Finland: innovative health education curriculum and other investments for promoting mental health and social cohesion among children and young people

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Executive summary

Finland is a Nordic welfare state. The health system is designed to provide universal coverage and equal access to health care services for everybody. Finland's public health policy is widely known as having been particularly successful in reducing coronary heart disease mortality through a multisectoral approach. Extensive health monitoring systems developed systematically from the 1970s demonstrate that Finland's population is healthier than ever and that the population health is improving continuously, but economic, social and cultural developments and the effects of globalization are challenging traditional ways of life and welfare structures. As in many countries, health inequalities are on the rise in Finland.

In this context, young people's health has been debated vigorously. Sources of concern include young people's risky health behaviours and an increase in mental health problems among (and marginalization of) children and young people. Results from the HBSC survey revealed that there is also a pattern of gradually increasing gender differences, with girls at comparatively higher risk for low self-rated health status and more recurrent subjective health complaints.

According to recent studies of the Programme for International Student Assessment (PISA) of the Organisation for Economic Co-operation and Development (OECD), Finnish students demonstrate the highest performance across all the OECD countries. Results from the HBSC survey, however, indicated that school satisfaction among Finnish students has been far from high. These contradictory notions relating to Finnish schoolchildren's school competence and health emphasize the need to consider more carefully the well-being of children and young people within the school context.

School is the health promotion setting in the Finnish case study. The aims of the study are, firstly, to explore public organization initiatives, actions and resolutions directed at promoting young people's health, mental well-being and social cohesion. The Ministry of Education, the National Board of Education, the Ministry of Social Affairs and Health and the National Research and Development Centre for Welfare and Health have launched several comprehensive initiatives to promote the health and well-being of children and adolescents in their everyday life contexts.

Secondly, some actions taken by NGOs are briefly described to enhance well-being and health learning at schools. There is extensive collaboration with NGOs in the field of health promotion, especially in promoting mental health among young people.

As background to the case study, the current social situation in Finland and results of recent health research on adolescents are described. There are good descriptions of the health care system elsewhere (such as the WHO country profile), so the description of structural determinants focuses on the education system.

Important interventions concerning health (especially mental health) include the creation of favourable circumstances for social cohesion among young people through 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). Intersectoral cooperation on these specific policy interventions, which have been complemented by activity in the nongovernmental sector, is an important prerequisite for successful health promotion.

Mental health and well-being status among adolescents in Finland

Surveillance of the health of Finnish young people is based on three different repeated studies. The adolescent health and lifestyle survey *(1)* (nationally representative samples of 12-, 14-, 16- and 18-year-old Finns repeated biennially since 1977) is performed by the University of Tampere. The HBSC study *(2)* started in 1984 with the aim of investigating the health and health behaviours of 11-, 13- and 15-year-olds within their daily social contexts. The Development Centre for Welfare and Health, in cooperation with the University of Jyväskylä, has been running the school health promotion study *(3)* since 1995. This is a service available to and used by municipalities which covers 50% of municipalities one year and the other half the following year. The study is particularly useful for participating municipalities and schools as it gives them direct feedback based on data gathered from basic education (from 14- to 16-year-olds) and from upper secondary schools (from 16- to 18-year-olds). In addition, the National Public Health Institute started monitoring the health of children below 12 years in 2007, based on information gathered in child health clinics. The new Department of Child and Adolescent Health supports the maternity and child health care system and school health care service.

Results from the HBSC study

The majority of children and adolescents taking part in Finnish HBSC surveys between 1984 and 2002 reported positive assessments of their self-rated health. Despite the fact that boys considered their health to be "excellent" or "good" more frequently than girls, a number of symptoms were quite commonly reported by adolescents during the entire period of the study. Older schoolchildren reported recurrent health complaints more commonly than younger ones. Gender differences were more pronounced in the older age groups, with 15-year-old girls reporting symptoms more often than boys. Experiencing multiple subjective health complaints weekly became more common from 1984 to 2002, particularly with girls in the oldest age group. Perceived good economic family wealth and adolescents' orientations towards higher education after compulsory school were positively associated with fewer perceived symptoms. Good social relationships with parents and friends were also associated with positive assessments of health *(4)*.

HBSC data from 2006 revealed that the quality of life of Finnish 11–15-year-old boys and girls was good. Very high percentages of young people placed themselves clearly above the mid-point of the Cantril ladder (scores > 6), with 93% of boys and 90% of girls indicating high satisfaction. Among 15-year-olds, 15% of girls and 8% of boys placed themselves below the mid-point of the ladder.

