Slovenia: mental health and well-being for all children

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Executive summary

The level of care of children and adolescents in Slovenia is adequate, but examination of the evidence, including HBSC survey results, reveals specific needs for this vulnerable population. There are many good programmes in the country, but they are not all connected or firmly integrated into the system. The key challenges that emerge are ensuring the integration of good practice and building a supportive policy framework for mental health of children and adolescents in Slovenia.

Slovenia has a population of approximately 2 million, with 22% being children and adolescents younger than 19 years. The birth rate is negative at 8.7, the number of live births has increased slightly over the past four years (in 2007, there were 19 585 deliveries) and the infant mortality rate is 3.8. A high proportion of women are in employment (60.5% of those aged 15–64 years), so many children attend high-quality public nurseries and kindergartens.

Health insurance coverage for children and adolescents is universal in Slovenia. Health care services are delivered at primary care level and cover preventive health care. Prescribed systematic checkups that consist of a staged approach to child and adolescent health are part of the fundamental elements of health care services. The programme of health education included in systematic checkups is currently being revised.

Counselling services for children, adolescents and parents are provided in every elementary and secondary school and the provision of diagnostic and therapeutic services is ensured through an additional network of public counselling centres.

Existing strategies that encompass mental health and well-being of children and adolescents are considered in the case study, as there is currently no specific national programme dedicated exclusively to mental health. The comprehensive "Programme for children and youth 2006–2016" lists priority areas concerning the health of this population and also deals with psychosocial development and mental health. Specific national policies and social and health care services have been developed for children and adolescents with developmental and mental disabilities.

A short review of regional and national policies impacting on disadvantaged and marginalized young people is offered in the case study, targeting social skills training of young people who leave school with few or no qualifications to increase their capacity for social inclusion. Health promotion based on web communication such as the "Youth web" counselling web site, which provides adolescents with fast, simple access to free expert psychosocial advice, is described.

The HBSC survey was carried out for the second time in Slovenia in 2006. Other surveys relating to the health of children and adolescents are also routinely conducted. These include a mental health and well-being perspective and are addressed in the case study.

Some of the key results regarding self-rated health/subjective indicators of health, psychosomatic symptoms, emotional problems/well-being and communication across age, gender and socioeconomic status are highlighted. Results reveal significant gender and socioeconomic differences regarding self-reported health status, life satisfaction, psychosomatic symptoms, satisfaction with weight and communication with significant others.

Mental health and well-being status among adolescents

Mental health and well-being status of children and adolescents in Slovenia was assessed and explored in two main surveys (the HBSC surveys, performed for the second time in 2006), and in research from 1998 called "Risk factors among Slovene high-school children" *(1)*.

"Risk factors among Slovene high-school children" study

The "Risk factors among Slovene high-school children" study was carried out in 1998 on a representative sample of Slovene high-school students (n = 4706) aged between 14 and 20.

Findings according to gender revealed:

- more girls (42%) than boys (21%) reported signs of depression (Zung Self-rating Depression Scale);
- girls had lower self-respect than boys (medium value on Rosenberg's Self-esteem Scale – 6.9 for boys and 6.3 for girls);
- girls were more often in conflict with their parents than boys (never or seldom – 49% of boys and 37% of girls);
- girls had fewer good girlfriends and boyfriends than boys (5% of girls and 22% of boys answered they had "nine");
- boys were more often victims of bullying, threats and physical violence than girls (never – 69% of boys and 83% of girls);
- girls more often had problems than boys (none or very little – 38% of boys and 22% of girls); and
- girls were less satisfied with their looks than boys (13% of boys were unsatisfied with their looks and 30% of girls – on a five-point scale).

Taking into account the suicide rate in the country, researchers were also interested in whether young people had ever thought of taking their life. Adolescents did indeed report suicidal ideation and some had contemplated (para)suicide.

