Summary of outcomes — WHO/HBSC Forum 2007

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1. Why address social cohesion for mental well-being among adolescents?

The WHO/HBSC Forum 2007 process, dedicated to "Social cohesion for mental well-being among adolescents", engaged intersectoral policy-makers, researchers and programme managers from 18 Member States in considering the following core questions.

- **Translate research into policies and action.** Are the data and evidence being collected on adolescent mental health and well-being sufficient and relevant to policy action, and are they easily accessible to those in policy-making who need to use them?
- **Engage in intersectoral action.** Which conditions enable intersectoral action to address the social determinants of adolescent mental health and well-being? Given the importance of the school setting for most adolescents, how can school-based interventions safeguard mental well-being? What is the role of the health system in this regard?
- **Address health inequities.** Are interventions "missing" those young people who, due to low socioeconomic status, gender, migrant status, having a parent with a mental disorder, or family structure are at increased risk for mental disorders? What mechanisms can help reach disadvantaged young people?
- **Involve young people.** Are young people adequately involved in the design, implementation and evaluation of interventions? What can be done to further involve them?

2. What is the issue?

- As highlighted by the WHO European Ministerial Conference on Mental Health in Helsinki in January 2005, mental ill health is currently one of the biggest challenges facing every country in the European Region. Mental disorders affect at least one in four people at some time in their lives. Young people are at risk, with 4% of 12–17-year-olds and 9% of 18-year-olds suffering from depression, and suicide being the second leading cause of death among those aged 15–35 years *(1)*. In addition to treating mental disorders, there is an increasingly recognized need for mental health promotion and the prevention of mental disorders, and this particularly concerns children and adolescents.
- Positive mental health and well-being are assets for growth and development at individual and Member State levels. The WHO collaborative cross-national HBSC study *(2)* shows that most adolescents are in fact satisfied with their lives, perceive their health to be good and do not regularly suffer from health complaints such as headaches, irritability or feeling low. Significant percentages, however, report their health to be either "fair" or "poor" and experience a number of recurring health complaints *(3)*. HBSC also provides evidence of inequities in mental health and well-being in relation to socioeconomic status, gender, migrant status, geography and family structure.
- To safeguard child and adolescent mental well-being, it is important to create social environments that offer protective factors for mental health and limit exposure to risk factors for mental disorders. Good relationships in the home, school and neighbourhood play a part in ensuring that young people can develop social competence and contribute to cohesive societies. Social approaches are essential in promoting the mental well-being of young people and supporting the reduction of inequities in adolescence and adulthood *(3)*. It is for this reason that the WHO/HBSC Forum 2007 focused on "Social cohesion for mental well-being among adolescents".
- Strong health systems are required to curb the prevalence of neuropsychiatric disorders in the European Region, which are the second greatest cause of the burden of disease after cardiovascular diseases *(1)*. As emerging lessons learned

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through the Forum process indicate, there are opportunities for increased action to be taken by health systems – through their service delivery, resource generation, financing and stewardship functions – to promote adolescent mental health and prevent mental disorders among this age group.

3. How is the issue known about?

- *The Mental Health Action Plan for Europe (4)* underlined the urgent need to scale-up policies, interventions and investment for promoting mental health and preventing mental disorders, and to ensure the provision of adequate care for children and adolescents.
- The knowledge about adolescent mental health and well-being is supported by the WHO collaborative cross-national Health Behaviour in School-aged Children study *(2)*, which involves 43 countries and regions and is conducted among 11-, 13- and 15-year-olds every four years. The study focuses on issues that affect and are affected by mental health and well-being. These include self-rated health status, life satisfaction, subjective health complaints, socioeconomic status and measures relevant to social cohesion, such as family support, bullying at school, peer support networks and the characteristics of local neighbourhoods.
- Additional resources include a range of studies examining related themes, such as the links between family income poverty and mental disorders in children and young people. The findings are reflected, for instance, in research by the United Nations Children's Fund (UNICEF) Innocenti Research Centre and WHO research into the provision of mental health services for children and young people in the European Region *(1)*. They are further illustrated by other national and subnational studies such as the Befragung Seelisches Wohlbefinden und Verhalten (BELLA study), conducted by the Federal Public Health Institute of Germany, which found that when several risk factors occur simultaneously (such as adverse family climate and low socioeconomic status), the prevalence of mental health problems increases markedly (see case study from Germany).