A large majority of Finnish 11–15-year-olds (91% of boys and 88% of girls) reported their self-rated health as "excellent" or "good". The amount of boys and girls rating their health as "fair" or "poor" increased with greater age, with 12% of 15-year-old boys and 15% of girls reporting having "fair" or "poor" health. Seventeen per cent of 11–15-year-old boys and thirty per cent of girls reported that they had symptoms indicating depressed mood approximately every week during the six months preceding the survey. Almost 10% of girls reported depressed mood about every day during the previous six months. Recurrent subjective health complaints were associated with students' reports of school-related stress, perceived psychosocial school environment index (student autonomy, student support, teacher support, demands concerning school work), being a victim of bullying and feeling lonely (Table 1).

The quality of school life is vital for the health of children and young people. The Ministry of Education, in cooperation with the Centre of Learning Research at the Department of Psychology, University of Turku, has launched a project which aims to reduce and prevent bullying in basic education in grades 1–9 *(5)*.

Results from other Finnish adolescent health studies

Self-rated health and subjective health complaints

Karvonen et al. *(6)* studied the common health complaints of 14- and 15-year-old Finnish pupils (n = 60 347) using data from the School Health Promotion Study in 1996, 1998 and 2000. Common health complaints increased steadily during the follow up for all schools, and varied across schools. Most of the variation was explained by individual pupils' health-related, school-related and family-related characteristics. Health complaints were common among those adolescents whose parents were not familiar with their friends and who rarely discussed matters of concern with them. Complaints also increased when

Table 1

Percentage of children reporting three or more subjective health complaints about once a week or more often

	Boys			Girls		
	11 years	13 years	15 years	11 years	13 years	15 years
Feeling lonely						
Often	68.5%	70.5%	84.6%	76.9%	81.2%	86%
Sometimes/No	26.5%	36.1%	42.0%	34.0%	48.4%	50.9%
P	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001
Perceived psychosocial school environment index						
Negative	37.3%	48.8%	53%	61.4%	72.5%	70.8%
Moderate	32.4%	37.2%	36.8%	41.9%	56.5%	50.9%
Good	22.3%	26.3%	38.8%	30.6%	39.4%	42.9%
P	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001
Perceived school stress						
A lot	58.6%	67.1%	77.8%	75.9%	83.6 %	79.8%
Some/Not at all	26.8%	35.1%	41.5%	36.7%	50.9%	54.1%
P	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001
A victim of bullying during the past couple of months						
Yes, at least two times	53.2%	65.1%	74.5%	60.0%	69.3%	76.3%
No	26.0%	35.7%	43.9%	36.9%	52.0%	56.2%
P	<0.001	<0.001	<0.001	<0.001	<0.004	<0.010
N	**884**	**845**	**781**	**960**	**890**	**889**

adolescents perceived that the amount of school work they had to complete was increasing, even after controlling for other school-related factors such as poor class atmosphere, bad relationships with teachers and bullying. Interestingly, the study showed that those who performed well at school appeared to be particularly vulnerable to poor health.

Although some school-level factors, such as teacher–student relationships and the average of school marks, were related to pupils' health complaints, they did not contribute to explaining the increase in health complaints. This was partially explained by increased smoking and alcohol use among pupils, but most of the trend remained unexplained. The study suggests that young people's psychosocial health involves a range of influences derived from individual susceptibility and from the social and educational functioning of schools. None of these factors alone, however, can account for the rapid decrease in young people's psychosocial health *(6)*.

Depression

In a longitudinal study of an urban community cohort, Pelkonen et al. *(7)* found that symptoms of distress in mid-adolescence (16 years) were a risk factor for later depression in males and females at the age of 22. Thirteen per cent of the females and nine per cent of the males had depression in young adulthood. Baseline distress symptoms, low self-esteem, dissatisfaction with academic achievement, problems with the police, poor atmosphere at home and having no close friends were predictive of subsequent depression. Risk factors for males included more "externalizing" aspects, and for females more "internalizing" factors. Adolescents' recurrent symptoms have to be taken seriously, as self-reported perceptions of psychological well-being have predictive value. Strengthening self-esteem and improving academic achievement seem to be essential preventive measures for depression-prone adolescents *(7)*.

Health inequalities

Higher rates of health complaints have been observed among adults from lower socioeconomic groups *(8,9)*. Health selection has been considered as one of the processes through which social class differences in health are created *(10)*. The basis of health selection is that an individual's health status is one of the factors influencing their chances of upward or downward social mobility. Alternatively, the social causation hypothesis explains socioeconomic health differences through the experience of adversity and stressors in low social status groups versus more favourable experiences in higher groups *(9)*.

