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MENTAL HEALTH IN YOUTH AND EDUCATION

CONSENSUS PAPER

Mental Health

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Mental Health in Youth and Education

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The foundation for good mental health is laid in the early years and society as a whole benefits from investing in children and families.
Good mental health in childhood is a prerequisite for optimal psychological development, productive social relationships, effective learning, ability to care for oneself, good physical health and effective economic participation as adults[1].
There is growing evidence on the long-term value of promoting the positive mental health of children and young people, for example through the shaping of early childhood experience, through positive parenting, and through more effective educational services and school programmes.
Although most children report a high level of mental well being, at present in Europe between 10 and 20% of young people have mental health problems.
Schools and the community can play an important role in reaching youth and determining their level of mental health. Effective mental health promotion in educational and community settings in turn strengthens the core objectives of education and the youth sector.

1. POLICY CONTEXT

Enabling young people to have a successful start into life is a key objective of Member States and EU-policies, and it is a precondition for Europe's sustainable success as a social entity, knowledge society and economy. The primary responsibility for action in this field is at the appropriate levels in Member States, in line with the principle of subsidiarity. Action at Community level, such as in the context of health, social, education and youth policies, can complement their activities.
An important step was the definition of educational targets for the Lisbon process. Five EU-benchmarks were established for 2010. They included the following:

- reducing the number of early school leavers to 10% (2006 level: 15.3%);
- increasing the level of completion of upper secondary education to 85% (2006: 77.6%).

The launch of the renewed Lisbon strategy in 2005 triggered the establishment of the European Youth Pact as an instrument to improve the consistency of youth-related policy initiatives across several policy fields (education, youth, training, mobility, vocational integration and social inclusion, reconciliation of working life and family life).
One contribution to support progress towards these targets was the adoption of a Reference Framework on Key Competences for Lifelong Learning in 2006[2]. The overall aim of the key competences is that they contribute to one's personal fulfilment, social inclusion and active citizenship and employability. The Framework stressed the importance of mental health and well-being ("constructive management of feelings") for educational and social performance, as an issue of cross-cutting importance for the acquisition of all eight competences, and as an own aspect in the context of social and civic competences.
Further to this, the focus of EU-youth and social policies is on helping young people to find their place in society, in particular by improving the opportunities of young people from disadvantaged population groups and the inclusion of those furthest away from the labour market.
These activities are underpinned by a Commission initiative, launched in 2006, to develop a comprehensive strategy to promote and safeguard the rights of children. Furthermore, they are

highlighted in the 2007 Commission Communication "Promoting young people's full participation in education, employment and society".
Finally, young people are identified as a target group in the Commission's White Paper on Health (2007). The document announced health-policy actions on children's and young people's health during the period up to 2013.
These developments show that the health and well-being of young people has become a priority, which cuts across several EU-policy fields.

2. TRENDS AND FIGURES

2.1. Mental Health and well-being are essential to positive growth and development

Mental health is a basic human right, and is fundamental to all human and social progress. It is a prerequisite to a happy and fulfilled life for individual citizens, for effectively functioning families and for societal cohesion. Fortunately, the majority of young people in the EU enjoy good mental health, with around 80% of young people in Europe reporting a high level of mental well-being[3].

Mental disorders in children and adolescents

However, a significant share of young people faces difficulties, including emotional, social and conduct problems, full-blown disorders, and learning disabilities. The change in configuration of childhood health and illness, with the decrease in most communicable diseases has highlighted new challenges, namely mental disorders and adverse socio-economic influences on health[4].
One fifth of children and adolescents suffer from developmental, emotional or behavioural problems, and one in eight have a mental disorder[1]. Half of all lifetime mental disorders begin before the age of 14 years[5], are often recurrent or chronic in nature, and similar types of disorders are reported in different cultures worldwide[6].
An estimated 10 to 20% of children and adolescents suffer from mental health problems [6,7]; however prevalence estimates in youth populations vary across European countries (ranging from 9.5% to 22% - Table 1), data is incomplete and not readily comparable due to the different study methodologies used.

	UK [a]	FR [b]	FI [c]	ES(Va) [d]	NL [e]	DE [f]
Prevalence	9.5%	12.4%	15.1%	21.7%	22%	22%
Time of prevalence data collection	6m	3m	3m	point	6m	6m

Table 1. Variation in prevalence of mental health problems across some European countries
([a] Ford, Goodman, Meltzer, 2003[8]; [b] Fombonne, 1996[9] ; [c] Puura et al., 1998[10] ; [d] Gomez-Beneyto, 1994[11] ; [e] Verhulst *et al*., 1997[12]; [f] Ravens-Sieberer *et al*., 2007[13])

Suicide is one of the three most common causes of death in youth and is a public health concern in many European countries. Suicide rates in EU-27 in 2005 for people between 15 and 29, were 8 per 100,000 people, with variation across Member States ranking from less than 5 per 100,000 in some Southern countries to around 25 per 100,000 in Northern and Eastern Europe[14].

The incidence of non-fatal self-harm is estimated to be 10–40 times more common than that of actual suicide (1:9 for males, 1:42 for females)[15], and is common also among female adolescents[16].

Early exposure to risk factors leads to mental health problems later in life

The foundations for mental health are laid before birth and during the first years of life, including the time spent in child care and preschool. Influential parental factors, such as smoking or alcohol consumption during pregnancy or other poor health behaviours, the failure to develop secure attachment, poor quality of parenting styles, parental conflict leading to divorce or separation, are all key risk factors leading to poor mental health in children and increased risk for later life mental disorders, which impact negatively across the life span[17].

Poor relationships at home, especially child maltreatment, have been associated with depression, anxiety, and suicidal ideation later in life[18]. Child abuse has been linked to many different adult outcomes: educational, social, behavioural and psychological. For example, physical abuse has been related to somatisation, anxiety, depression, hostile attitudes, psychosis and dissociation as well as violent behaviour in adults[18].

Childhood trauma, referred to as neglect, childhood adversity, and at times including physical or sexual abuse or exposure to domestic violence, has social and educational consequences, including interference with learning and behaviour at school, low academic performance, engagement in high-risk behaviours, and difficulties forming positive peer and family relationships. These outcomes in turn cause increased use of health and mental health services and higher risks of involvement with the child welfare and juvenile justice systems. Adult survivors of traumatic events may experience difficulty establishing fulfilling relationships, holding steady jobs, and becoming productive members of our society[19].

2.2. Deprivation and poverty in youth increase poor mental health

In the EU, children face a higher risk of relative poverty than that of the whole population over all age groups (one in five children and adolescents compared to less than one in six for the rest of population[20]). Poverty takes the form of deprivation in financial, material and/or educational terms and a decreased earning capacity.

Mental health and mental health problems are variables in a cyclic feedback of cause and effect, mediating the effect of socioeconomic inequalities on health outcomes and vice versa. Thus, low socioeconomic status leads to poorer mental health outcomes, and poor mental health reduces the individual's ability to improve or attain a high level of socioeconomic status.

Inequalities increase mental health problems

In some European countries more than one child in four grows up suffering under poverty and deprivation. Inequality of opportunities remains a serious problem in that people from disadvantaged families still face considerable obstacles in realising their full potential and achieving better living standards for themselves and their children.

Inequalities in socioeconomic status (whether understood in terms of neighbourhood deprivation or inequality, parental occupation or family affluence) are related to deleterious inequalities in mental health. Studies from Germany, the Netherlands, Slovakia and the UK, have shown that socioeconomic indicators such as living in a household that receives benefits, living in rented accommodation (rather than a self-owned house), low social class of the head of household, low family affluence, growing up in a disadvantaged neighbourhood (in terms of unemployment, instability, average income and high numbers of recipients of welfare benefits), or type of school attended, are associated with poor mental health and poorer health-related quality of life[21,22,23,24]. There is a graded association between household income and the frequency of children's emotional and behavioural problems[25]. Children with low socio-economic status more often manifest symptoms of mental disorders[26]. Children living in long-term poverty rank higher in emotional problems such as anxiety, and unhappiness whilst those

living in current, but not persistent, poverty show more prevalent externalizing problems, such as hyperactivity or peer conflict.