4. What factors influence child and adolescent mental health and well-being?

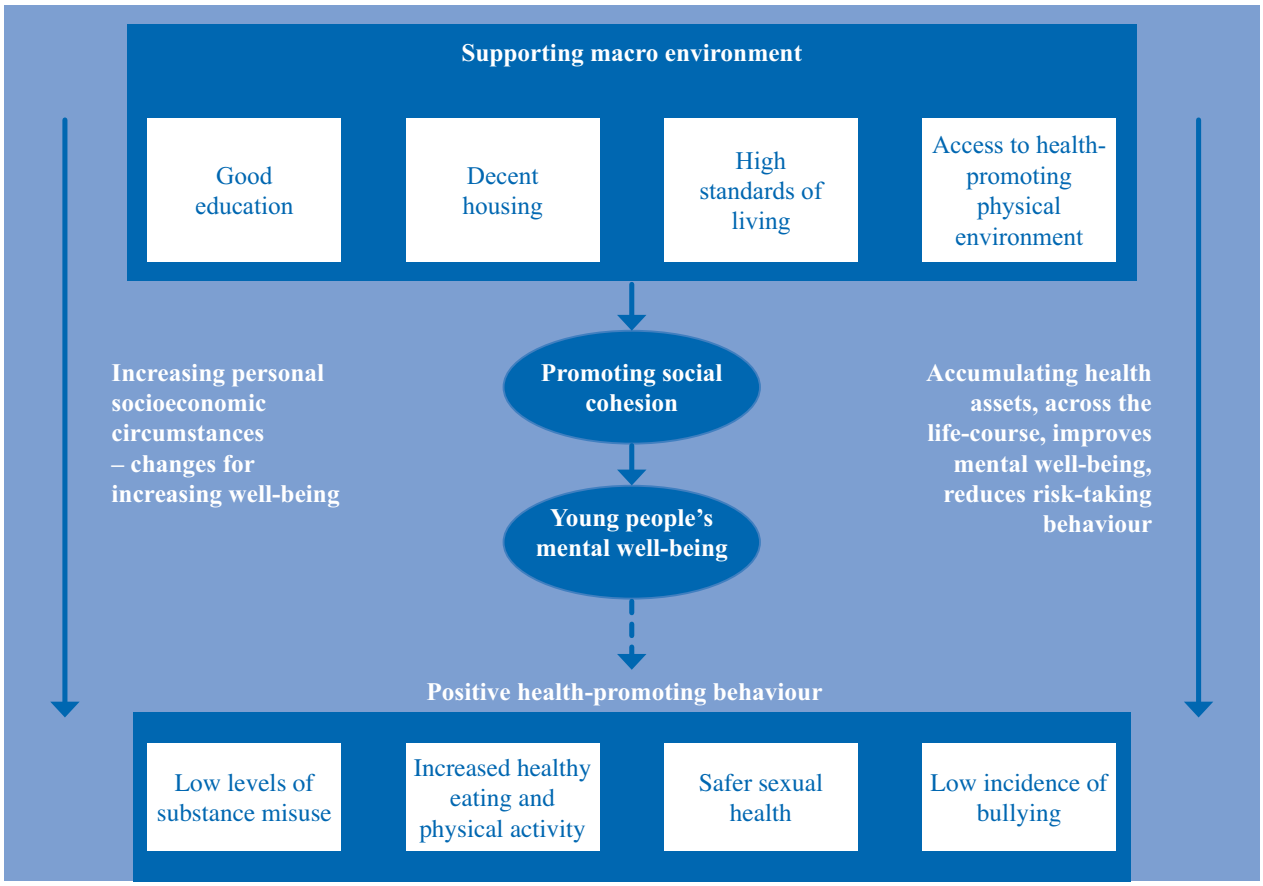
- Risk factors for mental disorders include, but are not limited to, poverty, social exclusion, violence, peer rejection, isolation and lack of family support. Protective factors for mental well-being are linked to cohesion at community level, family well-being and individual behaviours and skills, access to adolescent-friendly social services, including health services, and macro-policies (such as social transfers and minorities' integration) *(5)*.
- Children growing up in disadvantaged circumstances are most vulnerable to an imbalance between risk and protective factors. For instance, in 2006 in Belgium (Flanders), Slovenia, Spain, and Portugal, young people in less-wealthy families were more likely to report not feeling satisfied with their lives *(3)*. In Iceland, psychosomatic health is generally less among adolescents with unemployed parents, those who do not live with both biological parents, those who report material deprivation, and where there is less intergenerational integration.
- The migration process in countries of destination and countries of origin contributes to the increased exposure to risk factors for mental disorders. The case studies from Germany, Portugal, and Spain describe how foreign-born children generally report significantly poorer psychosomatic health. In parallel, in the Republic of Moldova, a country with high rates of emigration and in which 42% of emigrants leave children at home, children whose parents have emigrated are exposed to risk factors for mental disorders. The specific needs of these children require further research.
- The Assets Model (see Fig. 1) *(6)* indicates the importance of positive social and community networks and environments and the relationships these have with positive mental well-being. The more opportunities young people have in childhood and adolescence to experience and accumulate the positive effects of protective factors that outweigh risk factors, the more likely they are to achieve and sustain mental health and well-being in later life. This can be considered an "assets" approach in which young people are supported to accumulate "assets" that predispose to good mental health and well-being.