Huurre et al. *(11)* studied socioeconomic status as a cause and consequence of psychosomatic symptoms in a follow-up study of Finnish schoolchildren. The aim of the study was to investigate whether lower socioeconomic status led to higher levels of symptoms (social causation), or whether higher levels of symptoms led to lower socioeconomic status (health selection), or both. All ninth graders (aged 16 years) of one Finnish city completed questionnaires at school. Subjects were followed up using postal questionnaires when aged 22 and 32 years.

The researchers noticed a female excess of psychosomatic symptoms both in adolescence and adulthood. Higher rates of symptoms were found among:

- females of manual class origin at 16 years
- females and males with only comprehensive school education at 22 years
- those who worked in manual jobs at 32 years.

The findings supported both proposed paths: lower SES as cause and consequence among females, and a tendency towards health selection among males. Class-based differences in psychosomatic symptoms were more marked in early adulthood and adulthood than in adolescence. In adolescence, they were seen only among females *(11)*.

Social and policy context

Work on protecting and improving the health of children and young people is widespread in Finland, involving a broad range of multidisciplinary agencies in different sectors of Finnish society. In this case study, the focus is on activities that are linked to school well-being and the development and implementation of the new National Core Curriculum and health teaching.

The comprehensive education system, which covers the entire population, is a pillar of Finland's social and economic development. Young people grow up in school by developing a concept of themselves as individuals as well as members of social groups and society.

Children's and young people's health has been a priority in Finland for many years. The country introduced child health clinics in the 1940s, which was early in comparison to other nations. The primary focus was on nutrition, growth and physical development, early identification of pathologies and immunization.

The system of child health clinics has been developed from the 1950s as part of the expanding welfare state. Today, almost all Finnish families use the services of child health clinics, evidenced by the high take-up of the national immunization programme (97% in 2001 *(12)*). The legal basis of the service, delivered relatively independently by the municipalities, has been secured by re-adjusting and strengthening legislation along the years (Primary Health Care Act). A comprehensive guideline for the service was published in 2004 *(13)*. The child health clinics were followed by the establishment of maternity health clinics and a school health service, for which national authorities have also published guidelines *(14,15)*. The country has been covered by preventive social and health services since the 1950s. These have come under scrutiny when concerns over the well-being of adolescents have been raised. Social security benefits for families with children and for adolescents themselves have also been scrutinized *(16)*.

Finland experienced an extremely severe economic recession in the early 1990s, resulting in a simultaneous drop in the GDP and rise in unemployment. At the same time, power over the delivery of health, school and social services, including health promotion, was devolved to the local level, which consists of more than 400 municipalities whose populations range from some

hundreds up to 600 000 inhabitants. Resources for maternal and child health care, psychosocial services for children and school health were on average reduced by 15%. The devolution policy has resulted in local variations in the physical characteristics of schools, their social functioning and operational culture, reflecting significant differences in policy direction among the municipalities *(17)*. It has been suggested that these changes have led to a worsening of young people's health *(6)*.

The Finnish economy has recovered over the last decade, with Finland now being rated among the most competitive economies in the world and unemployment rates falling. The growing economy, which is tied to global economics, has brought changes in people's working lives. Long-term employment seems increasingly to have been replaced by short-term contracting, and work is generally felt to be more challenging than in previous eras. People find difficulties in combining work and family life, which has been suggested as a possible influence for the increase in ill health seen among children and young people.

Promoting the mental health of families and children in primary health care

Ongoing research and development programmes aim to enhance the mental health of families, children and young people. Child health clinics support early interaction between children and parents, and special attention has been paid to the prevention of mental health problems among children of mentally ill parents. Mental disorders and other severe illnesses in parents represent a risk to children's development. Children in such families are at higher risk of developing mental disorders both in childhood and as adults. These families can be helped, however, and disorders in children can be prevented. Provision is made under the Child Welfare Act and the Act on Welfare for Substance Abusers for the child's need for care and support to be met if the parent has mental or substance misuse problems.

The Effective Family project *(18)* aims to provide service delivery systems to support families and children when a parent has mental health problems, a severe somatic illness or other issue that makes it more difficult to cope with the responsibilities of parenthood. The Effective Family project has developed training packages and ways of embedding the method in practice, and has also carried out research involving international cooperation.

The education system

The Finnish education system is composed of:

- a nine-year basic education (comprehensive school)
- upper secondary education, consisting of vocational and general education
- higher education, provided by universities and polytechnics (see Fig.1).