Concurrently, lower prevalence of depression and emotional disorders is associated with higher socioeconomic status, whether socioeconomic is understood as education or as income of the family[27]. Positive mental health is also related to observed socioeconomic inequalities; across seven European countries, higher parental education level and greater family affluence were associated with more positive perceptions and emotions in children and more positive mental health[28,29]. For example, Figure 1 shows the relationship between higher family affluence and better mental health in adolescents, for all countries except Austria and France (Figure1).

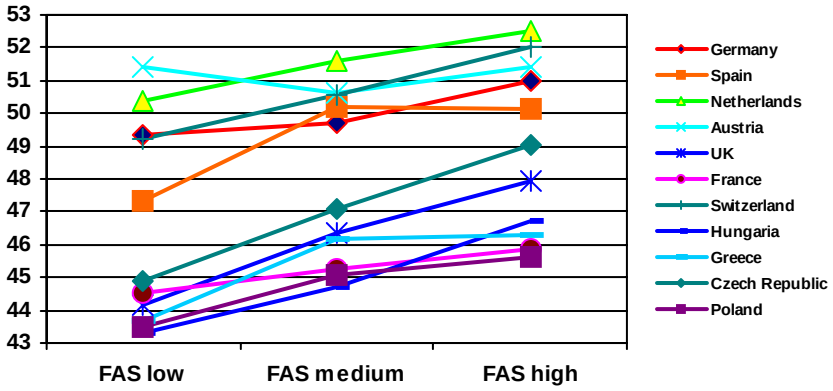

Figure 1. Adolescent positive mental health measure (KIDSCREEN-10) plotted against Family Affluence (FAS) in participating countries[30]

Additionally, higher prevalence of mental health problems is found across the lifespan among socially deprived groups, including migrant populations who are among the poorest in Europe. Such groups are often stigmatised by society as a whole, and also may be cut off from the potentially beneficial effects of family support (geographically or through stigmatisation), which has further harmful effects on mental health.

Inequalities and poor mental health lead to poorer outcomes in later life

Coming from a low-educational background represents a major obstacle to achieving a high level of education, particularly tertiary education. For example, pupils from a migrant background perform relatively lower than their peers who were born in their original country. Educational underachievement in turn translates into unequal occupational opportunities.

Low levels of familial wealth predict all facets of poorer quality of life in children and adolescents, including physical well-being, parent relations and home life, and financial resources. Low or medium parental education also impacts children's quality of life concerning their physical and psychological well-being, their moods and emotions, their perception of being bullied, and their financial resources[28].

Higher rates of mental disorders in adulthood are associated with multiple disadvantages in childhood, including parental divorce, economic hardship, and parental psychiatric illness. These causative factors are often also associated with social disadvantage[18].

Poor mental health in childhood is strongly related to other health and development concerns in young adults, notably substance abuse, violence, lower educational achievements, and poor reproductive and sexual health. Exposure to risk factors, especially in poor children's families and communities, combined with scarcity of protective factors increases the likelihood of

mental health problems in childhood, adolescence and throughout life and impacts on loss of productivity, social function and associated societal consequences.

2.3. Children's rights and mental health

Addressing mental disorders and promoting mental health in Europe should be understood within the framework of respect for human rights, including the rights of children and adolescents, which lies at the heart of a democratic Europe, and is reflected in the European Social Charter. Children's rights are one of the main priorities of the European Commission for its Strategic Objectives 2005-2009: "*Effective protection of the rights of children, both against economic exploitation and all forms of abuse, with the Union acting as a beacon to the rest of the world*"[31]. The EU is keen on protecting and promoting the rights of the child in both internal and external policies. To this end, in July 2006, the European Commission adopted a communication entitled "Towards an EU strategy on the Rights of the Child", which includes reference to more than ten of the EU's policies, including health[32].
Article 32 of the EU Charter of Fundamental Rights underlines that "young people, admitted to work must have working conditions appropriate to their age and be protected against economic exploitation and any work likely to harm their safety, health or physical, mental, moral or social development...". The rights of the child, and explicitly the right to health, also feature in the political agenda of the United Nations[33]. Mental health is directly related to the rights of the child and impacts upon reaching the set objectives for both international bodies.

Child rights may already be compromised before birth, for example through parental poverty or social exclusion. Over half of all mothers in the world lack adequate conditions including care during pregnancy and childbirth[32]. This situation handicaps the future of many children from the moment of birth, including the increased likelihood of suffering from a mental disorder.

Globally, one sixth of all children (predominantly girls) are not enrolled in primary school and will lack opportunities to learn, develop and integrate in society; one third of all girls are subject to coercive sexual relations; one fifth are subjected to forced marriages (a phenomena increasingly more common in Europe given migration patterns); and some 14 million girls between the ages of 15 and 19 give birth each year[32]. All these are at increased risk for a mental disorder, with clear implications on health and welfare costs over the life-span, in addition to reduced levels of employment, social participation and contribution to society.

Violence against children is of concern within the EU, and includes violence in the family and in schools, child trafficking and exploitation, child sex tourism and child pornography on the internet. The rights of children as immigrants, asylum seekers and refugees are also of importance in the EU and in Member States' legislation and policies.

Mental health is directly related to the enacting of the children's rights agenda including the mainstreaming of children's rights when drafting EC legislative and non-legislative actions that may affect them. In order to enact children's rights, children's participation and involvement is crucial. However poor mental health in children, often arising due to their lack of rights, impedes their full participation and input as a result of stigma, fear, or feeling incapacitated by a mental health problem.

2.4. Mental health, learning and education achievement

The European economy will require highly skilled labour in future decades, yet many children still leave education without complete secondary education qualifications. The attainment of general skills, educational qualifications, and gainful and productive employment thereafter are facilitated by good mental health. Many of the Competences for Lifelong Learning[34] and

acquisition of life skills are complementary to the objectives of mental health promotion in young people.

Life Long Learning and Life Wide Learning

Young people's mental health includes aspects of emotional well-being (e.g., happiness and confidence), psychological well-being (e.g., resilience, autonomy, sense of mastery) and social well-being (e.g., interpersonal relationships and citizenship). Many of these concepts are also integral to the EU Key Competences for Lifelong Learning, which overall aim is that key competences contribute to one's personal fulfilment, social inclusion, active citizenship and employability, and help to flourish in society and the world of work. The Competences Framework includes traditional skills such as language proficiency, but also includes horizontal skills, such as 'learning to learn', 'entrepreneurship', and 'social and civic competences', highlighting their importance to the economy. Entrepreneurship, for example, is not seen just in a business sense, but is framed as a life skill, encompassing motivation, taking responsibility for action, etc. Many aspects of these areas, such as decision making, assertiveness, and the abilities to communicate needs and set goals are synonymous with definitions of good mental health.

Life Long Learning is increasingly recognised as being also Life Wide Learning in that people learn at various places outside the formal education environments, such as with family and friends, which are settings for informal learning. Other sites, such as youth organisations, provide learning opportunities through Non-Formal Education, which gives young people the opportunity to develop values, skills and competencies other than those developed within the framework of formal education. These skills include a wide range of competencies such as interpersonal, team, organisational and conflict management, intercultural awareness, leadership, planning, organising, co-ordination and practical problem solving skills, teamwork, self-confidence, discipline and responsibility[35].

Good mental health supports learning and education attainment

The mental, physical and emotional well-being of young people are all essential preconditions for successful learning, and can only be developed in close cooperation with the school as a whole. Academic achievements contribute to better health in general and mental health in particular. Simultaneously, educational settings and professional staff (including teachers and school psychologists) play an important role in protecting children's rights and providing the necessary support system to allow the early identification of social, emotional and mental difficulties and effective resolution of problems. Equally better health leads to better education.
In turn, pupils who receive socio-emotional support and have access to preventive services tend to achieve more academically. School bonding, social and emotional skills and decision-making abilities are also critical to improved learning. School-based mental health programmes such as those promoting socio-emotional learning have successfully improved both mental health and academic achievement.

