Belgium (Flanders): beyond boundaries – integrating school and mental health policies

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Executive summary

Adolescents are an important target population for mental health promotion. Indicators of mental health show a decrease in well-being with increasing age in adolescence. Adolescents from low SES backgrounds are more likely to have low life satisfaction, low self-rated health status and a higher score on suicide ideation. School variables (especially acceptance of students within the school) have a (modest) impact on the negative association between SES and mental well-being.

In 2005, the Flemish Minister of Health formulated a health target aimed at reducing the high suicide rate in Flanders. A consensus health conference was organized to ensure that all relevant sectors were involved in discussing the evidence base of the health target and the proposed strategies with which it would be pursued. One of the strategies discussed was the implementation of a mental health policy in schools.

In January 2006, four ministers of the Flemish Government (the Minister–President together with the ministers of education, health and youth) signed a declaration of intent to support the implementation of a health policy in all schools. A framework was subsequently developed by the Commission of Health Promotion of the Flemish Educational Council, and all schools should have had a health policy in place by September 2007. The presence of a health policy in all schools will be verified in 2009.

The framework builds on the education sector's existing structures and facilities and the expertise of representatives of all stakeholders involved, including pupils and parents. Health promotion experts are full members of the Commission and act as advisers to representatives of the education sector on implementing evidence-based strategies identified during the consensus health conference.

Although the Belgium (Flanders) case study is not an example of a truly intersectoral approach, it does demonstrate how the focus shifted from the health sector and the policy-dominated consensus conference in the development of the mental health action plan, to the education sector and the fieldwork-dominated Commission of Health Promotion of the Flemish Educational Council for implementation of the action plan.

The weakness of this strategy is the dependency on individuals having links with both sectors and the lack of structures for intersectoral work. The strength is the participative approach adopted and the integration of health aspects in other initiatives in the schools, most importantly in actions to promote equal education opportunities for children from disadvantaged families and communities and for children with special needs.

The integration of health in all aspects of the school ensures the sustainability of the work and enhances the "reach" of activities. Evaluating the impact of the strategy on the mental health of young people, however, remains a challenge.

The Flemish case study does not focus on one specific policy or intervention, but describes how a mental health action plan, an initiative of the health sector, can build on initiatives taken in the education sector to reach all children and adolescents, even in the absence of a truly intersectoral approach.

Mental well-being in Flanders – the 2006 HBSC survey

The HBSC survey is administered in Flanders with students from 5th year elementary school (10-year-olds) to the last year of secondary school (18-year-olds). The study is financed by the Ministry of Health. Data from the last two survey rounds (2001/2002 and 2005/2006) are discussed below.

Self-reported health

Self-reported health was measured with the question: "Would you say your health is excellent, good, fair or poor?" The percentages of fair or poor health are shown by gender for the last two HBSC surveys in Table 1.

A clear linear association can be observed between having fair or poor subjective health and age, with older pupils more likely to report fair or poor health. In 2006, girls were more likely to evaluate their health as fair or poor. Girls' percentages were higher in 2005/2006 than they were in 2001/2002. No large differences were found in boys between the two surveys.

Table 1

Percentages of fair or poor subjective health in boys and girls

Age	Boys		Girls	
	2001/2002	2005/2006	2001/2002	2005/2006
11–12	10.3%	10.2%	9.3%	14.6%
13–14	11.0%	13.5%	15.8%	22.1%
15–16	17.1%	18.5%	23.0%	24.6%
17–18	20.0%	21.6%	25.1%	28.5%

Health complaints

Table 2 shows percentages of young people reporting health complaints at least weekly by gender and age. Most symptoms increased with age and were reported more frequently by girls than boys. Stomach ache and sleeping problems were more or less stable across ages. The same can be observed for "feeling dizzy", but only in boys.