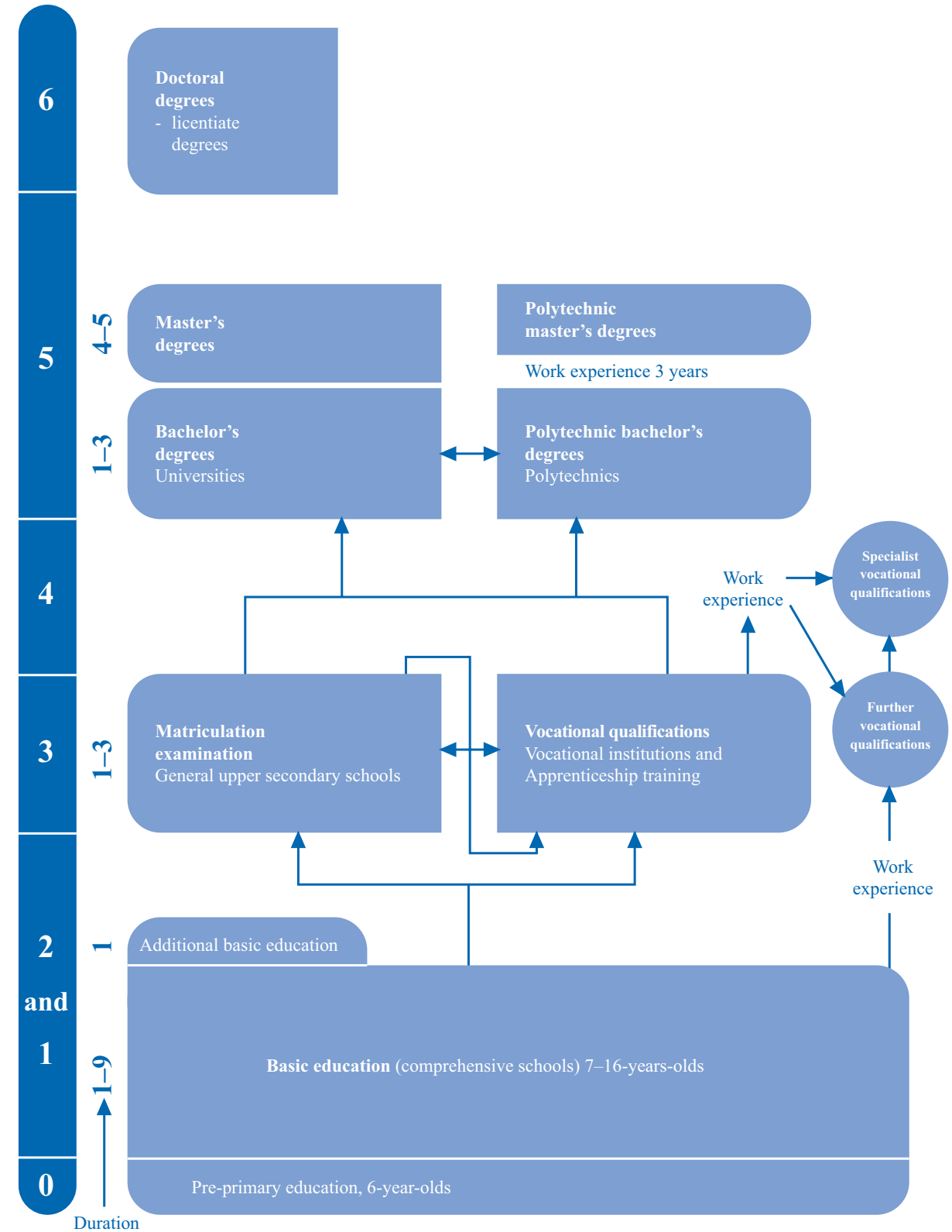
The main aim of the Finnish education system is to ensure that the entire population has access to education and training. The Finnish school system does not have any preschools, but preschool teaching (education during the year before children start comprehensive school) is provided at schools and day-care centres with the aim of improving children's capacity for learning. In practice, children are taught new facts and new skills through play. Legislation requires all municipalities to provide preschool teaching free of charge to all children aged six, but participation in such teaching is voluntary. Most 6-year-olds now go to preschool.

Compulsory education in Finland starts with comprehensive school, which generally commences in the year children turn age seven. Comprehensive school lasts for nine years and ends once a young person has completed the curriculum of the comprehensive school or when ten years have passed since the start of their compulsory education.

