

**“Promotion of Mental Health and Well-being of Children and
Young People – Making it happen”**

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**INVITED PAPERS:
EU PROJECTS IN THE AREA OF YOUTH AND EDUCATION**



Child and Adolescent Mental Health in Enlarged EU – development of effective policies and practices

Preliminary Recommendations

Background, rationale and problem definition

The foundation for good mental health is laid in the early years and society as a whole benefits from investing in children and families.

Fortunately, the majority of young people in the EU enjoy good mental health. However, on average, one in every 5 children and adolescents suffer from developmental, emotional or behavioural problems and approximately 1/8 have a clinically diagnosed mental disorder. Unfortunately, new and applicant countries are facing larger problems in the field of children and adolescents mental health (CAMH), revealed by strikingly high rates of ill-mental health among children and young people. Therefore, there is a clear and urgent need for development of effective CAMH policies and practices in enlarged Europe and for a creative process of interaction and a proactive exchange of information between European countries.

In response to this need, the CAMHEE project aims to provide a set of recommendations and guidelines for the effective CAMH policies and practices in the European Union, with particular emphasis on new EU countries, attention to three concrete problem areas and in the light of Declaration and Action Plan endorsed by WHO European Ministerial Conference on Mental Health. The project, led by Vilnius State Mental Health Centre in Lithuania, comprises a network of partners across 16 European member states, dedicated to disseminating, adopting and implementing modern effective public health approaches to CAMH.

Work Package 4: A Snapshot of Child and Adolescent Mental Health in Europe: Infrastructures, Policy and Programmes

CAMHEE WP4 is the main, umbrella work package of the project. WP4 has been developed with the intention of analysing the situation regarding CAMH in participating countries and identifying obstacles and opportunities to develop evidence based and multi-sector national CAMH policies within the enlarged EU. The work package aims to contribute to the improvement of information and knowledge in mental health and to the development of a comprehensive approach to mental health promotion (MHP) and mental disorder prevention (MDP) in children and adolescents.

A Questionnaire on “Infrastructure, Policies and Practices in Child and Adolescents’ Mental Health” was designed to collect key national or regional data, in a standardised format, from a variety of different European countries on indicators for infrastructures. Fifteen completed questionnaires (13

at the member state level and 2 at regional level¹) have been received and analysed to provide a European overview or 'snapshot' of the situation in Europe. In parallel, using the information collected in the questionnaire, the CAMHEE country partners have developed their country profiles, giving more detailed descriptions of the situation in each participating country.

Objectives of WP4

- to monitor and map available infrastructures, policies and programmes for CAMH across the 15 partner countries involved in the CAMHEE network;
- to analyse these aspects of CAMH at the European level in order to identify gaps and support recommendations for policy and infrastructure development for CAMH;
- to develop and produce detailed Country Profiles for 15 European countries.

Objectives of CAMHEE WP5, WP6 and WP7

Complementary to the aims of WP4, three critical issues for effective development of CAMH policies and practices throughout an enlarged EU have been identified, and CAMHEE work packages were developed with the goal of deeper analysis of those issues and making recommendations for policies and practices in the following fields:

WP5 – Parenting and caring for the children of the mentally ill

Most mental health disorders in adulthood have origins in childhood, and parental mental health problems are a major risk factor for children's adverse development. Furthermore, social marginalization and exclusion come hand in hand with the generational chain of mental health problems. The overall aim of the WP5 is to tackle this nodal point in adverse child development and the development of social exclusion. This represents an initiative on the European level to change the political, legislative and health and social service system to acknowledge and attend to the needs of children and families with parental mental health issues.

WP6 – Prevention of (self) destructive behaviour patterns in school settings

Destructive and self-destructive behaviour could be regarded as one of the indicator of the children mental health. It includes violence perpetrated by pupils and by school staff, suicidal tendencies, smoking, use of alcohol and other substances. WP6 aims to assess the magnitude of problem and the means by which participating countries address destructive and self-destructive behaviour in schools. Existing policies, programmes and actions in the participating countries will be analysed and three types of recommendations developed: for the European Commission, for national governments and for educational authorities/schools.

WP7 – Best practices and economic evaluation of CAMH community-based activities to promote alternatives to traditional practices of institutionalisation and social exclusion

¹ Countries involved are: Belgium, Bulgaria, England, Estonia, Finland, Germany (region: Heidelberg), Greece, Hungary, Latvia, Lithuania, Norway, Poland, Romania, Slovenia and Spain (region: Catalonia)

There has been a long tradition in Countries of Central and Eastern Europe to solve problems of children and families at risk through the network of residential institutions for children with a variety of different kinds of problems (developmental, mental, physical and social). Additionally, the balance in the bio-psycho-social paradigm has been distorted, as, historically, a biomedical component dominated the spectrum of therapeutic modalities, while effective psychosocial interventions and public health approaches in mental health promotion have been neglected. This has led to serious gaps in the spectrum of interventions in the field of CAMH and to worsening of children's condition with negative implications for children's well-being and poor outcomes for society. The aim of this WP7 is to share experience between different countries on how to implement the most effective activities focused on mental health promotion, involvement of primary care and high quality specialist child mental health services for children and adolescents in need.

Results and key messages

Preliminary analyses across work packages highlight several disparities at the European level:

- **Policy and legislation:** There was the general lack of emphasis on child mental health in legislation and policy papers in all countries, and particularly no provisions for support for the children of parents with mental health needs (with the exception of Norway and Finland).
- **Policy evaluation:** Whilst some evaluation of service and care policies are documented in the European countries included, the majority of countries report no evaluation of relevant policy and programmes aimed at preventing mental disorders or promoting mental health among children.
- **Positive indicators:** Only about 50% of countries reported prevalence rates on positive mental health in children. More specifically, 13/15 countries reported the existence of information about the prevalence of mental disorders, whereas just 8/15 reported collecting the prevalence of some indicator of positive mental health (e.g. wellbeing, self-esteem, quality of life, resilience).
- **Youth involvement:** Children are not often involved in the decision-making processes affecting practices in CAMH in European member states (6/15 report some example of this), especially those decisions behind policy development (only 3/15 report some positive example).
- **Training and Capacity:** There is a clear lack of CAMH issues in relevant higher education degrees. In particular, many relevant professionals are not trained in skills to prevent destructive behaviour.
- **Mental health understanding and awareness:** there is a gap in knowledge about the determinants of CAMH among stakeholders and the general public. In particular, there seems to be a lack of awareness and knowledge surrounding the importance of parenting and child development in families with parental mental issues.
- **Budgets for CAMH:** budgets dedicated to CAMH issues are rarely clearly identifiable, and generally they are mixed with other funds.

