based on an interdisciplinary approach. The Strategy aims at providing minimum conditions necessary for healthy and successful growth and development of new generations, elimination of risk factors for the development of behavioural disorders, as well as the treatment of existing disorders and reducing their consequences. It addressed social care, health care and educational institutions, police, judicial institutions, professional associations, local authorities and NGOs.*

The document defines measures of early support in facing risk factors, including counselling for families at risk and school-based preventive programmes. The strategy includes also procedures for social systems focused on work with high risk groups (children and young people who interrupt schooling, who run away from their families, or from foster care and social care institutions, etc.).

***Youth Access (UK,** www.youthaccess.org.uk/about-youth-access/) provides a holistic response to young people's social, emotional and mental health needs through a range of services provided 'under one roof', including social welfare advice, advocacy, counselling, health clinics, community education and personal support. The projects and activities ensure that links are fostered and sustained between the different sectors impacting on work with young people. Evidence base on young people's needs is provided so as to have a responsible influence on policymakers.*

c. Ensure that training is also made available to the members of the families and caregivers of children and adolescents. Provide opportunities for meeting and training sessions involving both teachers and families, according to a community level approach.

Family is the primary and the most influential system to which a child belongs and the dialogue between families and the educational context should always be encouraged. Parents can benefit from training so as to gain key competencies on how to play a more active role in the promotion of the mental well-being of their children and adolescents (Jané-Llopis, 2005). Parents-teachers combined training has demonstrated to be effective for the promotion of social competencies in children and adolescents (Webster – Stratton et al., 2001).

Examples of good practice

*The **European Early Promotion Project (EEPP**, https://www.webgate.ec.europa.eu/sanco_mental_health/public/GOOD_PRACTICE/45/show.html) is an EU co-funded project which was conducted between 1999 and 2003. It was developed as an innovative service implemented and evaluated in five European countries (Cyprus, Finland, Greece, Serbia, UK). The goal was to design, implement and evaluate a service, carried out by specially trained primary health care professionals (PHCPs), to promote the psychosocial adaptation of parents and infants, enhance their interaction and prevent psychosocial problems. One of its objectives was to train PHCPs in mental health promotion and preventative methods. This involved also training PHCPs to enhance parent-infant interaction and to improve families' problem-solving strategies and resource use. A major achievement of the programme was the development of a PHCP training manual (Davis et al., 2000), applicable to a number of different European countries with different primary care systems, different initial training for their employees and different cultural backgrounds.*

*At International level, **Lions Quest** (www.lions-quest.org/mission.php) is a comprehensive youth development program that promotes social and emotional learning (SEL) in primary and secondary education. It provides a holistic approach to youth development, addressing character development, social and emotional learning, civic values, substance abuse, bullying and violence prevention and service-learning. It is designed to integrate community and parent involvement into the implementation of the program.*

d. Ensure that particular attention is paid also to the positive mental health and well-being of teachers and school staff via continuous support and mentoring. Relevant guidelines for mental health and well-being promotion in schools should be jointly prepared and shared among sectors, including the youth organisations, under the coordination of the education sector.

Continuous education for teachers is foreseen in most European countries on curricular subjects: continuous professional development should apply also for mental health and well-being, involving all the sectors which have a stake in it. Educators have to face a number of emotions when they relate to pupils (Chang & Davis, 2009), therefore the positive mental health of teachers and other school staff should be supported by ensuring continuous access to the most recent materials and resources that can improve the understanding of their own mental health.

Examples of good practice

*The **UK Department of Education** prepares yearly an advice document including information and guidelines to support school teachers for a more effective promotion of mental health and well-being of young people. The **continuous professional development** for staff is one of the mental health promotion tools mentioned in the document. The advice includes a list of sources of support and information services, offering assistance for child mental health issues.*

*One of these sources, **Place2be**, (www.place2be.org.uk/) is a charity working in schools providing early intervention mental health support to children aged 4-14 in England, Scotland and Wales. Place2Be provides teachers and school staff with a consultation service and training sessions which help reduce teacher and staff stress, by providing practical approaches that enable them to support children more effectively.*

In the US context, as well as in the European context (e.g., Ireland, UK, Spain), Mindfulness interventions have been shown to be popular with students and staff. Specific interventions that teach mindfulness to teachers and other school staff have been developed, some connected to existing school based programmes, others within teacher education.