Everyone in Finland has the right to free basic education, including access to necessary equipment and textbooks, school transportation and adequate free meals. Post-compulsory education is also free. This means there are no tuition fees in general and vocational upper secondary education, in polytechnics or in universities. Students pay for their textbooks, travel and meals in polytechnics and universities, but school meals are free and students can get subsidies for school travel in general and vocational upper secondary education. Modest fees can be charged to students in continuing vocational education and in adult education. The Ministry of Education allocates government grants for basic, upper secondary, vocational, polytechnic and university education, with co-financing from local authorities. Universities, continuing vocational and professional education and adult education are state funded.

Fig. 1

The Finnish education system *(19)*



International Standard Classification of Education (ISCED)

0 Pre-primary education
1 Primary education or first stage of basic education
2 Lower secondary or second stage of basic education
3 (Upper) secondary education
4 Post-secondary non-tertiary education
5 First cycle of tertiary education
6 Second cycle of tertiary education

The Finnish Parliament makes decisions about the subjects taught in general education schools. The Basic Education Act, the General Upper Secondary School Act, the Act for Vocational Education and the Governmental Decree on the General National Objectives and Distribution of Lesson Hours, as well as the National Core Curriculum, provide the underpinning values, strategies and guidance from which municipalities construct their own curricula.

Education during the first six years is provided by the class teacher, who teaches all or most subjects, but each subject is usually taught by a specialist subject teacher during the last three years of comprehensive schooling. In general, local authorities are responsible for providing basic education. Local authorities assign pupils a place in a local school, but pupils are free to enrol in another school if it has places available. In addition to public schools, there are also a few private schools, which are funded by public authorities and follow the same national curricula as public schools.

Policy and intervention

The underpinning values of the Finnish education system are about supporting equality and human rights. Education promotes responsibility, a sense of community and respect for the rights and freedoms of the individual *(20–22)*. Schools are excellent places in which to promote children's and adolescents' health and well-being. Schools' responsibilities in educating children and promoting well-being are regulated by legislation in the Basic Education Act, which stipulates the following:

- education must be provided in accordance with the age and development level of the pupils/students, and in such a manner that it supports healthy growth and development of the child;
- the school must cooperate with pupils' homes; and
- the pupil has a right to a safe learning environment and student welfare.

Pupil/student welfare is the responsibility of all those working in school and in student welfare services (school nurse, school doctor, school counsellor, school psychologist) and is implemented in cooperation with families. Student welfare refers to the promotion and maintenance of good learning, good mental and physical health and good social well-being of students. It includes:

- student welfare in accordance with the curriculum approved by the provider of education and student welfare services, which is part of the school health care referred to in the Primary Health Care Act (school health nurses and doctors); and
- support for upbringing referred to in the Child Welfare Act (school social workers and school psychologists).

In general and vocational upper secondary education, the education provider shall ensure that students are given information about health and social services and that they are guided to seek these services *(23)*.

The obligation of taking a cooperative stance set out in school legislation is strengthened by the Primary Health Care Act (which came into force in July 2007). The headteacher is recognized as the pedagogical leader of the school, which includes a responsibility for matters of student welfare. He or she is also responsible for the functioning of the student welfare group, which is the key multidisciplinary cooperation group in the school working on pupil/student welfare.

The National Core Curriculum is the framework on which local curricula are formulated. Education authorities within the municipalities take responsibility for developing and preparing local curricula. The local curriculum sets out the educational and teaching elements, the objectives and contents specified in the national curriculum and other factors bearing on the provision of education. The education authority can delegate preparation of the local curriculum (or parts of it) to the schools, but is still responsible for ensuring the curriculum is acceptable and complies with the National Core Curriculum.

Cooperation among student welfare services, families and social and health authorities is present at national, municipal and school level. Curricular elements dealing with pupil/student welfare are prepared in collaboration with personnel from social and health services. In practice, this usually means cooperation with school municipal health authorities and school health nurses, the school social counsellor and the school psychologist.

The following examples depict the kinds of content areas addressed in relation to key principles of pupil welfare services that may impact on mental well-being and social cohesion in schools:

- activities to promote health, well-being, security, social responsibility and interaction in the school community;
- general pupil welfare support, guidance and counselling in schooling, and in support of the child's or young person's physical, psychological and social development;
- cooperation of pupil welfare personnel with families, school, pupil welfare experts and other experts, and local support networks;
- measures and division of labour and responsibility aimed at the prevention, observation or care of the following problem and crisis situations: monitoring of absences; bullying, violence and harassment; mental health issues; smoking and the use of intoxicants; and various accidents, misfortunes, and deaths;
- implementation of general safety objectives for transport to and from school;
- objectives for health and nutrition education and observing proper conduct in relation to eating meals in school; and
- curricular activities to promote pupils' mental health.