Mental health problems lead to early school leaving

So far, there has been little progress in reducing the rates of early school-leavers in Member States, although research shows an impact of the 'health promoting schools' initiative on improving attendance and reducing early leaving rates[36]. However, in the majority of countries, the rate is still well above the target of 10% (Figure 2)[37].

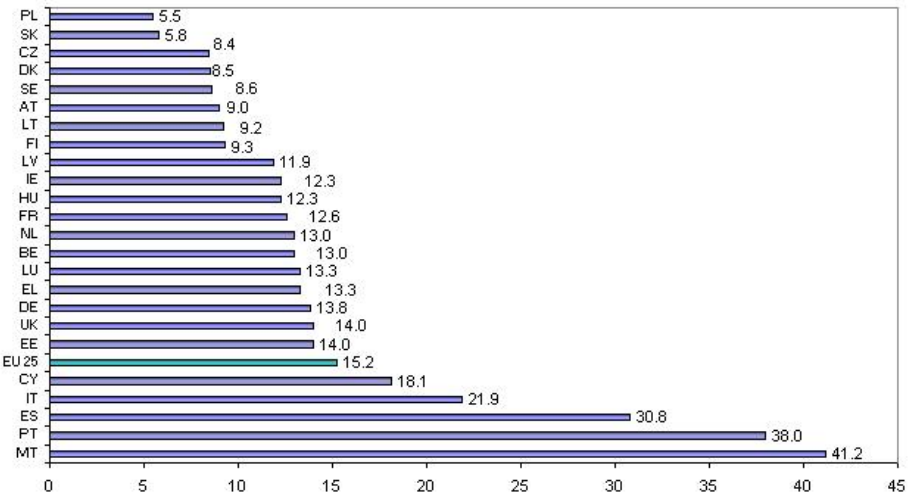

Figure 2. Early school leavers, EU 25 (%)

Important explanatory factors of early school dropout include socio-economic background, ethnicity, gender, prior school achievement, peer pressure, motivation and truancy. Poor mental health aspects are among the most important reasons for leaving school early, including lack of positive and realistic self concept, aggression or poor relationships with peers, disaffection with school, lack of engagement and participation, school stress and bullying. Although there are differences across countries, stress and bullying are highly prevalent in Europe (Figure 3).

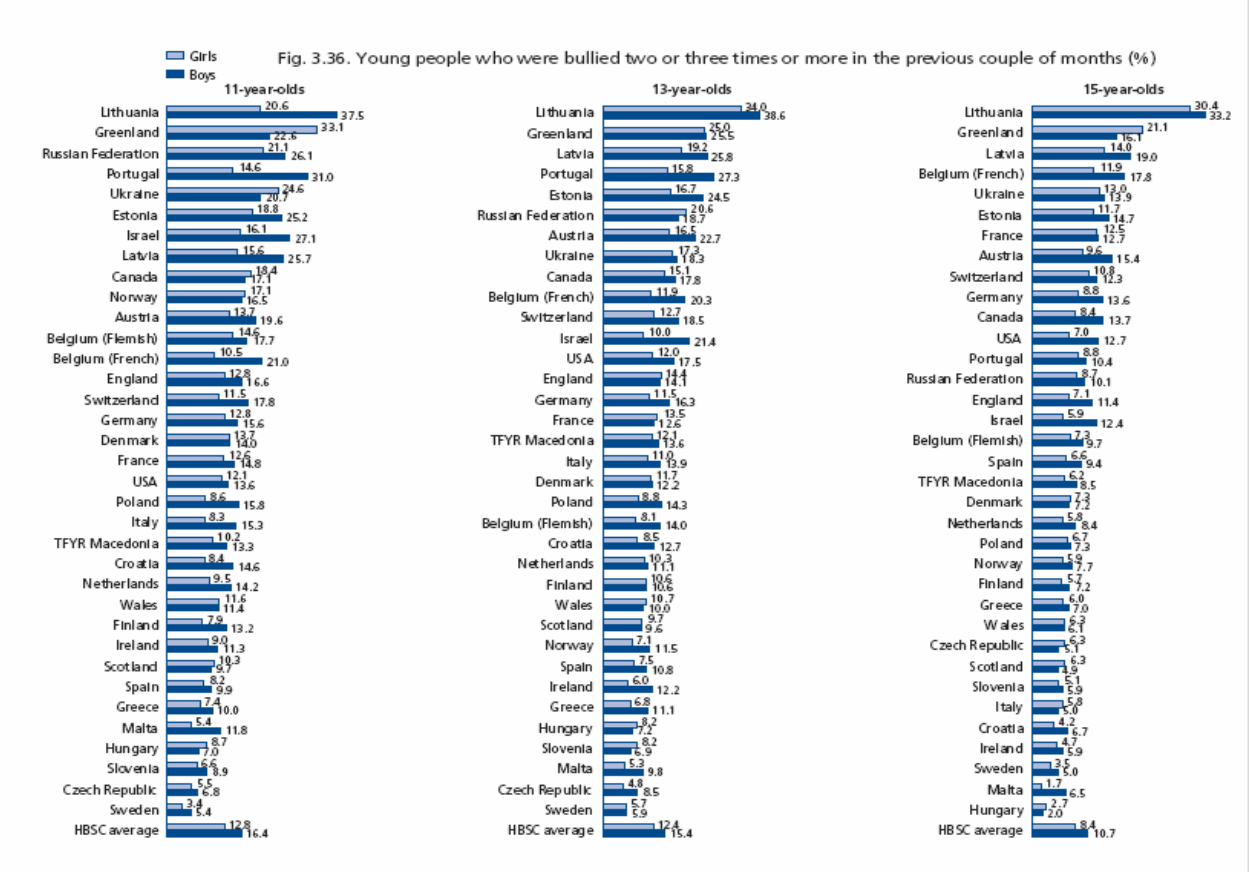

Figure 3. Young people who were bullied 2 times or more in the previous 2 months (%). Bullying in Europe - HBSC international report 2001/2002

2.5. Employment, productivity and long-term gains of mental health in youth

Mental health has long-term implications such as positive functioning in society. For example, good mental health leads to increased school attainment and completion, acquisition of transferable cognitive and social skills, less involvement in the criminal justice system, lower costs to public services, higher earning potential, and resilience for the life course.

On the other hand, poor school performance and early mental health problems can increase the risk of antisocial behaviour, delinquency, substance use disorders, teenage pregnancy, conduct problems and involvement in crime. Unemployment in youth is also linked to mental health problems, depression, anxiety and ill health, especially in the long run, along with its associated costs. In 2006, 17.1% of 15-24 year-olds in the labour market were unemployed in EU-25[38].

In general, the costs of poor mental health are larger for other sectors than for the health care sector, including costs related to lost employment, reduced productivity, and increased levels of crime. For example, costs of children with conduct disorder at age 10 have been estimated, 18 years on, to be 6 times larger for the education sector, and 20 times larger for the social justice system, than costs for the health care system[39].

Need for an intersectoral approach: Given the multidirectional connections between health and well-being, youth empowerment, participation, learning and educational outcomes, actions and outcomes should take into account the interplay of forces in multiple sectors.

3. FRAMEWORK FOR ACTION

Approaches are available to achieve better mental health and educational outcomes in children and adolescents while contributing to a productive Europe on the long term.

Health dimension

Health is a key factor for achieving the primary goal of the school: quality assured education, and mental health is essential to successful learning.

3.1. Parenting support is conducive to health and can prevent child abuse

Parenting programmes have shown to be effective in promoting the short-term psychosocial health of mothers, such as depression anxiety/stress, self-esteem and relationship with spouse, and have long term positive health outcomes for their children[40].

Similarly, group-based parent-training programmes of children with conduct problems can reduce parental depressive symptoms by between one third and one half and can improve the disruptive behaviour of children between the ages of 3 and 10 years[41]. They are more cost-effective and successful in the long-term than methods that involve working with parents on an individual basis.