Recommendations

Based on the preliminary project outcomes, and in line with the European Pact on Mental Health and Well-being (2008), several recommendations are put forward; for future research, to improve programme implementation in CAMH and for effective policy-making.

Several recommendations arise from the analysis of the **CAMHEE Country Profiles (WP4)**:

- ***There is a need for systematic evaluation of programmes and, more notably, of policies aimed at preventing mental disorders and promoting mental health among children and adolescents.***

The low level of systematic evaluation of programmes and policy is often linked to scarce resources (human, financial and organisational) for this type of evaluation, especially in some of the new EU member states, but above all to a lack of evaluation culture in the political arena of many member states. This would require that existing appropriate methodologies for evaluation and cost-effectiveness research be refined and disseminated through targeted publicity to raise political awareness of the importance and feasibility of evaluation for evidence-based policy; there is also a need to encourage the incorporation of basic evaluation designs into the planning and budgets of actions to be implemented, for example, through specification of this in calls for proposals from funding bodies (national and international).

- ***There is a need to widen the focus of the CAMH field to include positive mental health (not only mental disorders)***

There is still a preference for a disorder-orientated approach over a health-orientated perspective concerning practices, policies and infrastructures for CAMH. Both sides of the coin should be considered equally in order to provide the required services and infrastructures necessary to alleviate the burden of disease, and to design programmes and policy for promotion and prevention in mental health.

- ***There is a need to increase child and youth involvement***

While there are some commendable examples, although still not widespread, of children consulted on a practical level to contribute to programme designs and even be involved as implementers (through peer-led initiatives), there is a great need to include the voice of children and adolescents in the development of policies that affect their health and well-being. Mental health is directly related to policy and implementation supporting children's rights, and in order to enact children's rights, children's participation and involvement is crucial. The means of enhancing youth involvement in policy decision making include, among others, the consultation of child populations – through surveys or focus groups – and the use of this information by children's ombudsmen or commissioners. A more direct approach could be the introduction and participation of young people's representatives in parliamentary question time sessions.

- ***There is a need to introduce training in prevention and promotion for CAMH in relevant higher education degrees and to include CAMH issues in the training of diverse and relevant professions such as teachers and public health professionals.***

It is important that units on CAMH issues are included in the national curricula for relevant higher education degrees, such as medical undergraduate degrees, specialist training of primary care

doctors, public health professionals, paediatricians, psychologists, teachers and juvenile detention centre staff. It is important that such training covers childhood mental disorders, risk and protective factors and also includes training in practical skills (such as communication and consulting) for approaching and dealing with issues of relevance to children's mental health and well-being. It is also important that professionals are trained to define and explain the terminology of mental disorders to children and families of those who suffer from them as well as how to support such families.

- ***There is a need to raise awareness about childhood mental health determinants, especially among diverse stakeholder groups.***

One of the key challenges of mental health promotion and mental disorder prevention for children and young people is its interdisciplinary nature. There is need to raise awareness of childhood mental health determinants (and impacts), especially that good mental health is a responsibility not only of mental health professionals, but also of a wide variety of professionals in different sectors (for example, social services, education, leisure, etc.).

- ***There is a need to earmark specific funding for CAMH issues, rather than these funds being mixed in with those allocated for adults' mental health.***

Budgets should be transparent and available as public information. Earmarking specific budgets for CAMH issues would be likely to increase the amount of money allocated for CAMH. Otherwise, the funds can easily be spent on to other areas that have been traditionally funded (e.g. adult mental health) and that are sometimes not as justifiable as a priority in population health terms.

In specific work packages – **WP5, WP6, and WP7** – several issues have been identified as critically important for development of effective CAMH policies and practices across enlarged EU. These have given rise to the following recommendations in the areas of parenting, prevention of destructive and self-destructive behaviour in schools, and strengthening (especially in new member states) of the culture of evidence-based policy formulation and evaluation in developing an effective spectrum of CAMH services.

In the field of **parenting (WP5)**:

- ***There is a need for legislation to protect the rights of mentally ill and drug using parents and their children.***

It is necessary to ensure, through legislation, the human rights of persons /parents with mental illness and drug abuse problems and the rights of their children to good mental health whilst living with their families, so that the vicious circle of stigma, social exclusion and institutionalisation of children can be broken. In particular, in new EU member states, new policies and practices need to be introduced, as alternatives to existing practices in which children are not allowed to be raised by parents who have mental health disorders. A clear line of responsibility in the case of mentally ill parents is also needed, with the provision of services being expanded to include the care of children as well as care of mentally ill parents.

- ***There is a need to develop better parenting programmes.***

Societal and family level programmes for promoting good quality of parenting, with special focus on families with parents who have mental health and/ or alcohol and drug abuse problems and disorders must be developed. These should be made available in both universal settings

(especially for infancy, adolescence and for first time parents) and targeted at risk groups (where either parents or children have health or other stressful issues which compromise their emotional and social capacities).

- ***There is a need to prioritise stable family life in policy decisions.***

The foundations for stable family life and parenting (such as work and an acceptable level of income vs. child poverty, child health, social services and schools) should be made a priority, especially in times of economic recession, in order to support parenting and child development.

Across all Europe, and especially in new member states, the concept of investing in better parenting by improving the competence of parents (generally, and specifically – for parents having different risk factors) needs to be supported by Governments as a priority

In the field of **prevention of destructive and self-destructive behaviour (WP6):**

- ***There is a need for Europe wide implementation of action plans to address (self-) destructive behaviour in schools.***

A binding legislative document at the EU level is needed to stimulate countries to improve their policies and action plans addressing destructive and self-destructive behaviour in schools.

- ***There is a need for more evaluation and dissemination of information around effective programmes to prevent destructive behaviour.***

Identification of programmes meeting high standard of effectiveness at the EU level, as well as the transferability of these programmes to different settings and the cultural contextual issues which moderate their success, would provide the possibility for policy makers, governments, foundations and other organisations to make properly informed decisions about the investments needed for the prevention of mental health (and other) problems and associated with violence, suicides, self-harm and drug use.

- ***There is a need to fund existing programmes of proven effectiveness.***

The resources at EU level or EU member states level should be directed towards the implementation of evidence-based preventive programmes, targeting destructive and self-destructive behaviour in schools, and not for the development of new programmes.

- ***There is a need for further research into certain aspects of destructive behaviour.***

While certain forms of destructive behaviour are well-documented, the existing gap of knowledge about suicidal behaviour, self-harm and violence between adults and pupils in schools could be filled by the initiation of international studies in these areas.