Legislation and resolutions provide schools with positive potential to effectively promote mental health and social cohesion among all children and young people, and to target vulnerable or at-risk groups.

Supporting the growth, development and learning of children and young people is the most important task homes and schools have in common. All schools and education institutions must set down the principles of cooperation between homes and schools as a part of the local curriculum. This calls on teachers to initiate activity and interaction with parents and for a clear definition of the role of parents, teachers and students within the terms of the principles of cooperation. Parents must be able to acquaint themselves with the operating culture of the school and have a say (and be heard) when education objectives are being discussed. This can be implemented in practice by involving parents and giving them the opportunity to express their opinions on the local curriculum. The equality of all the parties involved must be the starting-point of cooperation between home and schools *(23)*.

The new National Core Curriculum – a tool for promoting mental health and social cohesion

The school curriculum provides an interesting reflection of the cultural development of a country. It reflects the current status of national education and its value base. Health learning and health literacy are considered as basic rights of children and young people, yet health education in Finland was not recognized as an autonomous and official school subject until this millennium *(24,25)*, when laws amending the Basic Education Act (453/2001) and the General Upper Secondary School Education Act (454/2001) introduced health education as an independent subject. The National Core Curriculum for Upper Secondary Schools was adopted in 2003 and came into force in 2005. The National Core Curriculum for Basic Education was adopted in 2004 and took effect gradually in grades 1–9, with instruction in all grades completed by 1 August 2006.

Instruction may be separated into subjects or integrated issues both in basic education and in upper secondary education. The objective of integrating instruction is to guide pupils in examining phenomena from different perspectives or fields of knowledge. In formulating the curriculum, cross-curricular themes must be included in the core and optional subjects and in joint events such as assemblies, and must be manifested in the school's operational culture. Health promotion is well represented within cross-cultural themes. In basic education, they are: growth as a person; cultural identity and internationalism; media skills and communication; participatory citizenship; responsibility for the environment, well-being and a sustainable future; and safety and traffic. In secondary education, the cross-curricular themes are: active citizenship; safety and well-being; sustainable development; cultural identity and knowledge of cultures; technology and society; and communication and media competence.

In basic education (forms 1–9), the foundation of health teaching is to understand health as physical, psychological and social capability. Health teaching is based on a multidisciplinary foundation of knowledge. The intention is to promote pupils' competence regarding health, well-being and safety. The task is to develop pupils' cognitive, social, functional and ethical capabilities and their capabilities for regulating emotions. The health subject is pupil centred and supports functionality and inclusion. Teaching must be based on children's and young people's everyday lives, their growth and developmental needs and the course of human life. It aims to develop important skills related to the acquisition and application of information and

to promoting critical reflection on the values of health and well-being *(20)*.

Health education is integrated into environmental and natural studies in grades 1–4; in grades 5–6, it is integrated into biology/geography and into physics/chemistry. In grades 7–9, health education is an autonomous subject with 3 courses and 38 school lessons of 45 minutes each. The main themes of health education are: growth and development; health in everyday choices; resources and coping skills; and, health, society and culture. Mental health and socioemotional skills are important contents of teaching for 13–16-year-old students. As an example, the curriculum states that the main content areas in "Resources and coping skills" are: health, working skills, and functional abilities as a resource; personal resources; emotions and their expression, social support and safety nets (social networks); interaction skills; and changes related to human development and lifespan, crises and coping with them.

Upper secondary schools and vocational education

Health teaching moves continuously from preschool to upper secondary schooling. In upper secondary schools, health is defined in terms of physical, mental and social working and functional abilities. Health education as a school subject examines phenomena relating to health and diseases by means of scientific and empirical knowledge, but also considers values in relation to health. There is one compulsory course, "Foundations of health", and two specialization courses, "Young people, health and everyday life" and "Health and research". Students taking the compulsory course familiarize themselves with factors influencing health and diseases from the perspectives of prevention and promotion of working and functional abilities. Another important theme is the development of self-care skills.

The first specialization course elaborates on the objectives of the compulsory course in relation to people's everyday health habits and means of coping. Students also reflect on their perceptions of themselves and other people on physical, mental and social levels. Important themes concerning mental health literature include: self-knowledge, growing up, the significance of social support in families and local communities, joy of life, maintenance of mental health and mental and physical resources, facing depression and crisis, physical and mental safety, non-violent communication, and sexual health *(21)*.