HBSC survey

The main findings of the "Risk factors among Slovene high-school children" study relating to mental health were consistent with some of the findings from the HBSC survey. In Slovenia, the HBSC research was conducted in the spring of 2006 for the second time. It included 5130 children aged 11, 13 and 15. Some of the key results on self-rated health/subjective indicators of health, psychosomatic symptoms, emotional problems/well-being and communication across ages, gender and socioeconomic status (by FAS) are highlighted.

The results on self-reported health show that girls in all age periods (11, 13 and 15 years) were more critical of their own health than boys. Only 39% of the girls estimated their health as excellent, while the percentage among boys was much higher – 53% of boys considered their health as excellent. More girls than boys estimated their health as fair or even poor – 15% of girls and 10% of boys. Girls who perceived themselves as less healthy were also less satisfied with their life and their weight and experienced more psychosomatic symptoms.

Life satisfaction was measured with the help of the Cantril ladder. Girls in all age categories (except for 11-year-olds) were less satisfied with their life than boys. Among all participants, 84% of girls and 88% of boys were satisfied with their lives. The least satisfied were 15-year-olds, with 77% of 15-year-old girls satisfied with their lives.

The comparison between genders regarding psychosomatic symptoms showed more girls than boys having these symptoms. As a result, at least once a week, girls reported the following:

- headache (22%)
- stomach ache (17%)
- feeling low (23%)
- irritable or bad tempered (32%)
- feeling nervous (31%)
- difficulties in getting to sleep (31%)
- feeling dizzy (10%).

Regarding *satisfaction with weight*, gender comparison showed that girls were less satisfied with their weight than boys: 46% of girls and 61% of boys said their weight was fine, while almost 18% of girls were on a diet at the time of the survey and 30% believed they were overweight.

The Strengths and Difficulties Questionnaire was used only with 15-year-olds. Results show that girls had more emotional problems in comparison to boys – 14% of the girls were placed within the "problematic" category. Girls had fewer problems in relating with others, however: 2% of girls and 5% of boys had troubles in relationships with others. In the categories of hyperactivity and behaviour, there were no statistically significant differences between boys and girls.

Boys of all age categories *fought* more often and also *bullied or were victims of bullying* more often than girls. In the months prior to the survey, 46% of respondents had been fighting at least once – 62% of boys and 29% of girls. Almost 25% of those questioned had been bullied in recent months, of which 27% were boys and almost 22% girls. Almost 28% of young people answered that they had cooperated in bullying of others at least once in the past few months. The differences between genders are statistically significant: substantially more boys answered that they had cooperated in bullying (34%) than girls (21.2%). Frequent victims of bullying and those who bullied others characteristically report higher frequency of suffering from psychosomatic symptoms more than once a week or even every day, such as headache, stomach ache, backache and pain in the neck. They feel low, irritable or bad tempered, nervous, dizzy and tired, and have difficulties falling asleep more often than others.

In *communication with their mother*, there were no statistically significant differences between genders, but there were differences in *communication with the father*, as boys found it easier to communicate with their fathers than girls. Only 28% of girls and 46% of boys thought that they communicated with their fathers easily. Boys were also more likely to socialize with their peers after school or in the evenings; 66% of boys and 58% of girls socialized with their peers at least once a week in the evenings. Some 9% of young people had no really *good friends* (2% of boys and 17% of girls), while 62% had three or more really good friends. Boys had statistically significantly more often three or more really good friends (79%) than girls (44%).

Socioeconomic inequalities are also an important determinant; results revealed that their impact on mental health was very strong. Children and adolescents with higher socioeconomic status (measured by the FAS) tended to perceive themselves as healthier (49% of those with higher FAS perceived their health as excellent and 40% with lower FAS), were more satisfied with their lives (89% with higher FAS, 80% with lower FAS) and their body weight, and had fewer psychosomatic problems/ symptoms (feeling low, restless and nervous less frequently) than those with middle and lower status.