- ***There is a need for training in this area.***

Teacher training, especially at the undergraduate level, should integrate more knowledge and skills development around destructive and self-destructive behaviour to facilitate implementation, on the ground, of preventive programmes.

In the area of searching for **optimal balance in the spectrum of CAMH activities – promotion, prevention, primary care and specialised services (WP7)**:

- ***There is a need to move away from institutionalisation in national CAMH policies.***

Especially in new member states, it is of great urgency to shift resources when developing and implementing national CAMH policies towards activities aimed at promotion and prevention, primary care and flexible community based services for families at risk. This must be done in an effort to avoid the unnecessary institutionalisation of children and to work towards breaking the vicious circle of stigma, social exclusion and helplessness. A multi-sectoral approach and the development of effective tiers in CAMH services needs to be strengthened. Also, gaps in the system of service provision should be filled, so that services can be both cost-effective and successfully meet the needs of children and youth, with specialised services being used only in severe and complicated cases that cannot be managed in primary care.

- ***There is a need to address problems of socialisation among adolescents in a comprehensive way.***

Modern public health approaches and implementation of the main principles of the Convention on the Rights of the Child offer new opportunities to better meet the needs of adolescents who have problems in social and emotional development. Adolescent-friendly culture, with an emphasis on principles of participation, autonomy and empowerment, needs to be introduced in all activities and interventions regarding adolescents. Better coordination between health, education and social welfare sectors must be secured, and adolescents should be involved in decision making in all levels, so that their views are taken into account.

- ***There is a need to prioritise the economic evaluation of CAMH policies.***

There is an urgent need to prioritise the evaluation and monitoring of outcomes for CAMH policies and services at all levels, with special focus on economic evaluation to assess the cost-effectiveness of CAMH activities.

A concluding word

These recommendations are relevant for all EU member states. However, it is of utmost importance to demonstrate political will and to invest with good quality, quantity and direction of resources in the aforementioned areas in new EU member states. In most new EU countries, there is still a lack of political will and good governance to invest in modern policies and practices in the field of children's mental health. New challenges – such as the migration of adults to older European countries, when parents often leave their children, and the current economic crisis – create an unstable situation in which issues of parenting, the prevention of destructive behaviour and reduction of institutionalisation through development of effective community-based services for children and families at risk, become of enormous importance for the future social cohesion of these countries. Governments need to receive a clear signal that it is an absolute priority to invest in the good mental health and emotional well-being of their nations' children through evidence-based policies and practices.

Parenting and children's mental health

Background

A healthy start is crucial for mental health and wellbeing throughout life, with parenting being the single most important factor. Parents provide for their children's basic needs for food and protection, they also care for them when sick, teach them language and help them master the basic skills of living in the community and society in which they are born. Without such care babies and children do not survive. It is, however, in the more subtle aspects of parenting, including the quality of parent-child relationships and different approaches to socialisation and discipline that the origins of mental wellbeing and mental illness lie.

Whilst most children in Europe experience a level of mental health that enables them to grow, develop, learn, socialise and participate actively in working and family life, the evidence suggests that parenting support could further improve their mental wellbeing both in childhood and in adult life. At the same time the mental health of a significant proportion of children is significantly compromised by poor parenting. Up to one in five children experiences developmental, emotional or behavioural problems, and up to one in eight suffers from a mental disorder. The consequences of poor mental health in childhood reach into adult hood, increasing the likelihood of low educational achievement, reduced productivity, criminality and violence as well as adult mental disorder, unhealthy lifestyles and the risk of ill health. Poor mental health brings a huge economic and social burden to European societies.

Parenting is a key factor for poor mental health in childhood. Hostile, rejecting parenting, and negative discipline practices are detrimental as well as neglect and abuse. Policies and practices to support parenting both in the general population and amongst those at greater risk have an important contribution to make to society beyond ensuing better mental health and wellbeing

Factors that can protect children from mental health problems include educational achievement, health and vitality, feeling respected, valued and supported, and being brought up in an environment with good quality schools, safe communities employment opportunities and financial security. Societal, political and cultural factors like changes in family structure, increases in the number of single parent families, and the economic migration of workers to richer countries can all have negative consequences for children's mental health.

What works?

The evidence for what works in this fact sheet is based on a detailed analysis of 51 systematic reviews published in the scientific literature that were in turn systematically identified¹.

1. Practices in the perinatal period

Some very low cost practices for all parents

There are a number of very low cost practices which could be adopted by all parents resulting in better sensitivity to and understanding of their infants needs and thus make parenting easier. It is true, that there is not so much evidence to support these practices, but, because they have little cost and very low possibility of harm, they can be recommended.

The practices are:

- (i) increasing parents awareness of the infant in the antenatal period by promoting **abdominal massage**
- (ii) promoting **skin to skin care** by putting the naked infant on the mother's naked breast immediately following delivery
- (iii) encouraging **kangaroo care** – both mothers and fathers carrying their infants with them in purpose made carriers for much of the day
- (iv) **media based** parenting programmes

¹ Promoting the mental health of children and parents. Evidence and outcomes. Home and community based parenting support programmes and interventions. Report of workpackage 2 of the Dataprev project prepared by Professor Sarah Stewart Brown and Dr Anita Schrader McMillan of Warwick Medical School, University of Warwick, England. September 2009.

Some slightly higher cost practices for all parents

These practices can also be adopted by all parents resulting in better sensitivity to and understanding of their infants needs and thus make parenting, and particularly fathering, easier.

The practices are:

Health care providers helping parents recognise their infant's abilities and developmental milestones, for example, the infant's sensory and physical abilities, through ***developmental guidance***.

Health care providers helping parents reduce sleeping problems and crying and managing temperamentally difficult infants through ***anticipatory guidance***.

Health care providers training mothers or fathers to offer their ***infants massage*** on a regular basis.

One practice found not to work

One approach to intervention in the perinatal period shown not to be effective is ***psychological debriefing after birth***. In fact, it might even do harm.

2. Practices to prevent and treat postnatal depression

Practices that prevent and treat postnatal depression, although more costly to implement, target a group where the detrimental impact on infant and child mental wellbeing is well known.

Preventive practices that focus on high risk groups are effective; these are delivered on a one to one basis and may be offered by a wide range of trained health care providers; they include a range of psychosocial approaches and usually offer a combination of practical and emotional support.

Universal approaches to the prevention of postnatal depression are not effective.

There is no evidence that ***screening*** using a brief questionnaire relating to mother's mental health is effective but this is still widely used in Europe.