Other successful examples of parenting support are prenatal and postnatal home visiting programmes, which have also proven to reduce child abuse, such as the Nurse Family Partnership[42] (Box 1). In the USA, where the model for the programme was developed, there are 23 states delivering the intervention to approximately 13,000 at-risk, first-time mothers. Sites in England, the Netherlands, and Germany are also field testing the model, and it forms a part of a new early prevention package being piloted in 10 UK cities, starting with Nottingham, one of the most socially disadvantaged areas.

Other actions in the early years of life, tackling issues such as child abuse, physical or sexual violence, discrimination and poverty address human rights and reduce associated negative mental health consequences[43]. Programmes to prevent child abuse include public awareness campaigns about physical and/or sexual violence against women and girls, specific education programmes about sexual abuse, or programmes for high risk groups, such as the use of a drop-in centres or home visiting (Box 1).

Box 1. Prenatal - Postnatal Home Visiting Programs

There is strong evidence that home visitation programmes can be effective in improving health, well-being and deterring a child's trajectory into violence[44]. The Prenatal Early Infancy Project or Nurse-Family Partnership[45] is a two-year home visiting programme designed to serve low-income, at-risk pregnant women bearing their first child. Several evaluations have shown health benefits for the newborns, including an increase of up to 400 grams in birth weight, a 75% reduction in preterm delivery, more than a two-fold reduction in emergency visits, a lessening of severity for hospitalisations when they occurred and a 46% difference in reports of child maltreatment. The programme showed improved health and social outcomes for the mothers as well, such as an 82% increase in employment rates. Health and social outcomes for the children extended up to age 15, when they were 56% less likely to have problems with alcohol or drugs, reported 56% fewer arrests and 81% fewer convictions. Olds and colleagues have argued that home-based programmes are cost-effective because a 'major portion of the cost for home visitation can be offset by avoided foster care placements, hospitalizations, emergency room visits, and child protection service worker time. Even the most expensive programmes pay for themselves by the time the children are 4 years old'[46].

3.2. Bullying and aggression can be prevented

Interventions can reduce risk factors for poor mental health, for example bullying, violence and exclusion. As aggressive behaviour in childhood is a risk factor for violence and criminal behaviour in adulthood, violence prevention strategies, implemented in primary and secondary schools aim to reduce aggression, increase empathy and produce improvements in behaviour. Effective programmes, such as the Olweus Bullying Prevention Programme (Box 2), successful in the management of school bullying, have been on a nation-wide scale in Norway and in Lithuania.

Box 2. The Olweus Bullying Prevention Programme

The 'Olweus Bullying Prevention Program' is a school-based prevention programme attempting to create safe and positive learning environments for school children aged six to fifteen years old. It is a multi-level and multi-component programme including school-wide, classroom-level and individual-level interventions. The programme aims to reduce existing bully/victim problems inside and outside of the school setting as well as prevent the development of new bully/victim problems by improving peer relations and reducing opportunities and rewards for bullying.

Within one year of implementing the programme among 5-7th graders, Olweus found reductions in self-reports of bully victimization of 42%, and 52% reductions in self-reported bullying others[47].

Results from an earlier evaluation also showed marked reductions in general antisocial behaviour such as vandalism, shoplifting, truancy and alcohol use and significant improvements of the "social climate" of the classroom[48].

3.3. Depression can be reduced

Already during the first five years of life, high quality educational child care has been shown to have a range of positive effects for vulnerable and poor children[49], among which there is also the reduction of depressive symptoms 15 years after the early educational child care has

ended. A prospective randomized study of poor and vulnerable children from infancy to adulthood showed that negative effects of lower quality home environments on depressive symptoms were almost entirely offset by early educational childcare[50].

As mentioned in the previous section, much evidence also supports as being key, early interventions for children at risk of mental and behavioural disorders during early years and implemented through different settings, which include reductions in depressive symptoms.

During childhood and adolescence, preventive strategies for depression and anxiety have been shown to reduce mental health problems, psychological symptoms and to prevent new cases of depression. For example, general cognitive, and problem solving and social skill-building programmes in primary and middle school can significantly improve cognition, emotional knowledge and problem-solving skills and reduce internalising and externalising problems, with 50% reductions in depressive symptoms[51,52,53].

For children already suffering from a mental disorder, more targeted behavioural and cognitive-behavioural therapy (CBT) individual psychodynamic psychotherapy, interpersonal therapy and family therapy can be effective in reducing severity and symptoms.

For children at risk, or already suffering sub-clinical symptoms, cognitive-behavioural models, life skills problem solving and stress management techniques can decrease depressive and anxiety symptoms by more than half and reduce the risk of anxiety and depression disorders by more than two-thirds[51,52,53], showing in some studies the prevention of onset of depression. For example, children who have a parent suffering from a mental disorder are at 50% increased risk for depression, and can benefit from preventive strategies aimed to help them learn, share and understand their parental mental illness while preventing new cases of depression in the children (Box 3).

Box 3. Coping With Depression Course

One effective approach to prevent depression among young people is the “Coping With Depression” course, a brief group cognitive therapy prevention programme which targets adolescents aged 13-18 years with mild depressive symptoms (but without the full clinical diagnosis of the disorder), and who also have a parent with a history of depression. A controlled study evaluating this programme found a significant benefit for those adolescents in the programme condition (only 9.3% cumulative major depression incidence) compared with the control condition (28.8%), indicating a 3-fold decrease in new cases of depression[54] .

3.4. Addressing violence, childhood trauma and protecting children´s rights

Schools serve as a critical system of support for children who have experienced trauma. Administrators, teachers, and staff (including school psychologists, social workers, etc.) can help reduce the impact of trauma on children by recognising trauma responses, accommodating and responding to traumatised students within the classroom setting, and referring children to outside professionals when necessary. The American National Child Traumatic Stress Network has developed tools and materials to help educators understand and respond to the specific needs of traumatised children. In Europe, several national centres exist to provide adequate support for traumatised children and adolescents[55].

An example of a national initiative to protect young people’s rights in relation to their mental health is the “Adolescents in Pain” report developed by the French children’s Ombudswoman (Box 4).

Box 4. Adolescents in Pain / Adolescents en Souffrance[56]

The report involved consultation with professionals involved in the issue (teachers, school nurses, medical doctors, psychiatrists, magistrates, social workers), roundtables, local surveys, hearings with individuals and working groups (secondary schools & medical and psychiatric services) to assess the effects of public policy and national practices on children and adolescents. The outcome was 25 recommendations along 8 broad lines, including reaching teenagers with innovative solutions such as "adolescent centers"; improving the information for young people and their families; compulsory training on the psychology danger signs for all professionals in contact with young people, and; creating interdisciplinary networks in order to ensure identification, orientation and an effective continuity of care.

On an international level, as part of the European Community's freedom, justice and security policy, the DAPHNE III programme combats violence in the form of challenges to the mental health and dignity against children, young people and women, in whatever environment it may arise, in schools, homes or other residential environments, such as children's homes.

3.5. Supporting children and adolescents with a mental illness

Schools and infrastructures in the wider society can also provide valuable support to young people who are experiencing mental illness, as well as their carers or families. Various European initiatives aim to aid recovery and prevent negative knock-on effects from the occurrence of mental disorders in youth. One such initiative is the German movement ADHD-net (Box 5), which works with all stakeholders connected with ADHD.

Box 5. ADHD-net

The German ADHD-net[57], supported by the German Ministry of Health, aims to support the broad health management and improve the health care conditions of patients of all ages suffering from ADHD and to develop national and international interdisciplinary cooperation. The initiative includes:
1. The provision of **information:** for experts, patients and their relatives by Internet-based information systems; for the public by statements and publications; and information networking by cooperation with specialist associations and self-help organizations.
2. Provision of **support:** of regional and interdisciplinary networks for ADHD; of further education and training in cooperation with training centres; and, of research in cooperation with research facilities
3. Provision of **advice:** of the German Ministry of Health; of other political decision-makers and associations.