In addition, children and adolescents from families with higher socioeconomic status found it easier to communicate with their mothers and fathers about their interests. Parents were more willing to help them with school problems and homework, were more encouraging regarding school work, more interested in school activities and were more willing to talk to teachers. Children and adolescents from families with higher socioeconomic status also had more friends compared to those with middle and low FAS (64% with higher FAS had three or more friends, against 56% with lower FAS). The frequency of physical fighting was also associated with socioeconomic status of the adolescent's family, in particular higher FAS. Most adolescents who had not engaged in physical fights in the previous twelve months came from families with low socioeconomic status, and most of those who had been fighting in the past year four times or more came from families with high socioeconomic status (9%).

Children and adolescents with a stronger social network (with more friends and good relationships with parents) were more satisfied with their life and also perceived themselves as healthier.

Briefly, the key issues or questions that emerge from these data are:

- how to address the existing gender and socioeconomic differences;
- how to address the association between bullying and psychosomatic symptoms;
- the importance of a social support network (relationships with friends and family) for mental well-being; and
- socioeconomic inequalities as an important determinant of mental health behaviour.

The presented data are valuable in shaping and planning health education programmes. HBSC data also represent an indicator of children's and adolescents' health and are a possible indicator of health promoting programmes and political measurements. It is therefore imperative that these findings reach those responsible for young people's health.

Following each survey, the results are disseminated through the preparation of press conferences, conferences, reports and publications. In March 2007 *(2)*, the National Institute of Public Health prepared a national conference on the health of children and adolescents in which three ministries (health; education and sport; and labour, family and social affairs) were actively involved. The ministers signed a statement declaring the health of children and adolescents a national priority and promising that in the following two years, all three ministries would prepare a collective action plan on the basis of the national programme for children and adolescents 2006–2016 *(3)*, with a special emphasis on mental health.

Social and policy context

The social and economic context of Slovenia reveals accelerated economic growth, improved standards of living and generally positive labour market trends. At the same time, the rates of people at risk of poverty and income inequality are decreasing, but a relatively high youth unemployment rate emerges as an important determinant *(4)*.

The health care service

The health care service has an essential role in promoting children's health and development. The public primary health care system in Slovenia delivers free preventive health care to all children and adolescents until the age of 19. The personal physician for children younger than six years is a paediatrician; for school-aged children and adolescents, it is a school medicine specialist. This ensures comprehensive care for this vulnerable population.

Primary health care for children and adolescents includes preventive programmes for preschool children and schoolchildren and health promotion for children and adolescents. These preventive programmes for children are regulated by legislation and include:

- preventive well-child visits for preschool children at 1, 3, 6, 9, 12 and 18 months and 3 and 5 years; and
- preventive well-child visits for schoolchildren before school entry, in the first, third, fifth and seventh grade of elementary school and first and third grade of secondary school.

All three-year-old toddlers also have a psychological examination and all five-year-olds are assessed by a speech and language therapist. All of the mentioned examinations consist of a medical examination, obligatory immunization in accordance with the immunization programme and health education (which is currently in revision).

National health strategies

Existing strategies that focus on mental health and well-being of children and adolescents will be briefly described below, but there is as yet no specific national programme dedicated to mental health. The Mental Health Act is in preparation. It addresses key issues regarding human rights, advocacy and community work for people with mental disorders. The act also foresees the development of a national programme for mental health which will also have a focus on mental health aspects of adolescence.

In the current situation, mental health issues are defined in the national plan of social care *(5)*. The main contributions for mental health and deinstitutionalization in this plan are definitions of:

- criteria for enlargement of the public social care network
- the range of programmes for people with long-term mental health problems.

During the time of preparation of its own national programme for children and adolescents, Slovenia collaborated in a pilot exercise in testing the *WHO European strategy for child and adolescent health and development* with assessment tools *(6)*.

The exercise was useful, as it offered an opportunity to reflect on data collection, policy issues, future action steps and the need for the development of a comprehensive strategy.

The most comprehensive document for children and adolescents is the *Programme for children and youth 2006–2016 (2)*. It lists priority areas concerning the health of this population in a specific chapter on health policy and also deals with psychosocial development and mental health. Valuable input from the pilot exercise was included in this chapter.