Three different psychosocial approaches to the treatment of post natal depression are equally effective: - ***cognitive behavioural approaches; interpersonal psychotherapy and non-directive counselling***.

There is no systematic review evidence as yet to support practices which aim to identify, prevent or treat ***antenatal depression***.

3. Practices that provide parenting support in infancy and early years

A range of practices that target demographically and socially high risk groups have been studied; they include short term practices based on manuals and very long term, multi-component practices which can be tailored to families needs.

The effective practices are:

Short (around six sessions) sensitivity focused practices which promote parent infant communication in high risk infants and clinical samples are safe and effective. It is more effective to target high risk infants than high risk parents. These practices offer interactional guidance; their focus is on enhancing parental observation skills and increasing positive interchanges and enjoyment. These interventions include video interaction feedback. The evidence suggests that it is more effective to start after the infant is 6 months old.

Multi-component long term home visiting practices can be effective in improving parenting and parent and infant mental health outcomes as well as indicators of child abuse in high risk groups such as teenage parents. Nurses offer at least weekly visits starting in the antenatal period. Practices need to focus on the positive, taking an empowering approach, and enhancing positive mother-infant interaction and enjoyment; these are more effective than psychodynamic practices focusing on problems in the relationship and difficult past life histories. The quality of the relationship that the practitioner forms with the mother is key to success. Practices which include an ecological model, taking other risk factors and environments into account are more successful. Longer term studies have found positive outcomes, which were missed in shorter term studies.

4. Parenting practices with a focus on the prevention of behaviour problems.

Parenting practices based on manuals using cognitive behavioural approaches and relational approaches are effective in preventing behaviour problems, reducing the severity of behaviour problems and improving parenting.

Practices have been mostly studied with high risk groups and seem to be most effective in the 3-11 years age group, although there is evidence of effect in older and younger children. Some studies have shown persistent effects in long term follow up.

Practices are effective with parents from a range of minority ethnic groups.

Practices improve maternal psychosocial health and improve indicators of abusive parenting.

Media based parenting practices using the telephone or DVDs can be effective and effectiveness is enhanced by up to two hours of therapist contact time.

Practices with a curriculum or manual, those including positive parent child interaction, emotional and communication skills, use of time out and parental consistency and requiring parents to practice new skills are more effective.

Practices in which parents' needs are respected and they are offered strengths based non-judgemental support are effective. The facilitation of support and acceptance by other parents in the group is also key.

5. Parenting support in very high risk groups

These are the most challenging groups to improve children's wellbeing and prevent mental ill-health. They have also been the most difficult to study, and, unfortunately, too many studies are of poor quality to be certain about the results.

However, the following can be concluded:

In families with documented physical abuse, intensive family support, multi-component multi-systemic approaches and cognitive behavioural based parenting practices show some promise.

Some families in which emotional abuse has occurred and those where anger management is a difficulty, respond to group based behavioural parent training with additional anger management techniques.

Non-abusing parents in families where sexual abuse has occurred can benefit from cognitive behavioural therapy as can their children.

Parent infant psychotherapy shows some promise with emotionally abusing families, but study quality is an issue with these practices

Practices with parents with drug problems suffer from high levels of drop out. Two practices showed promise: one, a multi-component practice targeting mood, views of self as a parent, drug use and parenting skills delivered on a one to one basis; and one an attachment based parenting education practice delivered in a group.

Making the economic case

What are the economic consequences of poor childhood mental health?

The economic consequences of poor childhood mental health are profound and can last into adulthood. A number of studies in the EU and beyond that have followed groups of children over many years indicate that, untreated, poor mental health and behavioural problems can lead to increased contact with the criminal justice system, a greater risk of homelessness, personal relationship difficulties and reduced levels of employment, often with lower salaries when employed. For example, in one English study, children with untreated conduct disorders followed for 18 years had ten times greater costs compared with children without mental health problems². Within childhood, there are also major costs for families, education, health and social services. Some of these costs might be avoidable with timely effective early actions, including low-cost parenting interventions.

Making the economic case for action

Significant gaps remain in what we know about the cost effectiveness of investing in measures to promote and protect child mental health: most studies to date have focused on the case for investing in pre-school educational interventions³. There is an emerging evidence base suggesting that investment in parenting interventions can be highly cost effective⁴; the costs of parenting interventions are modest in comparison to the potential avoidable lifetime costs of poor mental health that some children may experience.

For example, work in Australia suggests that one manualised parenting programme would only need to avert 1.5% of cases of conduct disorder to more than cover the costs of investing in the programme⁵. If one quarter of all cases of conduct disorder were prevented then cost savings to the public purse (health, education and social services) would be more than four times the costs of the parenting programme. In Wales a randomised controlled trial and cost effectiveness analysis looked at a group-based parenting intervention targeted at parents of children aged 3-5 at risk of

² Scott S, Knapp M, Henderson J, Maughan B. Financial cost of social exclusion: follow up study of antisocial children into adulthood. *BMJ* 2001;323(7306):191.

³ Karoly L, Kilburn R, Cannon J. Early childhood interventions: proven results, future problems. Santa Monica: RAND Organisation, 2005.

⁴ Dretzke J, Frew E, Davenport C, Barlow J, Stewart-Brown S, Sandercock J, et al. The effectiveness and cost-effectiveness of parent training/education programmes for the treatment of conduct disorder, including oppositional defiant disorder, in children. *Health Technol Assess* 2005;9(50):iii, ix-x, 1-233.

⁵ Mihalopoulos C, Sanders MR, Turner KM, Murphy-Brennan M, Carter R. Does the triple P-Positive Parenting Program provide value for money? *Aust N Z J Psychiatry* 2007;41(3):239-46.

developing conduct disorder. It also concluded, given the programmes modest costs and good clinical effectiveness, that it would represent good value for money⁶. It is important to note however that the cost effectiveness of these programmes will depend on the extent to which parents are willing to participate. Greater levels of participation can further help improve their cost effectiveness.

There is also some limited evidence that multi-component nurse home visit programmes can represent good value for money⁷. Effective intervention can avoid the future need for some expensive social service, social welfare, and educational interventions⁶. Turning to practices to prevent and treat post-natal depression, one recent study suggests that counselling women at high risk of developing postnatal depression may have the potential to be cost effective⁸.

⁶ Edwards RT, Ceilleachair A, Bywater T, Hughes DA, Hutchings J. Parenting programme for parents of children at risk of developing conduct disorder: cost effectiveness analysis. *BMJ* 2007;334(7595):682.