Life satisfaction

The Cantril ladder is used to measure life satisfaction. Pupils are asked to indicate how they see their lives at the current time, going from "0" (worst possible life) to "10" (best possible life). Pupils scoring "7" or less are considered to have low life satisfaction. In Table 3, percentages of low life satisfaction are shown from the two last HBSC surveys for boys and girls.

Low life satisfaction increased with age. Girls in older age groups were more likely to indicate a low life satisfaction compared with boys of the same age. No large differences were observed between the two surveys.

Table 2

Percentages of at least weekly health complaints by gender and age

	Headache	Stomach ache	Backache	Tiredness	Irritability	Nervousness	Sleeping problems	Dizziness
Boys								
11–12	15.2%	10.0%	8.9%	15.7%	17.1%	23.5%	25.4%	8.3%
13–14	17.7%	11.0%	18.6%	21.8%	22.0%	27.5%	25.4%	11.2%
15–16	17.0%	10.5%	22.5%	33.1%	29.0%	29.9%	28.4%	12.7%
17–18	18.8%	11.3%	25.9%	38.3%	30.4%	30.5%	26.3%	11.3%
Girls								
11–12	20.9%	18.4%	13.6%	18.9%	18.9%	26.8%	29.9%	10.0%
13–14	27.1%	19.4%	18.5%	28.2%	28.1%	30.9%	30.1%	13.8%
15–16	29.2%	19.0%	21.8%	38.9%	34.6%	34.0%	30.7%	16.2%
17–18	36.7%	20.5%	31.2%	47.9%	37.7%	35.7%	30.8%	18.7%

Suicide ideation

A question on suicide ideation was included in the Flemish version of the HBSC study for pupils in the highest grade of secondary schools. The results for pupils who had thought about suicide once or more are shown in Table 4.

Girls were more likely to think about suicide than boys. As with the two previous indicators of mental well-being, thinking about suicide increased with age. No large differences were found in boys compared with the 2001/2002 survey, but suicide ideation increased in girls. The (fatal) suicide rates confirm this trend.

Table 3

Percentages of low life satisfaction by gender

Age	Boys		Girls	
	2001/2002	2005/2006	2001/2002	2005/2006
11–12	30.3%	31.7%	28.1%	31.2%
13–14	40.5%	39.0%	40.6%	42.2%
15–16	46.5%	43.4%	52.0%	51.2%
17–18	49.0%	47.8%	52.5%	53.1%

Self-harm

Questions on self-harm were included in the 2005/2006 HBSC survey for the first time. Because of the sensitive nature of the questions, they were only asked of pupils in the two last years of secondary school. It was found that 11.2% of boys and 22.2% of girls had already deliberately taken too many pills or tried to damage themselves in some other way.

Table 4

Percentages of suicide ideation in boys and girls

Age	Boys		Girls	
	2001/2002	2005/2006	2001/2002	2005/2006
11–12	30.6%	33.9%	39.4%	45.5%
13–14	36.0%	35.6%	49.8%	49.0%
15–16	38.0%	36.3%	48.9%	52.1%
17–18	49.0%	47.8%	52.5%	53.1%

Relationship between socioeconomic status and indicators of well-being

Several indicators of socioeconomic inequality are included in the HBSC study. In these analyses, FAS II and the question on perceived family wealth were used.

FAS

The FAS consists of questions on: family car ownership; bedroom occupancy; family holidays; and computer ownership. Tertiles are used to compare groups. Logistic analyses were done, controlling for age and gender. Percentages and the odds ratios (OR) of the logistic regressions are shown in Table 5.

Adolescents having a low FAS score were more likely to have low life satisfaction and a low self-rated health status. They were also more likely to think about suicide. No significant relation was found between FAS score and self-harm.

Perceived family wealth

For perceived family wealth, the categories "(very) well off", "average" and "not (at all) well off" were compared. Table 6 shows the percentages of the well-being indicators by perceived family wealth and the OR of the logistic regressions controlled for age and gender.