Students could include health education in their matriculation examination for the first time in 2007, with test items also containing questions concerning mental health literature. The Matriculation Examination Board is responsible for administering the examination. The Ministry of Education nominates the chair of the board and its members (about 40 in number; the person responsible for health education is Professor Lasse Kannas). The curriculum for vocational education includes one course of health education which focuses on public health issues, occupational health, functional capacity and self-care skills *(22)*.

The Ottawa Charter identifies the fundamental conditions and resources for health and emphasizes a commitment to diminishing inequalities *(26)*. Health can be influenced by policies of other sectors and, in turn, has important effects on the realization of the goals of other sectors, such as education *(27)*. The principles of the Ottawa Charter and the *Mental Health Action Plan for Europe (28)*, as well as the spirit of the EU Green Paper on improving mental health *(29)*, are apparent in the contents, objectives and strategies in the new National Core Curriculum, which strengthens mental health literacy including socioemotional skills. These aspects are also taken into account in teacher training programmes for health education teachers.

Health education teacher training

Teachers have an important role in decisions concerning the running of schools in Finland. The PISA survey shows that Finnish teachers are responsible in many more instances than the OECD average for teaching content, choice of textbooks, discipline and assessment policies, school budgets and the distribution of resources. The unusually high potential for Finnish teachers to wield influence is a reflection of their university-level Master's training and their substantially high social status. An international comparison shows that respect for Finnish teachers is high. But the major challenges in teaching today require a more community-minded approach on the part of both teachers and schools *(30)*.

The Department of Health Sciences in the University of Jyväskylä has a long tradition of teaching health sciences for future teachers (mainly physical education teachers). When health education became an autonomous school subject, the qualifications for health education teachers in forms 7–9 in basic education and for teachers in upper secondary schools changed. After a transition period (to 2010/2011), health education teachers will need 60 credits in health sciences (school health education).

The Department of Health Sciences started the first new course (including study modules on mental health) for subject teachers in 2002, funded by the Finnish National Board of Education. Training programmes and shorter courses (five or eight credit points) have been organized for teachers in service by some universities and open universities (Jyväskylä, Turku, Oulu and Kuopio). Virtual learning environments have also been utilized by open universities of Jyväskylä, Oulu and Kuopio to assure regional equality in teacher training.

The production of materials for teachers is an integral part of the development of the new school subject. The Finnish National Board of Education and the Research Centre for Health Promotion at the University of Jyväskylä have published supplementary materials for teachers aimed at improving their knowledge and skills to teach topics on mental health and socioemotional skills *(31,32)*. Pupils and students in basic and secondary schools have received new textbooks which cover the themes of mental health and socioemotional skills. In addition, results from the HBSC study have been used widely in pupil/student materials.

Research supporting health teaching and teacher training

Research is an essential part of developing teacher training and the new school subject of health education. Quantitative and qualitative research projects are in progress to study the perceptions, teaching methods, knowledge, skills and attitudes of pupils, students and teachers and the resource allocation and operational cultures in schools.

The Research Centre for Health Promotion at the University of Jyväskylä, in cooperation with the Finnish National Board of Education, collected data in 2007 from health education teachers, pupils and students on their opinions and experiences of health education. The study is part of the assessment and development of the new school subject and also contributes to the development of the current teacher training programme. Implementation of health teaching is also being studied by videotaping lessons and interviewing students (in focus groups) and teachers.

The HBSC study is a vital tool in research because it covers health and school variables to produce a comprehensive picture of school-aged children's experiences. The HBSC questionnaire included particular questions on health teaching, with complementary and comparable data available from the School Health Promotion Study.

Health literacy, the key desired outcome of health teaching, is a relatively new research focus in school health teaching as well as in health promotion *(33,34)*. The role of basic education for health literacy and public health is crucial in health promotion *(35,36)*, but relatively little evaluative research has been done on school health education in Finland *(37)*. Pilot data on health literacy have been collected, but the challenge is to start new innovative research projects to evaluate health literacy (including mental health literacy) of adolescents and the impact of health education lessons on knowledge, attitudes and skills in schools.

The National Research and Development Centre for Welfare and Health gathers information on health promotion activities in municipalities, including those taking place in the school context. Information gathering on the school context is planned by the Finnish National Board of Education and the Research Centre for Health Promotion at the University of Jyväskylä. These data make it possible to monitor, for instance, cooperation in curriculum processes and in school welfare, as well as the implementation of health education.

NGO investments for mental health promotion in Finnish schools

This section describes select collaborative initiatives with nongovernmental organizations in the field of health promotion, especially in relation to promoting mental health among young people.