⁷ McIntosh E, Barlow J, Davis H, Stewart-Brown S. Economic evaluation of an intensive home visiting programme for vulnerable families: a cost-effectiveness analysis of a public health intervention. *J Public Health (Oxf)* 2009;31(3):423-33.

⁸ Petrou S, Cooper P, Murray L, Davidson LL. Cost-effectiveness of a preventive counseling and support package for postnatal depression. *Int J Technol Assess Health Care* 2006;22(4):443-53.

Questions for Consideration by Policy Makers

Universal or targeted approaches

There is a wide-ranging debate about whether preventive practices should be offered to all parents, or should be targeted to parents at greatest need. Some practices show the greatest effect when they are directed at parents with the highest level of need and with the greatest capacity to benefit. This is partly because most studies of targeted approaches measure clinical problems; because such problems are relatively infrequent in the overall population, it is difficult to measure any substantial improvement in studies of whole population approaches. This is now being remedied in more recent studies which measure aspects of children's mental wellbeing, where there is more room for improvement in the whole population. Both approaches are effective and can complement each other.

There are several arguments in favour of universally provided practices. First, they can improve mental wellbeing at population level. Second, they are less stigmatising. Third, universal practices can address problems before they reach clinical levels, and are therefore more genuinely preventive than practices that become available only after problems have developed. Fourth, the 'population paradox' refers to a situation in which a relatively large number of lower risk individuals carry the main burden of disease of the population as a whole, such that while people living in a specific area may be at high risk, the majority of high-risk people are actually spread out across a range of areas.

Policies to optimise children's mental wellbeing through parenting and family interventions are likely to be most effective if they offer elements of both approaches.

Engagement and retention in parenting practices

Practice providers need to give careful consideration to how participants are to be recruited into parenting practices (where will the practice be advertised? how can the practice be advertised to people most likely to benefit from the practice?) and to the potential barriers to participation. These could be real (people may not be able to afford to get to the practice venue, the venue may be difficult to get to by public transport or the practice may not be held at a suitable time) or perceived (taking part in a practice may be stigmatising or may be felt to be racist or culturally inappropriate). All these factors need to be considered locally prior to the implementation of a practice.

The success of most interventions with parents, or with parents and children, are inevitably influenced by contextual factors - poverty, poor housing, the absence of safe space for children's play and recreation, unemployment and a range of other sources of community and environmental stress. The independent impact of these issues has rarely been studied.

Skills of facilitators

One important component of effectiveness is the skills of the facilitators. Non judgemental strengths based approaches are essential, but these are not skills in which health care providers are routinely trained or skilled. The development of a skilled workforce is likely to be a prerequisite for successful mental health promotion through family approaches. It is one of the disadvantages of the research in this area that few of the studies have measured facilitators' skills.

Options

- Policy makers, health care managers and health care providers should provide a mix of relatively low cost practices for all parents, and higher cost effective practices for higher risk groups.
- The lower cost practices for all parents include promoting parental abdominal massage during pregnancy, skin to skin care immediately following delivery, encouraging infant carrying through kangaroo care, guidance on infant development and managing common problems, and promoting infant massage.
- These low cost practices can be supported by ensuring the relevant care guidance and training for health care providers.
- Employers can also assist by offering similar guidance and support to their employees who are parents to be and new parents.
- The higher cost effective practices for higher risk groups include targeted practices for postnatal depression in high risk groups, short sensitivity focussed practices for high risk infants, multi-component long term home visiting practices for higher risk parents, a range of parenting practices for high risk children to prevent behavioural problems and parenting support in families with high risk of emotional or physical abuse.
- These higher cost practices for high risk groups can be supported by relevant clinical and care guidance for health care providers, adequate training for health care providers to deliver practices based on non-judgemental approaches, and adequate staff and financial resources to deliver such practices to those in need.



This fact sheet was edited by Peter Anderson based on the report prepared by Sarah Stewart Brown and Anita Schrader McMillan of the University of Warwick England and as part of the DataPrev project coordinated by Radboud University, Nijmegen, the Netherlands.

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Promoting mental health in schools

Reviewing the evidence base for mental health in schools, and identifying European evidence based programmes and principles

Report from work package 3 of the DataPrev Project

Background

The DataPrev project aims to increase the understanding and knowledge across Member States of mental health promotion and mental disorder prevention policy and practice. It is developing and disseminating a standardized online information system that systematically gathers, describes, reviews and appraises best practices across settings; synthesizing the evidence base quantitatively and qualitatively; and translating the evidence based into guidelines.

One of the key settings included is schools. Children and young people spend a large amount of time in schools and the school represents an easy access environment with direct day-to-day contact with children, young people and, often, their families. Schools not only establish the competencies for learning, they are an important setting for mental health promotion, through their role in helping to establish identity, interpersonal relationships and other transferable skills (Greenberg et al, 2003). The school has for some time now been seen as a unique community resource to promote and foster mental, emotional and social wellbeing, and calls for it to be more active in this respect are growing (Mental Health Foundation, 1999; Hosman et al, 2004; WHO/HSBC Forum 2007 Task Force, 2007; Fundacion Marcelino Botin, 2008).

The past two decades have seen a significant growth of research and good practice on mental health prevention and promotion in schools (WHO/HSBC Forum 2007 Task Force, 2007; Fundacion Marcelino Botin, 2008). Across the world, an increasing number of schools are engaging in a wide range of mental health related initiatives and policies, which in many places are showing promising results. Activities operate under a variety of headings, not only 'mental health' but also those such as 'social and emotional learning' 'emotional literacy', 'emotional intelligence', 'resilience', 'life skills' or 'character education' (Weare, 2004).

The world leader in the field, both in terms of sheer numbers of programmes and also the amount of resource put into attempts to evaluate them rigorously, is undoubtedly the US, where literally thousands of what are effectively mental health programmes are operating with various levels of demonstrable success and twenty or so major programmes are

consistently identified as successful by rigorous systematic reviews (Zins et al, 2004). Australia is also the scene of thriving work and some of its programmes are starting to produce robust and positive evaluations (Shucksmith et al, 2007, Adi et al, 2007). Programmes and approaches are also to be found across Europe, often under titles such as mental health, social and emotional competency, violence prevention, anti-bullying and cognitive and coping skills, with programmes aimed at all three waves of need (WHO/HSBC Forum 2007 Task Force, 2007; Fundacion Marcelino Botin, 2008).