5. Why does this matter?

- Everyone has a right to the enjoyment of the highest attainable standard of physical and mental health. This right is enshrined within: the United Nations International Covenant on Economic, Social and Cultural Rights, Article 12; the

Fig. 1

The Assets Model
Source: Morgan *(6)*.



Human Rights Act; Article 152 of the European Community Treaty; and the United Nations Convention on the Rights of the Child. It is also reflected in the constitutions of WHO and Member States.

- Young people are the future. Young people with a positive sense of mental well-being possess problem-solving skills, social competence and a sense of purpose that can help them rebound from setbacks, thrive in the face of poor circumstances, avoid risk-taking behaviour and continue on to a productive life.

6. Why act now?

- The mental health and well-being of young people now will affect the economic stability and prosperity of the European Region over the coming decades. It is estimated that only 10–15% of young people with mental health problems now receive help from existing child mental health services *(1)*.
- The costs of mental illness among children and adolescents fall to a very large extent on sectors outside the health care system. Evidence suggests that in child and adolescent mental health, productivity costs (such as the costs associated with parents who must stay home from work to look after children with mental disorders) seem to take the highest burden (see background paper *Economic aspects of mental health in children and adolescents*). Children and adolescents with mental disorders can be at increased risk of mental ill-health in adulthood. It is estimated that currently, there is a loss of 3–4% of the European Union's (EU) Gross Domestic Product (GDP) annually through the effects of mental ill-health on productivity losses through absenteeism and reduced work performance *(7)*.

- Increased exposure to "the knowledge society" on the one hand and, on the other, the ageing of the population will together increase Europe's dependence on good mental health in future years.
- There is evidence of intergenerational occurrence of mental disorders in families, and that children of parents with mental disorders are particularly at risk *(8)*; actions to reduce mental disorders and promote well-being in young people now may serve to protect future generations.

7. What lessons did the WHO/HBSC Forum process identify for policy-makers?

Listed below are emerging lessons that focus on the four core themes of the Forum process: intersectoral action; addressing health inequities; involving young people; and translating research into policies and action.