Adolescents with a low perceived family wealth were more likely to have low life satisfaction, a low self-rated health status and to think about suicide. Remarkably, adolescents in the low and high categories of perceived wealth were more likely to have damaged their body once or more.

Table 5

Well-being by FAS score (logistic regressions)

	High	Medium	Low
Life satisfaction low	36.2% (OR = 1)	42.4% (OR = 1.22)***	48.7% (OR = 1.49)***
Self-rated health low	15.1% (OR = 1)	18.2% (OR = 1.15)*	25.5% (OR = 1.66)***
Suicide ideation	38.2% (OR = 1)	41.5% (OR = 1.10)	46.2% (OR = 1.30)***
Self-harm	16.3% (OR = 1)	15.6% (OR = 0.97)	20.0% (OR = 1.20)

School variables

School climate was measured by students' support ("students accept me as I am"), teacher support ("teachers show interest in me") and perceptions of the school ("school is a nice place"). The relationships between mental health and SES by school climate are shown in Tables 7, 8 and 9. Percentages of poor mental health in pupils of low SES 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. In logistic regressions, the school climate variables all had a significant positive influence on mental health, even when controlled for SES, gender and age.

Table 6

Well-being by perceived family wealth (logistic regressions)

	High	Medium	Low
Life satisfaction low	31.0% (OR = 1)	41.4% (OR = 1.56)***	62.2% (OR = 3.50)***
Self-rated health low	13.9% (OR = 1)	17.7% (OR = 1.25)**	33.1% (OR = 2.75)***
Suicide ideation	40.1% (OR = 1)	39.2% (OR = 0.89)	56.7% (OR = 1.77)***
Self-harm	17.0% (OR = 1)	15.3% (OR = 0.74)*	24.7% (OR = 1.37)

Dissemination of the HBSC results

The results of the HBSC survey were presented to the Flemish Minister of Health, with tables and a discussion of the results made public through the web site of the study. The HBSC team answered specific questions from the cabinet minister and administration of the Flemish Community and wrote contributions for the Health indicators report, a publication of the Ministry of the Flemish Community.

Reports of each HBSC survey have been presented and discussed within the Commission of Health Promotion of the Flemish Educational Council. The principal investigator of the Flemish HBSC team is Chair of the Commission for Health Promotion of the Flemish Educational Council and a member of the Flemish Health Council. HBSC data have also fed into the work of various committees and media outlets to provide an evidence base for their outputs.

Table 7

Relationship between mental health and SES by student support

	Fair or poor health	Low life satisfaction	Suicide ideation	Self-harm
Student support	%	%	%	%
Low FAS	23.9	45.7	43.6	18.0
Medium FAS	17.1	41.0	40.0	15.6
High FAS	14.0	34.7	37.0	15.5
Not well off	31.9	59.4	53.8	23.3
Medium well off	16.3	39.8	37.8	14.6
Well off	13.2	29.4	38.9	16.6
No student support				
Low FAS	38.5	74.3	66.2	34.9
Medium FAS	30.8	59.3	57.6	15.9
High FAS	28.7	54.1	51.1	23.9
Not well off	40.3	79.8	73.8	32.6
Medium well off	34.1	61.1	54.8	23.1
Well off	20.4	48.9	51.3	19.1

Table 8

Relationship between mental health and SES by teacher support

	Fair or poor health	Low life satisfaction	Suicide ideation	Self-harm
Teacher support	%	%	%	%
Low FAS	23.6	45.9	43.5	17.6
Medium FAS	16.5	39.6	39.0	15.2
High FAS	13.5	33.8	35.8	16.0
Not well off	31.3	59.4	54.3	21.5
Medium well off	16.2	39.0	37.3	14.8
Well off	11.8	27.8	36.5	16.6
No teacher support				
Low FAS	33.5	61.7	56.1	28.2
Medium FAS	26.9	55.6	51.5	16.4
High FAS	23.9	48.6	48.6	17.5
Not well off	39.7	72.3	64.5	33.3
Medium well off	26.1	55.2	48.1	17.3
Well off	22.9	44.0	52.4	18.1

Summary of HBSC

Adolescents are an important target population for mental health promotion, as mental well-being has been shown to decrease with increasing age. Girls scored worse on mental health indicators than boys. Adolescents with low socioeconomic status (based on FAS and perceived family wealth) are more likely to have low life satisfaction, a low self-rated health status and a higher score on suicide ideation. School variables (especially acceptance of students) have a (modest) impact on the negative association between SES and mental well-being.