For children and adolescents suffering from a mental disorder, such as conduct disorders or depression/anxiety disorders, improvements of their social and health care, including early diagnosis, access to pharmacological treatments adequate to their age and situation, availability of psychosocial treatments and adequately trained professionals to identify/refer (e.g., school psychologists, teachers) and treat (e.g., child psychiatrists, primary health care professionals), increase their well-being and adequate access to care and decrease their discrimination on the basis of having a mental illness. These measures are also supportive of their parents´ mental health.

3.6. Combating stigma and discrimination

Integral to the process of supporting young people with mental health problems is tackling issues of stigma and the resulting discrimination against those with existing mental illness. A few measures that address the youth sector specifically include the dissemination of information on the ubiquity of mental health problems, scrutiny and (re-)assessment of national legislation and practices, and dialogue and control of the media with regards to representations

and labelling of mental illness[58]. It has been shown that young people have less entrenched views about mental health problems than adults and therefore represent a key target group in achieving long-term, embedded improvements in public attitudes and behaviours[59], reducing stigma in youth and future adults. The 'see me' campaign, run by an alliance of five Scottish mental health organisations, was launched in October 2002 to challenge stigma and discrimination around mental ill-health in Scotland. Part of the campaign, "Just like me" (Box 6) used media images to effectively target and improve young people's awareness, knowledge and attitudes towards others with mental health problems.

Box 6. The 'Just Like Me' anti-stigma campaign[59]

To reach young people, the 'just Like Me' campaign used TV and posters which could be displayed in schools, youth clubs and similar venues. The material had to take an exceptionally sensitive and responsible approach, and to tackle this, the public relations campaign was informed through a series of consultations with young people, schools, organisations, professionals working with young people and policy-makers.

The campaign focused on the following overall messages:

- 1 in 10 young people in Scotland currently experience a mental health problem.
- Any young person can have a mental health problem but most will recover and get on with their lives.
- Stand by your friends if they have a mental health problem.

Following the campaign, a survey results suggested an impressive exposure to the 'see me' campaign with significant gains in knowledge and awareness of all mental health problems (especially those highlighted in the campaign, such as anorexia). The number of hits to access information on the see me website increased dramatically and young people who had seen campaign materials reported feeling much more confident in knowing what to do to help a friend experiencing a mental health problem.

School as a setting

Children spend a large amount of time in schools. Schools not only establish the competencies for learning and other professional skills, they are an important setting for establishing identity, interpersonal relationships and other transferable skills. Every child has the right to education, health and security. The central role of schools is teaching and learning, but they are also a unique community resource to promote and foster the healthy development of children both, outside and within families. The school represents an easy access environment with direct day-to-day contact with children and, often, their families. Because of this, the school is an ideal setting to build the protective factors that establish resilience, identify risk factors and support vulnerable individuals. "School systems are not responsible for meeting students' every need. But when the need directly affects learning, the school must meet the challenge"[60]. 'Effective practice has included approaches that combine traditional health education with more comprehensive, whole-school approaches that create a supportive physical, social and learning environment, and bring together the combined resources of parents, local communities and organisations'[61]

3.7. Mental health promotion in schools improves educational outcomes

Integrating health and mental health promotion in the school policy can help school to reach their overarching aim: the sustainable and efficient improvement in the quality of teaching and education, with benefits for pupils and teachers. Promoting mental health, in this sense, is not an additional obligation for schools, but an input which supports the school in realising their core function of improving learning. Well-being supports learning and successful learning also

supports well-being. A school culture with curricular and extracurricular activities which promote pupils' positive and realistic self concept, ability to manage emotions, resilience, optimism, the ability to cope with frustration and the social competences which allow them to empathise with others, demonstrate tolerance, and generally build good relations with their peers and environment, also support educational objectives.

School-based programmes that promote mental health are effective and can improve mental health and reduce the risk for mental disorders. Among others, "social-emotional learning" programmes, which target factors such as self-awareness, social awareness, resilience, responsible decision making, emotional self-management, relationship management, and increasing empathy, have shown to increase academic performance and mental health concurrently. Successful programmes are those developed and implemented to involve the whole school, optimise the school psychosocial environment, balance the need to promote the health of all members of the school community with the need to target those with problems, improving the personal skill development of both school students and staff, involving parents and the wider community, and are implemented over a long period of time[62].

There are effective examples across several Member States (Box 7) and nationally (Box 8), of how mental health can be integrated into the school policy (including the curriculum, school environment and school policy/school plan) in a comprehensive manner, rather than becoming an additional burden for teachers.

Box 7. Mental Health Promotion in schools

Health promoting schools: The principles of the health promoting schools approach encompass basic values, also common to mental health promotion, such as equity, active participation of students, parents and school staff, development of student's action competence, importance of the social and physical environment of the school, and integration of (mental) health promotion policies as part of school development (European Network of Schools for Health– SHE).

The good and healthy school: framework developed in Germany[63] addresses six major components of what would define a good school, through an assessment questionnaire to indicate the extent to which a school implements mental health measures. Aspects include:
(1) Results: e.g. students have been encouraged to learn and develop further
(*2) Learning and Teaching*: e.g. teachers try to build student´s action competence (efficacy)
(3) School-Culture: e.g. courses and projects for helping with crisis and conflict-management
(4) Leadership and School-Management: e.g. the school takes charge of matters of health
(5) Teacher Professionalism: e.g. the school is aware of physical and psychological burdens
(6) Goals & Strategies for Quality Development: e.g. plans are tailored to health/education situation

Countries which are members of the European Network of Schools for Health (SHE) are engaged in or have already integrated this framework approach to a certain extent into their school educational policies.

Box 8. Integrating mental health in the curricula in Scotland, Ireland and England

One example from Scotland of integrating mental health promotion in school activity is their new "Curriculum for excellence" approach.

Another is the "Social, Personal and Health Education" programme in Ireland that has successfully been incorporated into the school curriculum and has been introduced in all schools on a phased basis from September 2000.

Another example is the whole school, skills-based programme "Social and Emotional Aspects of Learning (SEAL)", which is now in two thirds of primary schools in England, and is set to be offered to all secondary schools by 2010.

3.8. Support capacity for school staff will facilitate the embedding of the well-being concept into curricula

Schools should be offered support to develop a 'healthy' school climate to create an optimal learning environment which would also foster optimal child development and early identification of emerging problems, as well as reducing stigma and promoting inclusion (Box 9). This could be achieved through inclusion of mental health education in the curricula for teachers´ training, highlighting the crucial role of school psychologists and counsellors, and, implementing a system in school health services to offer psychological support or referrals to available systems when needed.

Box 9. Mind Matters Plus

An example is Mind Matters Plus, which aims to enhance the capacity of secondary schools to support students at risk of developing a mental health problem, students showing early signs of problems or students with an existing mental health problem. Based on eight evidence-based programmes it also identified several education initiatives which provide specific curriculum activities with student centred and real life learning and increase student engagement in learning. The resource helps schools to identify mental health needs and to enhance their capacity as a school in supporting students and teachers. It also advises on how to develop an action plan so there is preparedness for action in case (urgent) support or help by external experts is needed.

3.9. Peer to peer support systems

School students play an important role in the school setting. For example, peer support systems are useful both when improving the social climate and when preventing problems such as bullying. Bi-friending interventions and peer support systems to counteract bullying have been perceived by teachers and pupils as effective in preventing the increase of negative behaviours and attitudes, in reducing the negative effects of bullying for victims, and in achieving benefits to users, peer supporters, and to the school as a whole (such as helping to create a socio-emotional climate of "care")[64,65]. Although such peer support systems have also been found to entail problems, engagement of pupils in the design and evaluation of how they can be overcome and further improved are available[64].

3.10. Collaboration between schools and external partners can strengthen community cohesion and youth participation

Children and adolescents live and act in several different settings: in the home, at school, in youth organisations and in the neighbourhood or streets, as well as in medical and non-formal educational settings. To maximise efforts to improve and maintain youth mental health, a holistic perspective is needed. Links must be built between schools and parents or families as well as peers and external service providers, such as health and social services and the community, to encourage agencies to work in and with schools, and thus enhance the social inclusion of young people (Box 10).