Intersectoral action

- Health systems have an important role in addressing socially determined risk factors for mental disorders and fostering protective factors for mental well-being. Through their stewardship function, health systems can build coalitions across government ministries to act on key determinants of adolescent mental health *(9)*. They can improve service delivery by making adolescent-friendly interventions for promoting mental health and preventing mental disorders available in schools and communities, including through strengthened primary care services.
- As education is potentially universal, the school environment plays a very important part in influencing the mental health and well-being of children and adolescents. Whole-school approaches are necessary, integrating mental health and well-being into the main function and ethos of schools and facilitating support for education objectives through health policy. In the United Kingdom (England), the whole-school Social and Emotional Aspects of Learning (SEAL) approach includes the explicit and planned learning of social and emotional skills within the school curriculum and creates the climate and conditions to promote the development of students' social and emotional skills while facilitating continuing professional development for all school staff in this area. Studies highlighted the importance of cooperation with parent associations, health and other services in implementing this approach.
- The case study from Germany highlights the need to evaluate school-based life-skills programmes and the need to use evaluation results to improve the programmes and/or scale-up the programme reach (beyond regional level) if it is proven to be effective and efficient.
- High-level support for working across sectors, especially where it results in legislation, can significantly facilitate intersectoral work to promote mental health among children and adolescents. In Finland, the new National Core Curriculum (National Board of Education), Quality Recommendations for School Health Care (Ministry of Social Affairs and Health) and the strategy for school well-being (Ministry of Education) were the outcome of, and further enablers for, intersectoral cooperation. In countries where supportive legislation for child and adolescent mental health is lacking, its adoption is cited as an opportunity for sustainability, connectedness/unity and integration of effective interventions.
- In developing intersectoral strategies and activities, consensus-building events and multisectoral committees may be convened. It is important that no single sector dominates on these occasions and that equal opportunities for engagement and input are built into the process. The Belgium (Flanders) case study suggests a stepwise process would be helpful, starting from the initial step of developing a common vision of actions to be implemented.
- It is essential to allocate sufficient resources for mental health promotion and the prevention of mental disorders both within and beyond the health system. At policy level, this needs to be backed by a recognition of the overall multisectoral responsibility for health and appropriate budgeting. In an environment of budgetary constraints and limited coordinated action for adolescent mental health promotion by public authorities, collaboration with international and national nongovernmental organizations (NGOs) may help provide solutions, as suggested by the studies from Lithuania and Romania, albeit with concerns related to sustainability.
- Training can play an important role in developing the vision and skills needed for intersectoral work. This was conveyed in multiple case studies, including those from Armenia, Portugal, Romania, and United Kingdom (England and Scotland). The Armenian study recommended that relevant staff in education institutes be trained in adolescent mental health and rights issues. In addition, authors suggested that the health system can strengthen its own capacity through the training of family doctors, paediatricians and other relevant health service workers in mental health.

- Being the victim of bullying has a direct negative effect on mental health. Bullies and victims demonstrated significant problems with health, emotional adjustment and school adjustment *(2)*. School-based interventions for mental health and well-being can offer options for preventing destructive and self-destructive patterns of behaviour. Activities could include training for school administrators and representatives of municipal education departments about modern principles of prevention of destructive and self-destructive behaviour in schools *(10)*.