The principal aims concerning health outlined in the *Programme for children and youth 2006–2016* are:

- meeting the conditions for healthy life of children and young people;
- improving mental health in all periods of childhood and youth and preventing the most common causes of mortality in children and young people; and
- ensuring quality health care.

Children and adolescents are also addressed in other strategies such as the *Resolution on the national programme of food and nutrition policy (2005–2010) (7)* and its action plan. It plays an important guiding role in the implementation of tasks and activities in the field of healthy food and nutrition, physical activity and overall health of children and adolescents in Slovenia.

Slovenia has also adopted and is implementing a document complementary to the nutrition policy, the *National strategy on health-enhancing physical activity 2007 to 2012 (8)*, which defines priorities in terms of providing a healthier and safer environment for physical activity for children. The strategy is an important policy framework that emphasizes environmental conditions, health promotion, role of transport, land-use policy, urban planning, urban traffic policies and the development of an infrastructure in urban environments for walking and cycling.

Another key document is the *Resolution on the national programme in the area of drugs (2004–2009) (9)*. It includes preventive activities in education and varied approaches to preventing drug use, reducing risks and controlling supply.

Protecting children against environmental threats has also become a priority and the National Institute for Public Health is preparing the *Children's environment and health action plan* and the *Children and chemical safety national action plan*.

Policy and interventions

A variety of policies and interventions at national and subnational level will be briefly introduced. They attempt to cover the key issues highlighted in the first section.

Children and adolescent health care services

According to the Health Care Act, the Health Insurance Act and the Health Services Act, children and adolescents in Slovenia have the right to preventive health care such as systematic checkups. The right to preventive health care applies to all children and adolescents as family members of an insured person until the completion of their regular education period (students are also included).

Since compulsory health insurance in Slovenia is tied to residence, every child and adolescent, even the most socioeconomically vulnerable, can access this service. There is a special dispensary for curative and preventive health care in the capital of Slovenia for refugees and homeless people, which is currently financed by the municipality.

The Instructions for the implementation of preventive health protection at the primary level (10) determine that even those children and adolescents who are no longer in the school system ("drop-outs", or those who finished school early) have the right to a systematic checkup at 18 years of age. In case they are already employed, preventive medical health care is regulated by a labour law that prescribes a medical checkup before starting the first job.

Systematic checkups include: medical examination; compulsory free-of-charge and recommended vaccination; and health

education planned according to the typical risks of individual development periods. According to the *Instructions for the implementation of preventive health protection at the primary level*, every systematic checkup should include health education and discussions with a nurse (or doctor-paediatrician) about current topics in the mental health area (well-being, development, social and emotional problems, social relations, leisure time activities and stress, for instance).

Health education during systematic checkups

The programme of health education during systematic checkups is currently being revised. In 2005, the National Institute of Public Health of Slovenia, together with nine regional institutes of public health, carried out an overview of health education programmes for children and adolescents in Slovene health care centres and schools. Results have shown that there are substantial regional and local differences in programmes of health education. The aim of the overview was to find examples of best practice and transfer them to national level. Recommendations from experts were also taken into consideration, results from various studies and statistics on the health of children and adolescents.

Regional and local differences in programmes of health education led the National Institute of Public Health of Slovenia to prepare an action plan for health education of children and adolescents in health care centres and schools. The plan includes education on communication skills, developmental psychology and health education topics for all medical personnel (mostly medical nurses) and pedagogues who are carrying out health education.

Counselling services for children, adolescents and parents

Every elementary and secondary school in Slovenia has a school counselling office employing a professional in mental health (psychologist, social worker or (social) pedagogue). They specialize in learning issues and preventive services in the school environment and also offer counselling and referral to children, adolescents and parents.

In addition, a network of public institutions established as early as 1955 provides diagnostic, counselling and therapeutic services. These are counselling centres for children, adolescents and parents, and are situated in four Slovene cities. The counselling centres integrate the fields of health care, education and social welfare and are professional institutions bringing together a wide variety of experts. The role of these centres is the provision of counselling activities (including assessment, interventions, consultation, supervision, training, prevention and psychological education) and therapy for children, adolescents and parents.