Box 10. Families And Schools Together

One successful initiative achieving collaboration between key actors in the youth sector is that of Families and Schools together (FAST) which has been implemented in USA, Australia, Austria and Germany. The theory behind this approach is that the domains in which children operate interact with each other and change over time, and can be used to reduce risk factors and prevent incipient dysfunction and delinquency. Four multiyear research studies that used randomised trials to assess the impact of the programme, showed that FAST children showed a significant decrease in risk factors for mental health problems (aggression, attention span problems, anxiety) when compared with control group children, one year after receiving the intervention.

Youth and community dimension

The perception of the neighbourhood as dangerous influences the mental health of adolescents: the more threatening the neighbourhood, the more common the symptoms of depression, anxiety, oppositional defiant disorder, and conduct disorder. Lack of social stability and, to a lesser extent, social cohesion, also emerge as contributing factors to adolescent disorders.

On the other hand, the role of youth organisations and other community programmes to promote youth participation are supportive to mental health. Positive transitions from childhood to adolescence to adulthood are most likely when young people live in a context in which they are: physically safe; personally valued; socially connected; morally and economically supported; personally and politically empowered; and hopeful about the future.

3.11. Neighbourhood and community settings for youth participation and improved mental health

Young people spend a large proportion of their time outside the home or school in community settings, in their neighbourhood, engaging in leisure activities. The quality and time spent in this environment has an impact on well-being and mental health. The more threatening the neighbourhood, the more common are symptoms of mental disorders and social exclusion. Lack of a suitable environment and social deprivation may also limit the possibility of recreation activity (mental, cultural and physical) with detrimental effects.

To approach issues of community deprivation effectively (both social and environmental), programmes require coordinated services, resident participation, and to focus on a neighbourhood or small area, ensuring that young people have access to meaningful participation opportunities. Examples of such community-based programmes in the UK include the Single Regeneration Budget (now subsumed into the Regional Development Agencies Single Programme), Education Action Zones and Health Action Zones (Box 11).

Box 11. Education Action Zones (EAZs) and Excellence Clusters

EAZs were built around groups of schools which are determined to raise educational standards in some of the most challenging areas of the UK. The aims of EAZs were to create new partnerships involving business, parents, local authorities, schools and their communities; to raise standards, and; to generate innovation from which the whole educational system can learn. When the initiative reached its end-date in 2006, Excellence Clusters (usually comprising both primary and secondary schools) were formed in areas of deprivation which are not located in the inner cities.
The Excellence Clusters initiative has four strands: Gifted and Talented (aimed at providing opportunities for exceptional children in these deprived areas), Learning Mentors (personalised help for those who need it), Learning Support Units (to tackle disruption) and the Tailored Strand (unique to Excellence Clusters and offers flexibility to define an area of work reflecting local needs and priorities). An evaluation of the scheme found various positive outcomes[66]:

- Strong links were formed between Cluster schools, and collaboration was often seen as the greatest benefit of the initiative.
- Pupils identified as Gifted and Talented were considered to have become more motivated, been stretched and made to feel special.
- The Learning Mentor Strand was considered to be the most successful, with their work being highly valued, and thought to have made a positive impact in terms of behaviour, social skills, attendance, self-confidence, self-esteem and attitudes to school.
- The main focus areas of the tailored strand were curriculum teaching and learning, parents and family, specific subjects, and cultural and community issues.

Likewise, physical activity and exercise are practiced in community settings and are beneficial to mental health, reducing depression and anxiety scores in children and adolescents (Box 12)[67].

Box 12. Physical recreation programmes

One approach to improve and maintain children and adolescents' well-being in a community setting has been increasing access to physical recreation activities (for example with recreation centres or sports clubs). Through these, children can learn valuable skills related to quality of life: intra-personal and interpersonal communication, perseverance, confidence, leadership, citizenship, goal-orientation, motivation, and personal satisfaction.

3.12. Poverty and inequalities can be reduced and improve mental health

Child poverty is a high priority for the EU and Member States, under the Open Method of Coordination on Social Protection and Social Inclusion (OMC). Within Europe, young people living in poverty are at increased risk to all health problems including mental disorders. The outcome of growing up in poverty is often lack of employment, admission to foster care, discrimination and social exclusion, leading to continuing health and social problems. This group also faces difficulties in establishing independent living arrangements as young adults, which in turn decreases their ability to develop, maintain and transmit mental health. These problems are exacerbated in areas where there is a large disparity in socioeconomic levels and where individuals face additional discrimination on account of their situation.

Approaches to tackle youth exclusion due to unemployment include initiatives to improve the employment opportunities for young people through social insertion in the labour market (Box 13).

Box 13. Youth Employment initiatives

In Germany, for example, agreements between the social partners tie schools and employment services to private employers in apprentice systems. Sweden and Norway even guarantee all citizens under 20-years-old either employment or education, an idea that has made its way into European-wide Employment Guidelines. Other effective initiatives include simply increasing information on employment opportunities to deprived youth populations.

Prevention or reduction of the negative impact of poverty on mental health and intermediate factors has also been achieved through benefits systems payable to mothers, which supplement incomes, rather than provide social support, to reduce disparity.

Programmes encouraging independent living among disadvantaged youth are also effective in reducing mental health and social problems. For example, programmes for youth leaving residential care, incorporating relevant skills training, personal development and vocational support, have reduced levels of homelessness, unemployment, dependency on public assistance, physical and mental health problems, and involvement with the criminal justice system[68].

Improving the knowledge base

3.13. Mental Health Indicators

There is a pressing need for cross-cultural European child mental health indicators allowing comparison across the EU. To date, there are existing tools in the health field, including KIDSCREEN[69] (box 14), PISA[70] and HBSC[71], which provide multi-state data, and to some extent, can monitor the mental health of children and adolescents. However, the administration of these tools (including consent procedures) and interpretation of data from their use must be carefully guided and monitored to avoid ethical issues, such as the unwarranted labelling of individual young people as mentally ill.

Box 14. KIDSCREEN

The KIDSCREEN project financed by the European Commission aimed at a cooperative European development of a standardised screening instrument for children's quality of life. Three instruments were developed in the 13 participating countries, to assess the quality of life from the child's perspective in terms of physical, mental and social well-being, and it can be used in health services research and health reporting. The KIDSCREEN instruments help to identify children at risk in terms of their subjective health and to suggest appropriate early interventions.

In spite of these existing tools there is to date no set of indicators that can be used comparably across EU Member States. Such indicators set should include the prevalence of mental disorders in children and adolescents (currently being monitored not systematically at the country level using different tools and methodologies), indicators for positive mental health, and infrastructural/resource information such as children's per capita spending on mental health and service provision, quality of services and continuity. The ideal set of indicators would be premised on the knowledge that positive and negative aspects of mental health are largely independent of each other[72], and should assess the aspects relevant for the mental health and well-being of children of different ages, linguistic backgrounds and cultures, by taking into account their views and perspectives. While there is a shift in clinicians and public health experts focus, to include positive aspects of mental health as well as disease indicators, as yet, no statistical instrument is in place at the Community level to monitor mental health

comprehensively in this age group. In addition, although high-quality sources of national data exist, information sources across the EC Member States vary, making cross-country comparisons difficult.

3.14. Evaluation and cost-effectiveness research

It is important that a firm knowledge-base on what improves mental health continues to grow so that it can further support action.

Evidence for the effectiveness of programmes, policies and legislation which affects the mental health of children and adolescents is increasingly recognised as important across Member States. National research programmes and organisations pay attention to mental health aspects, especially services and support for children and adolescents with mental illness. New areas of research have included testing the effectiveness of internet (E-health) programmes, for example in Netherlands, and the use of different research designs (such as cluster randomised controlled trials) to overcome difficulties faced by researchers in relation to collecting a large enough samples. Several European countries also have official national policies that support research programmes for mental health, including prevention and promotion, such as implementation with evaluation in the Netherlands and, recently, in Lithuania (Box 15).