Addressing health inequities

- Policies to improve economic security for families with children are necessary, as available evidence suggests links between low socioeconomic status and increased exposure to risk factors for mental disorders in children and adolescents. Public transfers and social security payments can significantly affect child poverty; countries that spend 10% of GDP on public transfers have less than 15% child-poverty rates, while those that spend less than 10% have rates of 15% and above *(11)*. As poverty is multidimensional, social programmes that improve housing, education opportunities, job market skills and other aspects of social inclusion for low-income households are also important for promoting mental well-being of children and adolescents.
- Further to the above point, the concept of "health and equity in all policies" is central to addressing the socioeconomic determinants of health, including those related to mental health. The rationale for this is expressed clearly in the case study from Belgium (Flanders), which states: "Equity is not only an issue in health; it is also an issue in education and in other sectors of society. Societal challenges are often intertwined. Sectoral policies can support each other or can counteract each other."
- Equity issues should be addressed in policies and strategies for child and adolescent health and mental health. In Ireland, the policy document *A vision for change: the report of the Expert Group on Mental Health Policy* sets out a comprehensive model of mental health services provision in Ireland and proposes a framework for how positive mental health should be implemented. The framework focuses on child populations at higher risk (those from poorer socioeconomic backgrounds). In Hungary, one of the first countries to adopt a national child and adolescent health plan harmonized with the *WHO European strategy for child and adolescent health and development (12)*, the national plan identifies issues represented by social risk conditions and inadequate provision of health care in underserved areas and for minority population groups.
- Positive relationships with parents are key protective factors for adolescent mental well-being. Parent training and comprehensive early childhood development programmes addressing socioeconomic determinants, health system access and social and emotional health (including effective parent–child relations) show evidence of enhancing possibilities for low-income young people to confront adverse circumstances *(13*; also see background paper, *Economic aspects of mental health in children and adolescents*). This becomes particularly important for children of a parent with mental illness, who often experience illness-related disturbances in the parent–child interaction that can lead to feelings of guilt, disorientation and loss of self-confidence and promote stigmatization and isolation.
- Policy-makers and programme managers should account for gender differences in the design of strategies and interventions. HBSC data suggest that adolescent boys typically have higher positive self-esteem, lower negative self-image and less unhappiness than girls. Conversely, boys may be more exposed to risk factors, including bullying.
- School settings can be used as non-stigmatizing "equalizers", as there is evidence that positive experiences in school can buffer the negative effects of risk factors for mental disorders (including low family income and migrant status). In Belgium (Flanders), percentages of poor mental health in pupils of low socioeconomic status were higher when students did not get support from students and teachers and when they perceived the school as not being a nice place to be. The Portugal case study highlights the importance of promoting and assuring school success as a means to stop the dangerous chain of "poverty–>social exclusion–>school failure–>health-compromising behaviours–>school drop out–>under or unemployment–>social exclusion–>poverty".
- For young people who have dropped out of school, governments can consider supporting initiatives to enhance emotional health and social skills, while also increasing academic and job-related skills. In the Pomurje Region of Slovenia, for instance, a programme for such young people provides teaching on social and coping skills and finding supportive social contacts, training for positive self-image and healthy behaviour, and vocational development and career counselling workshops (see case study from Slovenia).
- It is important that service delivery networks include initiatives at the primary level in the communities with the greatest needs. In Andalusia, Spain, "Forma joven" – addressing mental health, sexual health, and addiction – targets young people

while involving them proactively in programme implementation. The establishment of "Forma joven" points is prioritized for areas requiring social transformation due to adverse socioeconomic conditions. The initiative is part of an integrated strategy to increase social cohesion and improve access to public services in socially disadvantaged areas.

Involving young people

- "Count on our contribution when making decisions that affect our lives", expressed the WHO/HBSC Forum statement prepared through youth-run workshops involving 70 teenagers in Alcalá de Henares, Madrid, Spain. The statement was provided as the young people's contribution to the case study on the Manuel Merino Health Centre, which provides participatory youth-friendly services at primary care level. It clearly conveys the notion that policies and initiatives to improve mental health and well-being status of children and young people should, as a fundamental principle, feature the involvement of children and young people, particularly as the process of finding one's voice and having it listened to is mentally health-promoting in its own right (see case study from Scotland, United Kingdom).
- Student committees and/or peer facilitators are important in a whole-school approach to the promotion of mental well-being and effective school-based mental health programmes. The study from Lithuania reported that in school programmes, the presence of adolescent volunteers provided positive role models and allowed teenagers to gain self-confidence and to feel safe through peer group experiences, while also resulting in the most youth-appropriate solutions.
- Training on participatory methods can be incorporated into strategies and programmes. HeadsUpScotland (see case study from Scotland, United Kingdom), which supports implementation of recommendations in the Scottish Needs Assessment Programme report for child and adolescent mental health, established a participation partnership group. Actions included: a training programme for local staff, children and young people in participation methods; engaging children and young people in local community work; and a national consultation with 120 young people.
- Discussions at the Forum stressed the need for sufficient resources (human and financial) to be allocated to enable young people's involvement in a sustained and meaningful way. Higher priority needs to be given to this participatory approach in funding decisions.