***The UK Network for Mindfulness-based Teacher Training Organisations** (www.mindfulnessteachersuk.org.uk/) develops and disseminates guidelines and resources for teachers and meets annually to develop consensus on Good Practice Standards for teaching mindfulness-based courses and for training others to teach them.*

*The **Cultivating Awareness and Resilience in Education (CARE**) program for teachers (www.garrisoninstitute.org), run in several sites in the US, aims to improve teachers' overall well-being, their effectiveness in providing support for students' emotional well-being, behaviour and learning, their relationships with their students, to improve classroom climate and enhance students' pro-social behaviour.*

4. Consider schools as part of a wider network with other stakeholders and institutions involved in mental health of children and adolescents in local communities.

a. Ensure that the mental health and well-being of children and adolescents is considered when defining and implementing policy in different sectors, including (but not limited to) the health, education and social sector as well as the youth organisations.

The 2005 Commission Green Paper on mental health stressed the relevance of policy areas other than health for the promotion of the mental health of the population. The Vilnius Conference (2013) highlighted that the inter-sectoral dimension still remains one of the main challenges to be addressed in the promotion of mental health. Given the multiplicity of factors associated with early school leaving, the Education sector needs to cooperate with external bodies to contrast it, both at community and at political level (European Commission/EACEA/Eurydice, 2013).

Examples of good practice

The Finnish National Development Programme for Social Welfare and Health Care – Kaste *(www.stm.fi/en/strategies_and_programmes/kaste) is a strategic steering tool that is used to manage and reform social and health policy. It is made up of six sub-programmes and implements the Government Programme and the Strategy of the Ministry of Social Affairs and Health (MSAH). The purpose is that national, regional and local actors work together to implement the reforms. Municipalities and joint municipal boards for social welfare and health care can apply for discretionary government transfers for creating and implementing good practices. Creating more effective services for children, young and families with children is one of the targets of Kaste. Regarding the Social and Health Services, the MSAH is responsible for family policy as well as maintaining and developing the welfare of children, youth and families jointly with other ministries.*

'No health without mental health' (HMG*, 2011) in England is a cross government strategy which has been signed up to by a range of government departments. This mental health outcomes strategy (www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf) looks to communities, as well as o the state, to promote independence and choice, reflecting the recent vision for adult social care. It sets out how the Government, working with all sectors and agencies of the community and taking a life course approach, will:*

- *improve the mental health and well-being of the population and keep people well; and*
- *improve outcomes for people with mental health problems through high-quality services that are equally accessible to all.*

In ***Sweden****, new legislation (****Social Services Act and Health and Medical Services Act****, 2010) clarifies the responsibility of the different organisations when dealing with people offering a coordinated individual plan.*

b. Draw up national/regional legislation to consolidate, legitimate and regulate the terms of cooperation between sectors, also with a view to facilitating cross-sectoral budgeting and to defining the responsibilities of the different sectors.

Mental health policy and legislation are the foundation on which to develop action and services (WHO and EU policies and practices for MH in Europe, 2008). Policies are necessary to define the

values, direction, responsibilities, structure, functioning and outcomes of services and to regulate the responsibilities of different sectors with regard to the promotion of mental well-being. As a broad range of factors affects mental health, different policy areas administering resources have an impact on it. Therefore the cross-sectoral and coordinated budgeting is essential to optimise the use of resources.

Examples of good practice

*In **Iceland, the Regulation on Specialized Services by the Municipalities for Pre- and Compulsory Schools No. 584/2010 (art. 3)** states that municipalities are to ensure that appropriate specialist services are provided in pre- and primary schools, determine its form and facilitate its implementation in schools. They are responsible for rendering and financing the service. Municipalities shall specify in their school policies how the objectives of this Regulation will be met. In the delivery of specialist services, municipalities shall focus on, among other things, prevention in order to effectively contribute to the welfare of students, early assessment and counselling because of learning difficulties and social and psychological problems. The Regulation further states (art. 5) that municipalities shall initiate collaboration on behalf of individual students with specialist services within the community that provide state-based diagnostic and treatment services. The municipalities shall also ensure mutual exchange of information between service levels, as appropriate and in consultancy with parents, and be able to set standards for how these services are used.*

School principals shall initiate collaboration between specialist services within the municipality, social services, child protection and health authorities for individual students with special needs or long-term illnesses.

The Municipalities' Social Service Act states that public authorities responsible for projects or running institutions in the field of social services under the auspices of the municipalities shall cooperate as closely as possible, both on the organisation of services and the affairs of individual persons receiving assistance (art. 62) and counselling in the field of finances, housing, children's upbringing, divorce, including cases concerning custody and rights of access, adoption, etc. shall be applied in cooperation with other parties, e.g., schools and health care centres (art. 17).