These centres are founded and financed primarily by the municipality and by health insurance. All children and adolescents (from 3 to 29 years) have access to the centres, but because of local financing, children and young people from the cities have priority. Usually schools (teachers or advisers) suggest the idea of attendance to parents, but young people sometimes attend on their own volition. Specialists in the centres assess their problems and work with them, their parents and their communities.

The Slovene Network of Health Promoting Schools

The Slovene Network of Health Promoting Schools (SNHPS) has existed since 1993, when it was launched in 12 institutions. By 1998, the network had extended to 130 schools out of approximately 600. In 2008, the gradual inclusion of other schools will start and will be coordinated by the regional institutes of public health.

The notion of health in the framework of health promoting schools is holistic – physical, mental and social health are all regarded as being equally important. Twelve aims of the ENHPS serve as an instrument for setting tasks, programmes and projects. Health promoting schools strive to enhance healthy lifestyles of all people in the school setting. It is a matter of great importance that schools incorporate health promotion into all aspects of everyday life – into the formal curriculum as well as the hidden curriculum. Special emphasis is given to cooperation with parents, health care and other specialist services and with the local community.

One of the bases of health promotion in school settings is the education of teachers. In response to their wishes and needs, many seminars have been focused specifically on health promotion and mental health.

Social skills training for school drop-outs

Policies impacting on disadvantaged and marginalized young people address intraregional inequalities by supporting these vulnerable groups. Several national and regional programmes and services are provided for school drop-outs in a variety of settings.

The National and Regional Employment Service offers occupational counselling for young people who discontinue compulsory education and are aged between 15 and 19 years. There are also information and occupational counselling centres offering individual counselling in three Slovene cities. At the moment, these are dealing with financial problems. An especially successful project of the employment services and information and occupational counselling centres was "Counselling and social skills and knowledge for reinclusion in education"; while workshop based, a part of the project also involved street work with adolescents.

In the underprivileged region of Pomurje, a project targeting social skills training of school drop-outs to increase their capacity for social inclusion is under way. Pomurje is located in the north eastern part of the country, which is the least economically developed region of Slovenia and has the poorest health indicators. Intraregional health inequalities also exist and there are many people in risk groups, such as individuals with a lower level of education, the unemployed, older people and ethnic minorities. The unemployment rate in the Pomurje region in 2003 was 17%, which is higher than the country average, and the risk of suicide is almost double among people who have lost their jobs.

A health promotion strategy and action plan for tackling health inequalities in the Pomurje region *(11)* has been in place since 2005. It has a special focus on vulnerable groups, among them children, mothers and pregnant women, with the aim of increasing utilization of prenatal services, encouraging healthy nutrition in pregnancy and childhood and increasing social and coping skills of school drop-outs and unemployed young people.

The project targeting school drop-outs has been developed in accordance with the health promotion strategy and action plan for tackling health inequalities in Pomurje. It aims primarily to motivate these young people to continue their education. Each participant in the programme has access to an individual mentor who will guide them through the learning process. Each student starts by setting out her or his individual learning plan that has to be completed during the programme. This plan is the foundation for all his or her activities in the programme.

The programme aims to:

- prevent harmful consequences of social isolation of young people
- reintegrate young people into the cultural environment of peer groups
- reduce social problems in the environment
- change the environment's negative response to them
- facilitate establishment of mutual links and self-help among young people
- develop motivational mechanisms for returning to school
- help them to improve some of their everyday habits
- help them learn about learning.

Specifically, the curriculum covers:

- enhancing social and coping skills
- finding supportive social contacts
- training for positive self-image and healthy behaviour
- vocational development and career counselling workshops.

In addition, there are other programmes in Slovenia that address social inequalities with interdisciplinary actions. These include the "Production school" and "Learning for young adults" projects. They target social skills training of school drop-outs to increase their capacities for social inclusion.