Translating research into policies and action

- Case studies underlined the need for a sound scientific evidence base to inform policy formulation and underpin activities promoting adolescent mental health and preventing mental disorders. The study from Armenia, a country that in 2007 was not regularly conducting the HBSC survey, highlighted the fundamental importance of such a study in measuring current issues and trends, particularly taking into account the rapid transitions in the country. Armenia has since joined the HBSC network to address this need. The case study from the Republic of Moldova recommended the improvement of information systems as a necessary part of developing better ways of addressing adolescent mental health and well-being, and called for a scaling-up of comprehensive monitoring and data collection.
- There are opportunities to increase the use of HBSC and other data sources at local levels to develop and evaluate new and existing projects. As suggested in the case study from Iceland, further work is needed to map the community and individual-level differences to support policy-makers at local levels and to deliver programmes to reduce health inequities.
- Forum discussions emphasized the need to strengthen the evidence base on effective interventions (for those addressing mental health directly and those incorporating social and emotional health into other programmes for young people's health and welfare). The lack of solid evidence for the effectiveness of intersectoral mental health promotion hinders investment in intersectoral work (see case study from Flanders, Belgium). Developing a vision and a methodology to evaluate intersectoral interventions is a priority, and this should be addressed in efforts to strengthen the stewardship function of health systems.
- There are challenges in drawing generalized conclusions about the cost–effectiveness of interventions to promote child and adolescent mental health and prevent mental disorders among this age group, particularly in light of the limited number of economic evaluations conducted (especially in Europe, outside of the United Kingdom). More research is needed to understand the cost burden and the "return" on investment (see background paper, *Economic aspects of mental health in children and adolescents*).
- In relation to socioeconomic status and mental health, current data allow reliable conclusions to be drawn for some countries, while no or very limited data are available for other countries. Inconsistencies in measurements and methods impede the

making of accurate, valid comparisons between and within countries over time. Detailed, comparable, reliable and valid data on both socioeconomic status and mental health are required to enable political decision-making to be based on a strong scientific rationale (see background paper, *Socioeconomic inequalities in mental health among adolescents*).

- The Forum 2007 process has pointed to the importance of not defining mental well-being simply in relation to mental ill health. Promoting positive mental health and well-being is vitally important for children and young people, but the concept of positive mental health and well-being is subject to interpretation across different countries and cultures. The lack of a common understanding leads to problems in comparing research and survey data across countries and in collecting and using routine data within countries.
- An example of networking to meet the above-mentioned needs and enable the transfer of research into policies and action is the project *Child and Adolescent Mental Health in Enlarged European Union – development of effective policies and practices* (CAMHEE), funded by the EU Public Health programme. CAMHEE aims to provide recommendations and guidelines for policies and practices in the European Union, with special emphasis on new EU countries and in synergy with the *Mental Health Action Plan for Europe (4)*.

8. What immediate steps can policy-makers take?

The lessons learned through the Forum process reinforce and provide further impetus for the commitments of governments to act on child and adolescent mental health and well-being, as outlined in the following policy papers and strategies: the *Mental Health Action Plan for Europe (4)*, the EU Green Paper *Improving the mental health of the population: towards a strategy on mental health for the European Union (7)*, the *WHO European strategy for child and adolescent health and development (12)* and European key competencies for lifelong learning. Policy-makers are encouraged to increase their efforts in implementing the recommendations outlined in these, with due recognition of the diverse circumstances in each country. Action areas include, but are not limited to, the following:

- developing mechanisms to scrutinize the mental health impact of public policy for all age groups and ensure the implementation of policies across government to address social determinants of mental health;
- ensuring the coordination of programmes and interventions to maximize resources, avoid duplication and identify gaps;
- developing and implementing capacity-building programmes, including training for professionals working with children and young people with mental disorders. Ongoing support to enable professionals to use this training within their practice is also needed;
- developing governmental information systems that are fit for purpose and provide intelligence to support action to promote the mental health and well-being of adolescents, and ensuring that these systems make data available to the policy-makers and practitioners who need them; and
- supporting a culture of evaluation and mutual learning within and between Member States.

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Disclaimer

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