Box 15. Evaluation research priority setting

In the Netherlands, a national policy to prioritise the implementation of evidence-based programmes has been put in place which greatly favours the national growth of the knowledge base and encourages programme implementers to include an evaluation aspect in their budget planning and timekeeping schedules, and stimulates the implementation of evidence-based programmes. This also links to initiatives to disseminate information about programmes with proven effectiveness, such as the databases described below (Box 16).

One area where progress is needed is that of cost-effectiveness evaluation for youth and school programmes. Improving researchers' and implementers' knowledge of how best to apply economic research methods to answer pertinent research questions, are effective means to achieve these ends. Incorporating basic evaluation designs in the planning and budgets of actions to be implemented have proven to be an efficient way forward for example in the health promotion field. It has been argued that all sectors could evaluate the mental health impact of their policies and programmes, recognising the benefits to be drawn from promoting mental health, but this is still unrealistic given the priority setting of research in most countries.

3.15. Dissemination

The dissemination of information and evidence for effectiveness across Europe and within Member States is paramount. Often, practical decisions are made without first reflecting on, or checking, the evidence base, many times because of lack of access to this information, either due to the way that the information is presented or the lack of knowledge on where to locate such decision-guiding data. However this issue is increasingly recognised within and across Member States, and dissemination platforms, organisations, departments or databases (see Box 16) are being created to ensure this goal.

Box 16. Dissemination databases

The national Qui database is a registry of health promotion programmes, including mental health promotion that are being developed or implemented in the Netherlands. Information is provided about each programme (e.g., goals, target group, methods used and financial requirements) and, when available, its outcomes. Programme developers and implementers can report whether or not the programme is developed following the relevant literature, what kind of evaluation research has been done and the findings[73].

At the European level, several Commission financed projects have supported the creation of pan-European databases for effective programmes (DataPrev), policies (Imhpa), tools (PromenPol), indicators (Mindful), infrastructures (CAMHEE), all of which include information for children and adolescents. The next step for these user-friendly tools is awareness-raising of the existence of these databases themselves so that their usefulness may come into full effect.

Challenges of updating and maintenance of databases and identification of dissemination channels are being overcome by setting up national or European-level bodies (such as PHEA) with the role of ensuring continuity and uniqueness of projects with an information disseminating aim.

Translation of research findings into a language and dissemination channel that will reach practitioners (e.g., teachers, school personnel, policy makers) is still underdeveloped and although some Member States, such as Scotland or the Netherlands, have developed newsletters or evidence alerts, there is still a need to support and improve infrastructures behind such efforts. Finally it is important that available information highlights local and cultural specific sensitivities for each country/region when designing, implementing and disseminating programmes and information[74].

3.16. Capacity building and training

The education and training of relevant professionals prepare them to act as enablers, mediators and advocates for mental health in all sectors[75]. Education and training are most efficient when combined with support (for example support to schools, and support to professionals, such as psychologists) and when supplemented by improving the capacity and raising awareness of teachers and youth workers with regards to the topic, as requested in the 2007 Communication "promoting young people's full participation in education, employment and society".

Key challenges to addressing mental health needs in children and adolescents include the shortage of mental health professionals, both in the mental health system (e.g., child psychiatrists)[76] and in the schools (e.g., child psychologists), the fairly low capacity and motivation of non-specialist health workers and teachers to provide quality mental health support, referrer or address the stigma associated with mental disorders. Action integrating expertise in mental health with that of other youth, health and welfare experts has facilitated the addressing of these obstacles.

REFERENCES

[1] Child and Adolescent Mental Health: Policies and Plans, WHO, 2005.
[2] Recommendation of the European Parliament and of the Council, of 18 December 2006, on key competences for lifelong learning [Official Journal L 394 of 30.12.2006].
[3] Conclusions from Pre-conference "The Mental Health of Children and Adolescents", organised by European Commission, WHO European region and the Ministry of Health of Luxembourg, Luxembourg September 2004
[4] Palfrey JS et al. Introduction: addressing the millennial morbidity – the context of community. *Pediatrics,* 2005, 115:1121–1123.
[5] Kessler *et al*, (2005). Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry. 2005;62:593-602.
[6] WHO (2001). World Health Report " New Understandings New Hope"
[7] WHO (2005). Mental health: facing the challenges, building solutions. Copenhagen, WHO, 2005.
[8] Ford T, Goodman R, Meltzer H. The British Child and Adolescent Mental Health Survey 1999: the prevalence of DSM-IV disorders. *Journal of the American Academy of Child and Adolescent Psychiatry,* 2003, 42:10:1203–1211.
[9] Fombonne E. Increased rates of psychosocial disorders in youth. *European Archives of Psychiatry and Clinical Neuroscience,* 1998, 248:14–21.
[10] C: Puura K et al. Psychiatric disturbances among prepubertal children in Southern Finland. *Social Psychiatry and Psychiatric Epidemiology,* 1998, 33:7:310–318.
[11] Gomez-Beneyto M et al. Prevalence of mental disorders among children in Valencia, Spain. *Acta Psychiatrica Scandinavica,* 1994, 89:5:352–357.
[12] Verhulst FC et al. The prevalence of DSM-III-R diagnoses in a national sample of Dutch adolescents. *Archives of General Psychiatry*, 1997, 54:4:329–336.
[13] Ravens-Sieberer U et al. Psychische Gesundheit von Kindern und Jugendlichen in Deutschland. Ergebnisse aus der BELLA-Studie im Kinder- und Jugendgesundheitssurvey (KiGGS). *Bundesgesundheitsblatt – Gesundheitsforschung – Gesundheitsschutz*, 2007, 50:871–878.
[14] WHO mortality database
[15] MONSUE project. Schmidtke et al., (2004)
[16] Madge *et al.* (2008). Deliberate self-harm within an international community sample of young people: comparative findings from the Child & Adolescent Self-harm in Europe (CASE) Study. *Journal of Child Psychology and Psychiatry.* OnlineEarly Articles.
[17] Stewart-Brown S, Fletcher L. and Wadsworth M (2005). Parent–child relationships and health problems in adulthood in three UK national birth cohort studies, The European Journal of Public Health 2005 15(6):640-646
[18] Freyers T. (2007). Children at Risk. Childhood Determinants of Adult Psychiatric Disorder. Stakes: Finland.
[19] The national child traumatic stress network (http://www.nctsnet.org/nccts/nav.do?pid=ctr_ctte)
[20] Child Poverty and Well-Being in the EU: Current status and way forward (2008)
[21] Von Rueden U et al. The European KIDSCREEN group. Socioeconomic determinants of health related quality of life in childhood and adolescence: results from a European study. *Journal of Epidemiology and Community Health*, 2006, 60:130–135.
[22] Richter M. The role of social inequality for adolescents' health. *Gesundheitswesen*, 2005, 67:10:709–718.
[23] Geckova AM et al. Socioeconomic differences in health among Slovak adolescents. *Social and Preventive Medicine,* 2004, 49:26:3–5.
[24] Drukker M, Feron FJ, van Os J. Income inequality at neighbourhood level and quality of life – a contextual analysis. *Social Psychiatry and Psychiatric Epidemiology,* 2004, 39:6:457–463.
[25] Prescott-Clarke P, Primatesta P, eds. *Health survey for England 1997. The health of young people 1995–97.* London, The Stationery Office, 1998.
[26] Bradley RH, Corwyn RF. Socioeconomic status and child development. *Annual Review of Psychology,* 2002, 53:371–399.
[27] McMunn AM et al. Children's emotional and behavioural well-being and the family environment: findings from the Health Survey for England. *Social Science and Medicine,* 2001, 53:423–440.
[28] Ravens-Sieberer U, Wille N, Erhart M, Nickel J, Richter M. (2008) Socioeconomic inequalities in mental health among adolescents in Europe. In: *Social cohesion for mental well-being among adolescents*. Copenhagen, WHO Regional Office for Europe.
[29] *Socioeconomic Inequalities in mental health among adolescents in Europe*. WHO/HBSC Forum 2007. Background paper. World Health Organization, Regional Office for Europe

[30] The KIDSCREEN-10 index is the shortest of 3 health-related quality of life measures for children and adolescents developed within the European Commission funded project "Screening and Promotion for Health-related Quality of Life in children and Adolescents" (Box 13).