*The **Slovak National Programme of Care for Children and Adolescents** (www.rokovania.sk/Rokovanie.aspx/BodRokovaniaDetail?idMaterial=8013) is based on the European strategy for health and development of children and adolescents. On the basis of the recommendations of the WHO Regional Office for Europe, the Slovak National Programme provides regulation of the responsibilities of different sectors with regard to:*

- *the promotion of health for perinatal health care;*
- *the healthy development of children and adolescents from the perspective of healthy nutrition, including breastfeeding, prevention of infectious diseases and physical activity, domestic violence, sexual abuse;*
- *the environment in the sense of a positive relationship with nature, society and culture;*
- *the education of children and adolescents to empower them for their own health and lifelong habits;*
- *the psychosocial development of good mental health by focusing on the prevention of negative behaviour, aggression, discrimination and the promotion of positive preventive activities to reduce the incidence of mental disorders and behavioural disorders.*

c. Estimate the data on workforce and financing specifically dedicated to the mental health of children and adolescents per sector and ensure adequate, sustained and shared financing by the different sectors. This also includes aligning budget timetables and approval mechanisms to ensure timely and coordinated interventions, selected on the basis of their effectiveness.

WHO guidelines on mental health policy and services (2008) underline that the definition of quantity and quality of human resources should be part of a comprehensive mental health policy: this would favour continuity, complementarity, efficient use of resources and long-term planning. Data on the status quo is the basis for the identification of gaps in services provision, for the appropriate allocation of investments and for the sound planning of interventions.

Examples of good practice

*Data on workforce dedicated to MH, essential to inform the political debate, are still lacking at EU level but can be retrieved in the **U.S.** context (www.fas.org/sgp/crs/misc/R43255.pdf): the report **"The Mental Health Workforce: A Primer"** provides workforce size estimates and salaries/costs divided by five categories identified as "core mental health professionals" by the Health Resources and Services Administration. These are: clinical social workers, clinical psychologists, marriage and family therapists, psychiatrists, and advanced practice psychiatric nurses.*

*In 2008, the U.S. Department of Health and Human Services established the Advisory Council on Child and Adolescent Behavioural Health, to develop recommendations to improve the delivery of child and adolescent mental health care (www.businessgrouphealth.org/pub/f3128bcc-2354-d714-51c2-273384e74888). These recommendations, reported in the publication **"An Employer's Guide to Child and Adolescent Mental Health"** can help to:*

- *Improve the delivery of behavioral health care services in both the general medical and mental health sectors;*
- *Improve employee health and productivity;*
- *Improve the health status of the future workforce;*
- *Reduce unnecessary healthcare expenditures; and*
- *Reduce the use of Family Medical Leave (FMLA).*

The document includes also an economic analysis of the direct and indirect costs of children and adolescents mental health.

d. Evaluate the effectiveness of school based interventions, also with the aim to reduce costs related to mental health in all sectors.

At International level there are thousands of school mental health interventions: nevertheless just a small number has been evaluated in terms of effectiveness (Weare & Nind, 2011). Research shows that in European countries there is a lack of knowledge about which programmes for mental health promotion, disorders prevention, or treatment in children and adolescents provide the greatest societal benefit for the invested money (Kilian et al., 2011). The financial crisis puts the public sector budgets under substantial pressure, making it even more critical to highlight whether investment in the promotion of mental health and well-being might represent good value for money and help avoid future costs of poor mental health (McDaid & Knapp, 2010).

Examples of good practice

***Norway**, conducts evaluation of interventions of school based interventions in the area of mental health on large samples (e.g., 20 000 students or 45 000, e.g., Zero project) uses RCT and quasi experimental designs and foresees adequate follow up (2-3 years), pre-post evaluation and qualitative methods.*

*Evaluation of effectiveness of school based mental health promotion interventions is not yet run systematically. Researchers strongly underline the importance and the need for evaluating the interventions. To carry out a proper evaluation, standard tools and methodology and appropriate criteria should always be applied. The **Quality Assessment Tool for Quantitative Studies** developed by the **Canadian "Effective Public Health Practice Project" (EPHPP,** www.ephpp.ca/tools.html) represents an example of good practice to support the decision-making process, especially when designing, implementing and evaluating public health programmes and policy.*

For example, this tool was used by a team of researchers led by Prof. M. Barry in a recent "systematic review of the effectiveness of mental health promotion interventions for young people in low and middle income countries" (2013).

*In **England** an analysis of interventions was carried out (www.gov.uk/government/uploads/system/uploads/attachment_data/file/197436/DFE-RB098.pdf) to examine which strategies schools use to deal with episodes of bullying, and which are supported by local authorities, why schools choose these strategies, how choice of strategy varies by sector and type of bullying; to evaluate the effectiveness of a range of strategies, from the perspective of the anti-bullying lead, pupils and other school personnel; and to make a final report and recommendations to the Department for Education (DfE).*