The Finnish Centre for Health Promotion

The Finnish Centre for Health Promotion *(38)* aims to increase the functionality of communities and the potential of individuals to manage their everyday life by enabling health-supporting choices to increase equality between various population groups. This goal requires society to adopt health promotion as an integral part of social policy. The centre works in collaboration with partners in various related fields, including schools. It has 124 members representing organizations in the health care sector and other communities.

The School Health Programme is a national project which continues the work with the European Network of Health Promoting Schools (ENHPS) in Finland. The project supports health promotion teams in their work, promotes student participation and increases cooperation with pupils' families.

The Finnish Association for Mental Health: pupils and teacher as learners of mental health

The Finnish Association for Mental Health *(39)* started a four-year project in 2006 which aims to improve the positive mental health skills of young adolescents in basic education (grades 7–9). The project has been planned and executed in close cooperation with the Finnish National Board of Education. The message of the project is that there are numerous ways in which personal mental health can be maintained and improved. The subject is approached from the "well-being of the mind" standpoint instead of the "mental health" point of view in an attempt to change attitudes from negative to positive. The project has three main objectives:

1. to devise a comprehensive school course that is taught within the health education school lessons during a three-year period (This study package includes information on how to support and maintain personal mental health, starting from the basics, such as nutrition, rest, exercise, personal relationships, family and friends and hobbies. The pilot study includes three schools with about 500 students.);
2. to support teachers' educational skills on the subject; and
3. to include parents in the project by developing cooperation between schools and parents. Long-term cooperation between schools and families during the hectic adolescent years is a valuable resource for young people.

Evaluation and research are built into the project.

Parents' associations

The role of parents' associations is important. There are two nongovernmental associations representing Finnish parents operating at both national and local level. The two central parents' associations in Finland are the Finnish Parents' Association, which has 1100 local parents' associations with 200 000 parents engaged, and the Home and School Association in Finland, which represents parents whose children attend Swedish-speaking schools in Finland, with 193 local parent associations and about 55 000 parents engaged.

The common goal of parents' associations is to combine parents' resources to build a good learning and growing environment for all children and young people. The associations strive to influence national opinion and decisions and work in cooperation with education, social and health institutions at national and local level. The most important forms of activity for the associations are supporting the upbringing of children and young people, informing and exerting influence, advising, providing education seminars and running the so-called Parental Parliament, where parents gather once a year to discuss current issues of social relevance *(40)*.

Lessons learned

The development of the National Core Curriculum and associated activities has involved a long process of advocating, lobbying and negotiating with different levels and sectors of society. There are still challenges to be met, such as developing teaching methods to meet pupils' health learning needs and learning styles, developing health education textbooks and teaching materials for schools and for teacher training, and assuring finance for health education teacher training.

Important changes in the National Core Curriculum include:

- the role of municipalities, schools and teachers
- the unity and coherence of the comprehensive school
- the role of home–school relations and cooperation between schools and other authorities or partners
- the importance of school culture and learning environment

- the role of individual support in learning
- special needs education
- pupil welfare services
- interactive ways of drawing up the curriculum.

On the whole, a holistic view of health and learning enables and fosters long-term investment and the development of the school as a health-promoting setting. Adolescents' own experiences of health should form an integral part of any health education and health promotion that is directed at them. Research results indicate that everyday support and help received from adolescents' immediate social circle was of particular significance to their health *(41)*. Other important factors that have facilitated the development of comprehensive school reforms are:

- management by national goals in legislation and in the national core curriculum
- strong autonomy of municipal authorities as providers of education
- good and flexible interaction between national, municipal and school levels
- teachers' expertise in curriculum development at all levels
- the curriculum being seen as a process that has a central role in school improvement.

Important resources in the promotion of mental well-being and social cohesion among Finnish schoolchildren include, firstly, the role of universities in teacher training. Combining research and practice is a strength in Finnish teacher education along with international cooperation in the fields of educational and health research. Secondly, the value basis of Finnish education is based on equality. In mental health promotion, it is important to offer necessary knowledge and skills to all children and young people and to foster awareness of the importance of mental health. It is also necessary to monitor the situation and to develop research on health literacy and on school as a social context.

Health education as a new school subject, and mental health-related learning goals at the core of the health education curriculum, have an important role in improving schoolchildren's mental health literacy. New school and public health legislation has also strengthened the potential to support and promote mental health and social cohesion in Finnish schools. On the whole, the very important prerequisite for mental health is that the schools can promote mental health in their everyday life and function as mental health promoting settings.

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