Evidence for effectiveness

Alongside this international outpouring of school-based programmes, the last 20 years or so have seen a growing evidence base for the effectiveness of this work. Systematic reviews of programmes, using the most rigorous and exacting criteria, are repeatedly demonstrating definitively that the best of them are effective (Shucksmith et al, 2007; Adi et al, 2007; etc) Taken together, the reviews provide growing evidence that well designed programmes to promote mental health and social and emotional wellbeing and learning can have a very wide range of positive impacts. They include impacts on specific mental health problems, such as aggression, depression, reduced commonly accepted risk factors, such as impulsiveness, and antisocial behaviour, and developed the competences that promote mental health such as cooperation, resilience, a sense of optimism, empathy and a positive and realistic self concept (Wells et al, 2003). Programmes have also been shown to help prevent and reduce early sexual experience, alcohol and drug use, and violence and bullying in and outside schools (Greenberg *et al.*, 2003), promote pro-social behaviour (Durlak and Wells, 1997) and in some cases reduce juvenile crime (Caplan *et al.*, 1992). Children who receive effective and well designed mental health and social and emotional learning programmes are more likely to do well academically, in some cases achieving higher marks in subjects such as mathematics and reading, to make more effort in their school work, and to have improved attitudes to school, with fewer exclusions and absences (CASEL, 2009; Weare, 2004; Zins et al, 2004).. A recent major US meta-analysis across the whole field (CASEL 2009) summarised research on 207 social and emotional programmes and suggested that schools with effective programmes showed an 11 per cent improvement in achievement tests, a 25 per cent improvement in social and emotional skills, and a 10 per cent decrease in classroom misbehaviour, anxiety and depression.

Objectives for work package 3

There is therefore a good deal of work on mental health in schools taking place internationally, some of it proven to be effective. Some demonstrably effective programmes have a presence in Europe, some of them imported from countries outside Europe, some home grown. However the picture is far from clear, and there is a need to clarify what is happening across Europe in terms of evidence based practice on the ground. There is also a need to clarify the principles that support effective programmes in order to help those in Europe who want to develop their own programmes to understand the evidence based principles they need to follow, and/or have some clear criteria from which to select from existing programmes.

DataPrev work package 3 is therefore undertaking a search for evidence based effective programmes which promote mental health in schools and are currently used in Europe and identifying the principles that support effective programmes.

More specifically this work package is:

- undertaking a systematic review of reviews of work to promote mental health in schools, and coding and describing the key reviews,
- enquiring of leaders of effective programmes and engaging the relevant stakeholders at country level to find out what programmes are in Europe,
- selecting effective European school mental health programmes according to specified criteria, describing and assessing them, and eventually inputting programme descriptions into an internet database,
- identifying best practice through evidence appraisal guidelines and outlining the principles which drive effective programmes,
- preparing a publication on the methodology, process and findings

Methodology / inclusion criteria

The literature

Our focus is global to ensure that we capture all potential programmes and principles. As there has been a considerable number of good quality reviews of this area already we are looking at overviews that bring the results of studies of individual programmes together in an organized and rigorous way– so called systematic reviews, reviews of reviews, data synthesis, data extraction, and meta-analyses. Our time frame is 1990 onwards. We are focusing mainly on reviews published in peer reviewed journals through academic publishers to ensure that the papers have been properly scrutinized by the scientific community. We are finding this literature by undertaking systematic searches of the databases of literature routinely used by the scientific community. These databases include MEDLINE, EMBASE, ERIC, CINALH, Sociological Abstracts, ASSIA, PsychINFO, the Cochrane Database of Systematic Reviews, DARE CENTRAL, SIGLE, the Social sciences citation index (SSCI), and several others.

We are also identifying well conducted reviews through our existing contacts with various national and international research agencies in the field that use rigorous evaluation methods to ensure quality. Some of these agencies have websites that we are also scrutinizing carefully. The agencies include CASEL (the Collaborative for Academic, Social and Emotional Learning) in the United States, in Britain the Cochrane Database, the EPPI Centre, and the National Institute for Clinical Excellence, the Australian Network for Promotion Prevention and Early Intervention for Mental Health, as well international agencies such as IMPHA, Mental Health Europe, Intercamhs (the international alliance for child and adolescent mental health and schools) and the WHO.

Once an effective programme is identified, if it is not a European programme in origin, we are looking at its website, if such exists, and contacting the programme leader by email to find out if it currently has a presence in Europe. If it does we are recommending it be included in the database. We are noting programmes that are effective but do not have a presence in Europe, but not at this stage recommending their inclusion the database. We are extracting the principles of effective programmes both from programmes that have a presence in Europe and from those that do not.

The population



The population we are looking at is school aged children and young people aged 4-19. The setting is schools and classrooms, including sixth form colleges, including mainstream, special, independent and private schools.

The interventions and their outcomes

The interventions include programmes that are aimed at everyone (so called 'universal' programmes), and those that are targeted at people with problems or who there is reason to believe might develop problems. The programmes include those for the whole school, the whole class, for a small group or one to one with individual children. They are programmes which aim to improve mental health, and/or prevent mental illness/problems and/or tackle mental health problems, aimed at children and young people, with their parents if appropriate, based in classrooms and/or schools.

One issue we are acknowledging is the problem of definition and terminology. The term 'mental health' is by no means the only or the most obvious one to use: there are many other terms used to cover this issue. Our search terms for outcomes are therefore very wide and inclusive and include over 80 terms. We include overarching terms such *wellbeing, quality of life, character, autonomy, empowerment, social behaviour, and relationships*. We include words that describe positive mental states such as *happiness, contentment, satisfaction, confidence, connectedness, sense of coherence, and self esteem*. We include terms that apply to mental health skills and capacities such as *communication, decision making, conflict resolution, emotional intelligence, optimism, resilience, motivation, and coping*. We also include terms that are variations on mental health problems, such as *delinquency, depression, anxiety, stress, bullying aggression and anger*.

Preliminary results

To date, we have identified over 40 recent systematic reviews from which we have identified 16 successful evidence based school mental health programmes or interventions currently being implemented in Europe. Many of these originate in the United States, some come from Australia and some from Europe itself. Some typical examples include:

- Second Step to Violence Prevention. US in origin, found in Sweden, UK, Denmark, Iceland, Germany, and Norway.
- Promoting Alternative Thinking Strategies, US in origin, found in UK the Netherlands, Germany, Switzerland Croatia, Northern Ireland.
- Friends Australian in origin, Found in the UK Ireland, Germany, Finland, Netherlands. Portugal.
- Incredible years. US in origin, Found in UK, Ireland, and Norway.
- Olweus Bully-Victim programme. Originated in Norway, found across Scandinavia.