Table 9

Relationship between mental health and SES by perception of school

	Fair or poor health	Low life satisfaction	Suicide ideation	Self-harm
School is a nice place	%	%	%	%
Low FAS	23.3	46.3	43.0	18.2
Medium FAS	16.0	39.8	39.3	14.5
High FAS	13.4	33.3	36.0	15.4
Not well off	30.2	58.8	53.9	22.0
Medium well off	15.7	39.2	37.4	14.4
Well off	12.6	27.9	36.8	16.7
School is not a nice place				
Low FAS	33.8	58.7	57.0	25.0
Medium FAS	27.8	54.0	49.9	18.1
High FAS	23.8	50.4	47.8	19.2
Not well off	42.8	72.7	65.4	31.7
Medium well off	27.3	52.3	46.9	18.0
Well off	19.5	45.2	51.6	17.2

It can be concluded that mental health promotion programmes for the general school population are required. Equally important is the finding that student support, as part of a positive school climate, can have an impact on socioeconomic inequalities in mental health.

Social and policy context

The Flemish communities

Belgium is a federal state consisting of three communities (based on the three official languages – Dutch, French and German) and three Regions (Flemish Region, Walloon Region and Brussels–Capital Region). The communities have a parliament and a government. In addition to cultural matters, issues such as health, social services and education are responsibilities for the communities.

Health promotion in Flanders

Following the WHO Health for all strategy *(1)*, five Flemish health targets aimed at decreasing smoking rates, enhancing nutrition habits, preventing infectious diseases, increasing breast cancer screening and decreasing accidents were adopted in 1998. In 2005, and following the *Mental Health Action Plan for Europe (2)*, the Flemish Minister of Health formulated a sixth health target aimed at reducing the high rate of suicide in Flanders.

The decree for preventive health policy (21 November 2003) *(3)* stated that a health target and the strategies necessary to reach the target must be formulated in a health conference. After the health conference, the government and parliament would have to approve the health target and action plan. By this process, a broad social basis for the health target could be obtained.

The Ministry of Health has established 26 local health organizations (LOGOs) in Flanders and Brussels to help the government reach the health targets. Their task is the realization of the health targets in their specific region. LOGOs are networks of local partners, such as local authorities, schools, companies, health and other organizations, health insurance services and general practitioners. The Flemish Institute of Health Promotion gives support to the LOGOs.

Education in Flanders

Compulsory education starts when a child reaches the age of 6 and lasts 12 full school years. All children who reside in Belgium are subject to compulsory education, including children with a foreign nationality. Vulnerable groups of children are protected. Schools are not allowed to use the absence of a residence permit to refuse pupils access to their school. Children in this situation are eligible for subsidies from the government from the moment of enrolment. To guarantee the right to education, Flanders has made arrangements with the Federal Ministry of Home Affairs and the Federal Police on picking up illegal refugee children. A federal circular letter confirms that it is prohibited to pick up children of illegal migrants who are of school age at school during school hours.

Although nursery education is not compulsory, almost all children receive nursery education in Flanders (from the age of 2.5 years). The fact that children can go to school at this very early age is a special stimulus to children from deprived backgrounds. The results of the HBSC survey showed that children in lower SES situations are at particular risk of mental health problems, and that schools are able to reach these children and provide an environment that enhances mental health.