The "Learning for young adults" project is a publicly verified, non-formal education programme for unemployed young people aged 15 to 25 who have discontinued their schooling. Programme evaluation reveals that the programme has a positive long-term impact on social integration.

A very similar programme for school drop-out is the "Production school" project, which runs only in the capital of Slovenia, Ljubljana. It is designed for adolescents between 15 and 18 who have finished compulsory schooling and who have dropped out of the secondary school because of learning and behavioural difficulties. The purpose of this programme is not to obtain formal education but to acquire good working habits, gain a sense of responsibility and to develop the young people's confidence in their own abilities to get the job they need.

Youth web counselling site

The Regional Institute of Public Health Celje developed an online health promotion project titled "This is me" *(12)* in 2001. The web site has quickly become a popular tool for adolescents all over Slovenia. The approach is based on web communication, providing adolescents with fast, simple access to free expert advice. The aim of the site is to promote self-esteem and a positive sense of personal identity and to help young people set goals, develop self-efficacy and gain a sense of social responsibility. The objective is to stress not only the prevention of behaviours harmful to health, but also to emphasize positive life skills such as decision-making, managing emotional reactions of anger and fear, overcoming boredom, resolving conflict, dealing with peer pressure and enjoying leisure time.

The guiding principles are: anonymity (reduces the effect of stress on the individual and increases honesty); direct and quick access to experts (no referral forms, waiting periods and queues); and the interdisciplinary nature of counsellors' expertise and approaches (psychologists, physician specialists and experts from social work, social education and sports education). A broad counselling network has been developed. On the web counselling site, young users have access to 30 counsellors: 12 psychologists, 9 physician specialists and 9 experts from other fields (social worker, social educator and sports educator).

As many as 111 000 different users were recorded over a five-year period and approximately one fifth of questions are related to mental health issues. Every month, there are approximately 14 000 visits and almost 80 000 pages read.

Web counselling cannot replace personal counselling, but by offering understanding and prompt expert advice within the framework of the web intervention, the counsellor may be able to help in a crisis and direct young people towards considering constructive strategies for solving problems. The youth web counselling site is an additional form of support, complementing existing sources of help.

Another advantage of web counselling and communication (besides anonymity, quick access and the interdisciplinary nature of counsellors' expertise) is the usefulness of a single reply which can offer insight to numerous users into the experience of others and their problem-solving approaches. Web counselling also poses some disadvantages, such as lack of personal contact, reduced opportunities to set up a meaningful therapeutic relationship, lack of information about the seeker of help, insufficient description of a problem and the dilemma of authenticity of the virtual identity.

The web site is regularly and meticulously moderated. It has an editorial staff, all of whom are experts; the web counsellors are volunteers. The Institute of Public Health Celje sponsors the project with support from the Ministry of Health. The project has also received the Izidor 2005 award (a Slovene award for web projects in the health field) for web excellence. For "This is me", web communication has proved to be an efficient tool in the field of health promotion for young people.

Parental involvement

Health care of children and adolescents in Slovenia encourages active parental involvement. Free health education is provided for future parents in health care centres and maternity hospitals. Education for healthy parenting represents one of the basic

elements of health education. Childbirth classes are aimed at all pregnant women and future fathers or companions of pregnant women. Health education covers:

- information and preparation for delivery and parenthood (infant care, physical relaxation and breathing exercises, legal rights, social care and labour rights, breastfeeding, nutrition and injury prevention);
- psychological issues (parental role, understanding the infant's messages, communication, setting boundaries, separation); and
- education about important health topics.

As not every future parent is involved in this kind of education, some other health education programmes are needed, especially for at-risk groups of pregnant women (pregnant women with certain health risks, those who are underage and the socioeconomically vulnerable). Parents are also actively involved in their child's health care from the first child's systematic checkup.