Preliminary conclusions: key features of effective programmes

Our preliminary results bring together the findings of earlier reviews in a more comprehensive way than has been done previously, and show that there is internationally a strong group of school-based mental health programs that have evidence of impact across a range of mental health, emotional and behavioural problems, including depression, anxiety, stress, and behaviour problems, which can promote positive mental wellbeing, and incidentally often improve academic learning. A new finding is the number of these programmes which can be found in Europe, and although many of these originate in the United States, transferability is apparently possible in some cases.

The review is also picking up a lack of total consistency in results and most reviewers have concluded that interventions have the potential to be effective but that their effectiveness can not always be relied upon. It is therefore important to clarify what the key principles of effective programmes and what implementation factors make them more likely to be effective. Understanding these principles can also help those who wish to develop their own programmes in countries rather than buy into an existing programme. We are therefore extending our knowledge of the key principles of effective interventions and appropriate approaches by adding more recent findings from the systematic reviews and from papers about the interventions themselves. These principles are drawn from programmes implemented right across the world not just Europe.

Key principles identified so far include:

- Programmes need to be implemented consistently to be effective.
- Effective programmes are more likely to be multi-modal, and ideally ‘whole school’, rather than restricted to one part of the school. Mental health work, including teaching and learning, needs to be integrated across the school and the curriculum, not seen as a separate issue or subject. The most effective programmes are those that have effect the entire school ethos and process, are supported by the whole school environment, leadership and policies, and built explicit links between skills and features of school life. They are supported by a school culture, environment and ethos which supports mental health by being, for example, warm, caring, respectful, ordered, inclusive, participative, creative and positive.
- Mental health cannot be done to people. More effective programmes involve children and young people, for example through peer-learning. Similarly parental involvement has been repeatedly shown to be essential, both to ensure that parents support the mental health process and that children and young people have opportunities to practice their skills in the real world.
- Mental health is not spread by osmosis. All effective programmes include extensive and explicit work to help students and school staff learn and develop appropriate mental health skills. Most interventions, despite their different branding, offer a very similar mix of CBT and social skills training for children (often including attribution training to prevent negative attributions of hostile intent of others), training of parents in appropriate reinforcement and better methods of discipline, and training of teachers in the same. This mix seems to be very similar whatever the problem or diagnosis.
- It is best to have a balance between approaches aimed at everyone in the school and those that are targeted at those with difficulties. Once a solid background of universal work is established there needs to be extension work for children with particular emotional, social and behavioural difficulties, which is designed along the same lines as that offered to all students, but is more intensive and extensive.
- Teaching and learning methods need to be diverse, participative and experiential rather than didactic, to appeal to a range of learning styles, engage learners’ attention and ensure that skills are practiced.
- Staff development is essential – the best programmes are supported by extensive and in depth professional development for the staff involved in transmitting the programme – modelling is a powerful determinant of whether or not pupils acquire the skills.



- One off interventions are never effective. In some cases short interventions (e.g. twice weekly for 8 to 10 weeks) have been shown to be effective for mild problems, but on the whole programmes need to be allowed time to work if they are to impact on deep seated problems such as anxiety and behaviour problems.
- Programmes need to start early – the most effective programmes are those that target the youngest children. Programmes need take a long-term developmental approach through a spiral approach in which key learning is constantly re-visited.

We have not yet completed the review process, and expect to be able to add some further programmes and refine the principles as the review progresses.

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ProMenPol Project

The ProMenPol project funded by the European Commission under the 6th Framework Programme is being undertaken by partners from Germany, Austria, Ireland, Finland, Estonia, Greece and Belgium and coordinated by the Federal Institute of Occupational Safety and Health (BAuA).

It aims to support the practices and policies of mental health promotion in the three settings of schools, workplaces and residential homes for older people over the 2007-2009 period by:

- developing a database and toolkit of mental health promotion tools;
- assisting practitioners in implementing such tools (field trials); and
- providing research-based policy support

Each year ProMenPol runs a practitioners conference that is followed by a policy workshop for national and European policy makers. These activities allow for the mutual exchange of information concerning positive mental health between experts and for timely feedback to those responsible for designing services and policies.

The ProMenPol Database and Toolkit

The first version of the ProMenPol toolkit and database can be accessed from the ProMenPol website (www.mentalhealthpromotion.net).



The screenshot displays the ProMenPol website interface. At the top, there is a navigation menu with links for News & Events, About, Resources, Database & Toolkit, Field Trials, Forums, FAQ, and Contact. The main content area shows the breadcrumb path: Home > Database & Toolkit > Browse Database > Sandwell Healthy Schools Scheme (SHSS). The title of the page is "Sandwell Healthy Schools Scheme (SHSS)". Below the title, there are tabs for Details, ICF Details, MHP Details, and Full View. The "Details" tab is selected, showing "Tool Information" dated 26/08/2009. The tool information includes: Settings: Education; MHP Steps: Implementation | Needs Analysis | Preparation; Country of Origin: United Kingdom; Languages: English; URL: Click here for Tool Website; Evaluation: Unknown; Available Formats: Paper Based; Free: Unknown; Restrictions on Use: No; Tool Focus: Individual and Organisation; Tool Type: Programme; Download(s): sandwell_impact_evaluationdoc - 164 KB. On the left side, there is a sidebar with a search box, a members area with email and password fields, and a login button. The sidebar also lists navigation options: ProMenPol Database, Browse Database, Simple Search, Advanced Database Search, and ProMenPol Toolkit.

Figure 1 - ProMenPol Database

To date some 443 tools are available in the ProMenPol database of which 191 are associated with the education setting, 120 with the older peoples' residences and 140 with the workplace

settings. The database is available in English, German, Finnish and Estonian. Tools can be searched for using the simple, advanced or free text search mode.

All tools are categorized according to an extensive coding system that is based upon the ICF and mental health promotion models and guidelines. Additionally the tools were rated on four descriptors: Application in the field, Stage of Development, Evaluation and Research, Beneficiary Involvement in Design.