The Flemish Government recognized in the 1990s that school curricula will increasingly reflect dynamic interactions taking place in society at local and global levels. School policies and curricula are consequently becoming the subject of more and more debate. Decisions on what has to be taught in schools are taken in the parliament, based on scientific information. One of the challenges is to ensure that the whole community is involved and can support what is learned in schools.

Several pieces of legislation and instruments have been developed to help in attaining this goal. They are crucial in developing sustainable integration of health aspects in Flemish schools and in reaching vulnerable groups of children.

Instruments/facilities in the school system supporting sustainable implementation of a school mental health policy

The following policy instruments and facilities have been developed in accordance with the principles of the *WHO European strategy for child and adolescent health and development (4)*, which are: a life-course approach, equity, intersectoral action and participation.

Tackling inequalities: Act on Equal Opportunities in Education of 28 June 2002

The Flemish Government approved a strategic plan for an inclusive and coordinated minority policy in 1996. Within the education and training policy area, preference was given to policy measures that touched upon the very core of the education system and resulted in structural reform: an integrated regulation paying special attention to children from deprived backgrounds. This new regulation provides full opportunities for all children to learn and develop and to counter exclusion, social separation and discrimination.

The Act on Equal Opportunities in Education *(5)* stipulates the following.

- Each pupil has in principle the right to enrol in the school of his or her (parents') choice. Only in a strictly limited number of cases can a school refuse an enrolment or refer a newly enrolled pupil to another school. The governing body or school board has to justify the refusal or referral in writing. Local accountability is enhanced through local consultation platforms that have a mediating capacity. Pupils or parents who are of the opinion that they have been wrongfully refused enrolment can file a complaint with the pupil rights committee.
- The establishment of local consultation platforms, with a threefold task: to ensure the right of enrolment, act as an intermediary in case of conflicts, and cooperate in implementing a local policy on equal opportunities in education. The platform consists of different participants (including representatives of the target groups) involved at local level in the implementation of equal opportunities in education. All schools and guidance centres in the action zone of a local consultation platform are obliged to participate constructively in the consultation. Participating in and cooperating within a consultation platform is a condition for funding and subsidies.
- Provision of additional resources to enable schools to develop integrated support for deprived children. Support is given to schools with a large number of pupils who meet specific, mainly socioeconomic, indicators. Additional teaching periods or additional teaching hours per teacher are financed for these schools. Individual schools choose the goals they want to

achieve, determine the way they want to reach these goals and establish how self-evaluation will be realized in the course of the second school year.

The government provides additional staff in educational guidance services. These educational advisers support schools in carrying out the policy on equal opportunities in education. Both educational guidance services and central organizations with representatives in local consultation platforms get additional staff members and operating resources to support and monitor schools and activities within the local consultation platform.

The Act on Equal Opportunities in Education enables schools to create a learning environment that caters for the needs of all children. The schools can choose the priorities on which they want to focus based on the characteristics of their school population and can decide what support they need.

Several pilot projects have been started, with integration of the school in the local community as a priority area. These schools reach out to parents, open themselves to the local community and enhance social cohesion in the often disadvantaged neighbourhoods in which the schools are embedded. Supporting children of migrant parents is also a priority in many schools.

Cross-curricular themes in relation to health promotion *(6,7)*

Cross-curricular themes in the Flemish education system reflect a societal consensus on important goals for the schools and are based on a broad vision of what should be learned at school. Cross-curricular final objectives act as a kind of "safety net" for core objectives that are rarely if ever raised in the topics taught in schools. In secondary education, not a single subject completely covers all aspects of such themes. A cross-curricular approach is therefore required, setting objectives for the whole school.

The cross-curricular themes were developed by the Department of Educational Development of the Flemish Ministry of Education, supported by working parties with representatives of relevant organizations for the specific themes and scientists (the health promotion working party was chaired by the Principal Investigator of the Flemish HBSC survey). The cross-curricular themes were discussed and adopted by the Flemish Parliament. They include not only topics such as drug prevention, sexual education, nutrition and physical activity, but also social relations, emotional well-being and social cohesion.