Lessons learned

The level of care of children and adolescents in Slovenia is adequate and in many aspects satisfactory. The main strengths are:

- universal health insurance coverage for all children and adolescents as a central pillar of the health care system;
- a well-developed and organized system of public primary health care centres;
- good projects for school drop-outs (the challenge is how to integrate all of them);
- current work on linking primary health care with health education and school curricula;
- formation of a health education programme with operationalized standards of implementation;
- systematic implementation of a comprehensive health education programme which includes the school environment and health service staff;
- a strong Slovene network of health promoting schools, transferring to regional level and the inclusion of all (interested) schools; and
- examples of intersectoral collaboration.

The following concerns and needs of children and adolescents in Slovenia emerged from the data and the evaluation of policies and interventions examined in the case study:

- how to address specific issues such as the connection between bullying and mental health;
- the dilemma of whether existing gender and socioeconomic differences are addressed appropriately (population-based approach), or whether special programmes for at-risk groups are needed;
- formation of a supportive (student-friendly) school environment;
- psychosocial aspects of development – respectively, the problems of youth (heavy workload, achievement orientated and competitive atmosphere at schools, levels of depression), which are especially pronounced in the high-school population;
- greater involvement in promotion of health by mental health departments located in children's dispensaries and school counselling offices;
- greater emphasis on multidisciplinary training and communication strategies;
- the need for human resource development;
- the need for a national programme of mental health; and
- regular financing.

Possible explanations and conclusions

The area of mental health and well-being is very wide and complex. The consequence of this is that it is difficult to define which sectors are responsible for establishing the conditions and circumstances that affect mental well-being. The question of accountability for the area of mental well-being is only one of the difficulties and obstacles for financing, re-establishing and implementing existing interventions, as well as new ones. Consequently, certain activities, such as counselling centres for children and adolescents and various associations, have no regular financing assured and are going through a crisis.

Another problem is how to measure the effectiveness of these kinds of interventions. There is a lack of studies which would provide evidence of improvement in mental health among children and adolescents.

People of all political persuasions should see that health is above political categories and concerns all sectors, and that health is everyone's business.

Legislation on mental health has not as yet been adopted. Slowly, however, public and political awareness about mental health issues is improving. As is evident from this case study, there are many good programmes and interventions, even though they might not be connected and firmly integrated into the system. A more unified and holistic approach is therefore needed.

The modernization of programmes of health promotion and health education for children and adolescents will link the school and health sector even more and provide for unified implementation of preventive health care at primary level. Until now, these programmes have not been integrated, so certain regions and health centres prepared their own programmes to varying degrees. Continuous evaluation will enable measurements of their effectiveness and will provide the groundwork for further progress.

The special needs of the population of drop-outs or unemployed young people should be addressed to a greater degree, since all of the described programmes are not available in all Slovene regions. All youth, whether unemployed or those who have stopped attending school, should be invited to join one of the above-mentioned projects. It would also be beneficial to extend these activities throughout Slovenia. Local communities should ensure they play a role in financing the measures. Young people should be enabled to enter regular schooling and visit the "Learning for young adults" project at the same time, and not have to choose between one or the other, as is the case at the present time.

Continual support of research in this area gives insight into the healthy and unhealthy habits and behaviours of all age groups, especially of children and adolescents, through, for example, HBSC, the European School Survey Project on Alcohol and other Drugs (ESPAD) and qualitative research in focus groups.

The development of an overview of research findings is necessary. Ministries have begun publishing reports and findings of projects they are financing on the Internet over the past few years, which contributes to a greater overview of the work in this area. It would also be useful to set up a web portal holding findings of research and examples of successful practice.

In its attempt to establish effective mental health prevention and promotion, Slovenia, under the leadership of the Ministry of Health, is striving to integrate the themes of a multiagency approach, prevention programmes for some high-risk groups and active parental involvement. Various good projects encouraging mental health of adolescents are underway, but there are still many challenges in this area. The national programme of mental health has to be prepared, different sectors working in the field of mental health of adolescents have to consolidate their policies and activities, and a more systematic and holistic approach in this area has to be adopted.

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