[31] Strategic objectives 2005-2009. Europe 2010: A Partnership for European Renewal, Prosperity, Solidarity and Security - COM(2005) 12, 26.1.2005.

[32] Towards an EU Strategy on the Rights of the Child. COM (2006) 367 http://ec.europa.eu/justice_home/fsj/children/fsj_children_intro_en.htm

[33] 1989 UN Convention on the Rights of the Child: Article 24 "the right of the child to the enjoyment of the highest attainable standard of health…".

[34] EU Key Competences for Lifelong Learning, OJ C 394 of 30.12.2006

[35] Policy paper on recognition of non-formal education: Confirming the real competencies of young people in the knowledge society. Adopted by the European Youth Forum / Forum Jeunesse de l'Union Européenne / Forum des Organisations Européennes de la Jeunesse, Council of Members / Extraordinary General Assembly, Brussels (Belgium), 11-12 November 2005

[36] National Foundation for Educational Research and Tomas Coram Research Unit, 2004.

[37] http://ec.europa.eu/education/policies/2010/nationalreport_en.html

[38] EUROSTAT. http://ec.europa.eu/eurostat/

[39] Scott S, Knapp M, Henderson J, & Maughan B. (2001) Financial cost of social exclusion: follow up study of antisocial children into adulthood. *British Medical Journal*; 323:1–5.

[40] Barlow J, Coren E, Stewart-Brown SSB. Parent-training programmes for improving maternal psychosocial health. Cochrane Database of Systematic Reviews 2003, Issue 4.

[41] Barlow J, Parsons J. Group-based parent-training programmes for improving emotional and behavioural adjustment in 0-3 year old children. *Cochrane Database of Systematic Reviews* 2003, Issue 2.

[42] Prenatal/Postnatal Home Visiting Programs and their Impact on the Social and Emotional Development of Young Children (0-5), D. Olds, entry in the Encyclopaedia on Early Childhood Development (July 9, 2004)

[43] Conclusions from Pre-conference "The Mental Health of Children and Adolescents", organised by European Commission, WHO European region and the Ministry of Health of Luxembourg, Luxembourg September 2004.

[44] Junger, Feder & Cote (2007). Policy implications of present knowledge on the development and prevention of physical aggression. European Journal of Criminology Policy Research. 13; 301-326.

45 Olds et al. (1998) Long-term Effects of Nurse Home Visitation on Children's Criminal and Antisocial Behavior. A 15-Year Follow-up of a Randomized Controlled Trial. JAMA. 1998;280:1238-1244.

[46] Olds *et al.* (2002) Home Visiting by Paraprofessionals and by Nurses: A Randomized, Controlled Trial. *Pediatrics*;110;486-496

[47] Olweus, D. (1999). Blueprints for violence prevention: Bullying Prevention Program. Institute of Behavioral Science, University of Colorado, Boulder.

[48] Olweus, D. (1991). Bully/victim problems among schoolchildren: Long-Term Consequences and an Effective Intervention Program. In Hodgins, Sheilagh (Ed), Mental disorder and crime. (pp. 317-349). Thousand Oaks, CA:Sage.

[49] Campbell, F.A., Ramey, C.T., Pungello, E., Sparling, J., & Miller-Johnson, S. (2002). Early childhood education: Young adult outcomes from the Abecedarian Project. *Applied Developmental Science, 6,* 42-57.

[50] McLaughlin, A., Campbell, F.A., Pungello, E.P., & Skinner, M. (2007). Early educational child care reduces depressive symptoms in young adults reared in low-income families. *Child Development, 78*(3, 746-756.

[51] Greenberg et al., 2001; Greenberg, M. T., Domitrovich, C., & Bumbarger, B. (2001). The prevention of mental disorders in school-aged children: Current state of the field. Prevention and Treatment, Vol 4, np. 31

[52] Jané-Llopis E, Hosman C, Jenkins R, & Anderson P. (2003). "Predictors of efficacy in depression prevention programmes. Meta-analysis". British Journal of Psychiatry; 183: 384-397

[53] Merry S, McDowell H, Hetrick S, Bir J, Muller N. (2004). Psychological and/or educational interventions for the prevention of depression in children and adolescents. *The Cochrane Database of Systematic Reviews* 2004, Issue 2.

[54] Clarke, G.N., Hornbrook, M., Lynch, F., Polen, M., Gale, J., Beardslee, W., O'Connor, E., & Seeley, J. (2001). A randomized trial of a group cognitive intervention for preventing depression in adolescent offspring of depressed parents. Archives of General Psychiatry, 58, 1127-1134.

[55] European Society for Traumatic Stress Studies (http://www.estss.org/index.htm)

[56] Adolescents in Pain : Thematic report 2007 / Adolescents en Souffrance : Rapport Thématique 2007. Défenseure des Enfants, Dominique Versini

[57] www.zentrales-adhs-netz.de

[58] WHO Mental Health Action Plan for Europe: Facing the Challenges, Building Solutions (WHO 2005) EUR/04/5047810/7
[59] See me so far: A review of the first 4 years of the Scottish anti-stigma campaign. http://www.seemescotland.org.uk/about/index.php
[60] Carnegie Council Task Force on Education (1989). Carnegie Council of New York.
[61] Schools for Health, Education and Development. A Call for Action, WHO meeting 8 June 2007
[62] Stewart-Brown S. What is the evidence on school health promotion in improving health or preventing disease and, specifically, what is the effectiveness of the health promoting schools approach? Copenhagen, WHO Regional Office for Europe, http://www.euro.who.int/document/e88185.pdf.
[63] www.anschub.de
[64] Naylor P. & Cowie H. (1999). The effectiveness of peer support systems in challenging school bullying: the perspectives and experiences of teachers and pupils. Journal of Adolescence, Volume 22, Issue 4, Pages 467-479
[65] Menesini E, Codecasa E, Benelli B, Cowie H,(2003). Enhancing children's responsibility to take action against bullying: Evaluation of a befriending intervention in Italian middle schools. aggressive behavior, Volume 29 Issue 1, Pages 1 – 14
[66] The Evaluation of Excellence Clusters: Final Report. NFER and the Centre for Educational Research at the London School of Economics (LSE).
[67]Larun L, Nordheim LV, Ekeland E, Hagen KB, Heian F. Exercise in prevention and treatment of anxiety and depression among children and young people. *Cochrane Database of Systematic Reviews* 2006, Issue 3.
[68] Donkoh C, Underhill K, Montgomery P. Independent living programmes for improving outcomes for young people leaving the care system. *Cochrane Database of Systematic Reviews* 2006, Issue 3. Art. No.: CD005558.
[69] http://www.kidscreen.org
[70] OECD Programme for International Student Assessment http://www.pisa.oecd.org
[71] Health of School Aged Children http://www.hbsc.org/
[72] Tennant, A. (1995). Quality of life – a measure too far? *Annals of the Rheumatic Disease*, 54: 439-440.
[73] http://www.quidatabank.nl
[74] Jané-Llopis, Katschnig, McDaid & Wahlbeck (2007). Commissioning, interpreting and making use of evidence on mental health promotion and mental disorder prevention: an everyday primer. Lisbon: 2007
[75] Jané-Llopis & Anderson (2005). Mental Health Promotion and Mental Disorder Prevention. A policy for Europe. Nijmegen: Nijmegen University.
[76] Levav I, Jacobsson L, Tsiantis J, Kolaitis G, Ponizovsky A (2004). Psychiatric services and training for children and adolescents in Europe: Results of a country survey. *Eur Child Adolesc Psychiatry* 13: 395-401