Besides health promotion, other cross-curricular themes are also relevant for the health and well-being of pupils, such as social skills, citizenship, environmental education, learning to learn, creative education and technical education (for general education students). Schools can choose how to organize these topics within their school curriculum. There are no examinations for the students on these topics, but the cross-curricular themes are part of the evaluation of schools by the schools inspectorate.

Integration of all pupils

The following measures have been put in place to promote integration of all pupils.

- Special educational care: young people whose physical, psychological, social or intellectual development is hampered by a disability, or who have learning or behavioural difficulties, can temporarily or permanently access special assistance and education adapted to meet their needs. The aim is to integrate the pupil as far as possible in the education environment and in society by means of individually tailored education and teaching measures. Young people with a disability can also be admitted to a school for mainstream secondary education through the system of integrated education *(8)*. They are supported by experts from special education.
- Framework for learning support: the Government of Flanders is currently discussing a memorandum concept, proposed by the Minister of Education, for the reorganization of compulsory education. This concept is a framework for tailor-made learning support for every child. The reason for this new concept is the increasing demand for learning support in schools for children with emotional and behavioural problems and who lack social skills. Schools and school teams have expressed the need to increase their competences to cope with these problems. There is also a demand to create more inclusive settings for children with specific learning disorders. The new framework offers possibilities for support and measures to address these problems.

"To your health": a declaration of intent for an intersectoral strategic plan for school health promotion

The Flemish Government has set out an agreement to create a Flanders in which all people can live together on a basis of equality and active citizenship. The ultimate goal is to attain sufficient social cohesion in society to give individuals the best possible opportunities in their lives. Preventive health care is one of the tools to achieve this goal.

The ministers of education, health, youth and the Minister–President agreed on 26 January 2006 on a policy to stimulate the implementation of a health policy in all schools *(9)*. Each school should have had a policy to enhance eating habits and physical activity of children and adolescents in place by September 2007. These first topics were chosen to reflect international and national interest in the prevention of obesity. In coming years, new topics such as mental health can be the focus.

The post of Flemish Health Coordinator was created to support schools to develop a health policy and the Commission on Health Promotion of the Flemish Educational Council was re-established to support the work of the Health Coordinator. The Commission includes representatives of all stakeholders in the school sector and experts in different areas of health promotion and is chaired by the Principal Investigator of the HBSC survey. The Coordinator and the Commission have developed a four-year strategy, "To your health" *(10)*, which has been developed to empower schools to create their own health policy. Schools will also be supported by educational guidance centres that will give seminars throughout Flanders. New tools have made available at an informative web site *(11)* and a DVD with examples of good practice has been developed. Funding is provided by the Ministry of Education, while the health sector gives support by making expertise on health promotion available.

The participation of teachers, parents, pupils and external partners is central to the process of building a school health policy. Actions take place at class, school and environment levels. The structures that help this process are described in the participation decree.

Partners in the school health policy include pupil guidance centres, an existing service funded by the government to provide information, help and guidance for pupils, parents, teachers and school management teams. The pupil guidance centres monitor the welfare of pupils and play an important role in contacts between pupils, parents, the school and welfare and health institutions.

Pupil guidance centre advice is free of charge and is based on four important pillars: learning and studying; the school career; preventive health care; and social and emotional development. The pupil takes a central place in the process, and guidance is offered in an atmosphere of trust and dialogue. Supervision provided by the pupil guidance centres has a multidisciplinary character and focuses particularly on pupils with learning difficulties due to their social background and situation. In addition to officering medical examinations, pupil guidance centres are also responsible for preventive health care for young people.

Other key partners in the health policy are:

- educational guidance centres;
- umbrella organizations for parents and the Flemish umbrella organization of pupils;
- LOGOs and the Flemish Institute of Health Promotion;
- expert centres such as the Organization for Alcohol and other Drug Problems, SENSOA (the Flemish expert organization on sexual health and HIV) and the Red Cross; and
- executive organizations such as the Nutrition Information Centre and the Flemish Foundation of School Sport.

Financing arrangements are described in the declaration. The Minister of Health subsidizes partner organizations (such as the LOGOs and the Organization for Alcohol and other Drug Problems) who develop the methods that can be used in schools. The Minister of Education finances the costs of dissemination of information to stakeholders in the education sector. The Minister for Agriculture finances the costs of cooperation with the Nutrition Information Centre, and the Minister of Sports finances the costs linked with cooperation with the Flemish Foundation of School Sport and the focal point, Sports, Movement and Health. The Department of Education receives €150 000 yearly for the development of the action plan To your health. The application of this budget will be determined by the Commission on Health Promotion in consultation with the Administration of Health and the Administration of Support.

The Flemish health target on the prevention of suicide and depression

The target *(12)* is to reduce death by suicide by 8% in 2010 compared with 2000. Three subtargets were formulated:

1. a decrease in suicide attempts
2. a decrease in suicide ideation
3. a decrease in depression.

Although the target is formulated in terms of reducing risk factors, mental health promotion is also part of the action plan.

The new health target was prepared by a working group and discussed within a health conference (or consensus conference) in which representatives of all sectors and organizations involved participated, including representatives from the school sector. They discussed the evidence base for the new health target and the strategies and interventions identified to enhance mental health and to prevent future suicides. An action plan was developed and approved by the Flemish Government in January 2007.

The five strategies described in the action plan are:

1. improve the mental health of the individual and society
2. improve access to care by telephone
3. enhance the expertise of professional carers and optimize networking
4. reduce predisposing factors for suicide
5. give special attention to specific target groups.

The last item on the list has a focus (among others) on adolescents and the development of a mental health policy in schools.

The strategy was further developed by a working group consisting mainly of mental health and health promotion specialists, with no representatives from the school sector. This phase was taken forward within the health administration. A literature review revealed two effective approaches: a suicide-specific approach, and a global mental health approach. In a first exploratory meeting, the working group concluded that a global mental health strategy would be the better choice in the Flemish context.

The proposed action plan for schools has six components:

1. the implementation of a health promoting environment using an integrated approach; protocols on bullying (and cyber-bullying), violence in schools and substance use will be developed;
2. training of relevant stakeholders, including teachers, with special attention to the needs of young people who are homosexual, and information evenings and e-learning packages for parents;
3. an intervention strategy on suicide prevention (crisis and postvention) in cooperation with schools, school guidance centres and centres of mental health;
4. recognizing signals for early detection of pupils at risk in schools, in cooperation with guidance centres and centres of mental health;
5. activities promoting mental well-being of pupils in schools; and
6. counselling in schools and in school guidance centres, with adequate processes for referral to treatment.

The implementation of the mental health action plan for schools can build on the existing initiatives and structures identified above. Integrating implementation within existing structures makes best use of initiatives that support the mental health action plan, such as integrating mental health in the activities of the Act on Equal Opportunities in Education and the Special Care Act. This is an essential element in reaching the most vulnerable children and adolescents. The Commission on Health

Promotion of the Flemish Educational Council plays an important role in bringing the different stakeholders together, facilitating the discussion of ways of integrating mental health and the strategies identified in the action plan into existing initiatives and developing new initiatives to support the work of all involved.

There is no intention to have an isolated evaluation plan. Strategies identified in the mental health action plan for schools are already evidence based, and it would make little sense to try and evaluate an action plan that is intended to be integrated within a variety of existing structures in the school sector. The following activities and research will, however, make it possible to assess the impact of the mental health plan in the short and long term:

- the Health Coordinator of the Flemish Educational Council writes an annual report on the implementation of activities planned by the Commission for Health Promotion, suggesting measures to enhance implementation if necessary;
- the inspectorate of the Department of Education visits all schools subsidized by the government regularly, and implementation of the cross-curricular themes and school health policy is part of the inspection, with inspection reports being made public;
- the Flemish Institute for Health Promotion monitors the implementation of several aspects of the school health policy every three years *(13)*;
- the HBSC survey, carried out every four years, monitors several aspects of the mental health of young people;
- the health interview survey monitors several aspects of mental health of adults; and
- mortality rates for suicide are a final instrument for evaluating the health target on suicide.

The declaration of intent of the ministers of education, welfare, health, youth and agriculture to implement a school health policy *(9)* has strong potential to promote evidence-based health promotion (including mental health) in Flemish schools. The development of a strategic plan for a health policy in schools *(10)*, provision of a comprehensive framework for learning support and the creation of an intersectoral commission to advise, support and create tools for action provide a good start to the effort to achieve the final goal.

Lessons learned

Precondition: health and equity as elements of the education policy

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. In Flanders, the education policy supports the health promotion policy in many ways, even in the absence of a truly intersectoral policy. Although the decree on preventive health care foresees the participation of other sectors in the development of health targets through the organization of health conferences, the development of health targets is not a truly intersectoral exercise.

Implementing a health policy in schools (in this case, a mental health policy) would be difficult in the absence of structures within the education sector that have the same final aim – the creation of a supportive society with equal opportunities for all children. In Flanders, the education system provides a framework in which all children, including the most vulnerable, can be reached with health initiatives.

Barriers: intersectoral work remains difficult

Even if opportunities to integrate mental health in school policy exist, recognizing and making use of them depends on individual people and the vision, capacity and willingness to take advantage of opportunities. Training can play an important role in developing the vision and skills needed for intersectoral work. At policy level, recognition of an overall responsibility for health and the willingness of the health sector to invest in other sectors are needed.

Health promotion (mental health promotion in particular) can only reach its objectives through the integration of health aspects in other policies; this is the strength, but also the weakness, of health promotion. Leadership in this context is often problematic.

Intersectoral committees are often dominated by the health sector (as in this case study, in which the health conference was the instrument used to foster discussion on the integration of mental health considerations across other sectors). The dominant position of the health sector hinders representatives of other sectors from making a full impact on decision-making, leading to frustration and withdrawal. Ways to encourage the participation of other sectors in the decision-making process within the health conference must be sought. A more stepwise process could be helpful, building from a first step of developing a common vision about actions to be implemented.

As problematic (especially from a political point of view) is the health sector's ability to provide support and financial resources for initiatives in other sectors. Representatives of the health sector were members on a voluntary basis of the Commission for Health Promotion of the Flemish Educational Council. The functioning of the Commission depends to an extent on the willingness of health experts to listen, discuss and accept consensus.

The Commission for School Health Promotion has survived by adapting to political reality and taking opportunities when they arise. Launched more than 15 years ago to guide the implementation of health education packages initiated by the Minister of Health in schools, it is now the advisory commission on school health policy of the Flemish Educational Council and is financially supported by the Flemish Minister of Education. Efforts to agree a co-financing arrangement between health and education have as yet been unfruitful, and attempts to align the Commission to a more "neutral" body have not been successful.

In addition to structural problems, the lack of "hard" evidence for the effectiveness of intersectoral mental health promotion hinders important investment in intersectoral work. Developing a vision and a methodology to evaluate this type of intervention is an urgent priority.

Although representatives of pupils are members of the Commission on Health Promotion, their impact on the work of the Commission is minimal, as health is not a priority action point of student school committees. The impact of the student committees within the schools is more important, but more initiatives to engage students in the work of the Commission are required.

A recent education inspectorate report *(14)* on the state of health promotion (one of the cross-curricular themes) and health policies in schools provided some important recommendations. One of these was that schools need support to develop a school policy that includes health promotion, rather than support with ad hoc actions and themes.

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