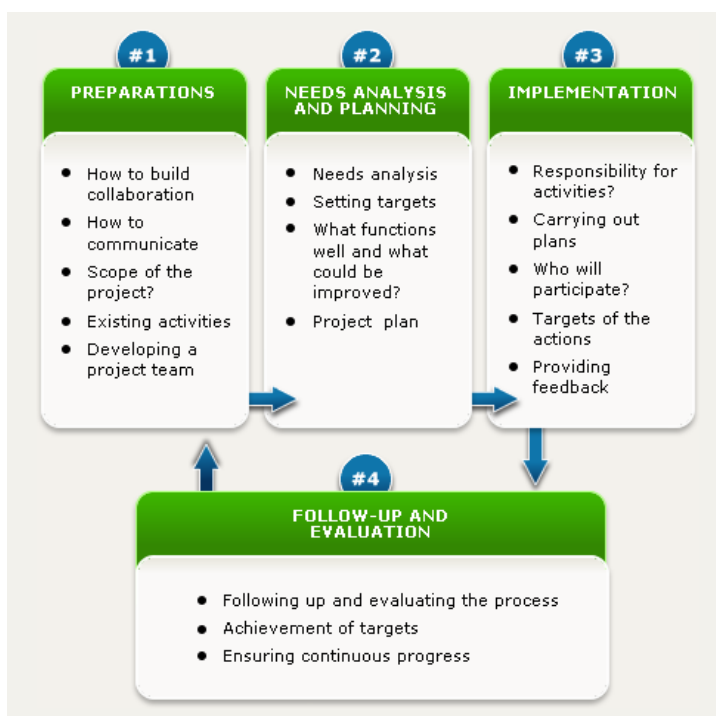


Figure 2 - ProMenPol Step Approach

The ProMenPol toolkit consists of the ProMenPol database in addition the toolkit manuals. The manual provide guidance on implementing MHP tools. The manual is split into a more extensive generic part giving advice on the general project management procedure in order to implement Mental Health tools/initiatives and three shorter setting specific modules as a supplement to the generic part.

The manual will also be available online until October 2009.

The database and toolkit have been evaluated in the context of so-called type I field trials.

The ProMenPol Field Trials

Within the framework of ProMenPol three types of field trials are taking place:

- **Type I** is a usability-test of the online database and toolbox for mental health promotion and protection instruments. The questionnaire will ask users -who have tested the toolboxes- about the toolsets' utility, functionality and practicality for the organisation.
- **Type II** will document the experiences of implementing the tools practitioners have chosen from the toolset of mental health promotion instruments.
- **Type III** is a standardised report on a tool which is already in use by the organisation in the course of an existing initiative. In addition organisations will be asked to report on its utility and practicality, too.

The field trial phase has started in July 2008 and will finish by the end of September 2009. Results of the ProMenPol Field Trials will be made available on the website.

The ProMenPol Conferences and Policy Workshops

Until now the first two conferences and the first policy workshop have been carried out successfully involving practitioners and policy makers from various countries across Europe.



Figure 3 - ProMenPol Conference 2008

While the first conference focused on the conceptual framework, i.e. the classification system which constitutes the basis for the database, the second ProMenPol conference mainly dealt with the different types of field trials. Additionally participants discussed the recently published European Pact for Mental Health and Wellbeing. ProMenPol partners have been active in the preparation of background papers and in the corresponding High level EU conference of the Pact. Karl Kuhn and Richard Wynne were closely involved with the development of the workplace consensus paper; STAKES are partners in the EC Mental Health Process consortium and SUPPORT project; and Mental Health Europe took part in the development of the consensus papers on youth and education and on older people. ProMenPol was referenced as an example of cross policy action in the **Background Paper** for the conference produced by the SUPPORT Project.

The practitioner's feedback on the European Pact received at the last ProMenPol conference was a key theme at the 2nd ProMenPol policy workshop that took place on December 11th 2008 in Brussels. As well as at the first annual policy workshop, national policy makers as well as representatives from DG Employment, Research, Sanco and Education and the European Parliament were present. The aim of the workshop was to inform participants about the project in general and in particular to inform them about the unique approach that ProMenPol is developing to effective communications between policy makers and practitioners. The workshops also undertook extensive discussions on the issues on identifying appropriate policy makers and on the types of information that policy makers need to improve policy making. A distinction was drawn between policy makers, policy administrators and policy influencers. ProMenPol is committed to developing strategies for each of these groups over the coming months in order to ensure a maximum impact on mental health policy in the future.



Figure 4 - Policy Workshop 2007

The 3rd ProMenPol conference in combination with the 3rd policy workshop will take place on October 8th and 9th 2009 in Berlin. Presentations and discussion outputs will be available on the ProMenPol website www.mentalhealthpromotion.net.

Partners and Contact Details

Below all ProMenPol partners are listed. For more information about the project and ways to get involved the Project Manager Katrin Zardo can be contacted by e-mail or phone.

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ProMenPol-Partners:

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Work Research Centre Ltd. (WRC)

The Rehab Group (REHAB)

Research Institute of the Red Cross (FRK)

EWORX S.A. (EWX)

National Institute for Health and Welfare (THL)

Estonian – Swedish Mental Health and Suicidology Institute (ERSI)

Mental Health Europe – Sante Mentale Europe (MHE-SME)

<http://www.baua.de>

<http://www.wrc-research.ie>

<http://www.rehab.ie>

<http://www.wrka.at/forschungsinstitut>

<http://www.eworx.gr>

http://www.thl.fi/en_US/web/en/home (English)

<http://www.suicidology.ee>

www.mhe-sme.org

Summary of EU Kids Online: Final Report

Sonia Livingstone and Leslie Haddon

Coordinator, EU Kids Online

London School of Economics and Political Science

June 2009

www.eukidsonline.net

Introduction

- With 75% of European children using the internet, some celebrate their youthful expertise while others worry that they are vulnerable to new forms of harm. Policies to balance the goals of maximising opportunities and minimising risks require an evidence-based approach.
- Funded by the European Commission's Safer Internet plus Programme, EU Kids Online (2006-9) is a thematic network that aimed to identify, compare and draw conclusions from existing and ongoing research on children and online technologies conducted in Europe.
- Research teams from 21 European countries were chosen for diversity across countries and range of research expertise: Austria, Belgium, Bulgaria, Cyprus, Czech Republic, Denmark, Estonia, France, Germany, Greece, Iceland, Ireland, Italy, Netherlands, Norway, Poland, Portugal, Slovenia, Spain, Sweden, United Kingdom.
- The network adopted an analytical framework which divided the research field into individual (child-centred) and country (macro-societal) levels of analysis. This was operationalized by the construction and testing of policy-relevant research questions and hypotheses. Both individual and country level comparisons were contextualised in relation to the wider structures of children's lives.

The project objectives were to:

- Identify and evaluate findings on children's internet use, noting gaps in the evidence base.
- Examine research contexts shaping the research agenda and identify best practice methods
- Compare findings across Europe, contextualising similarities and differences.
- Develop evidence-based policy recommendations for actions promoting safer internet use.

The evidence base¹

- The network constructed a publicly accessible and fully searchable 'Data Repository' of all empirical studies that have been conducted and identified across Europe, provided they meet a certain quality threshold. The repository contains details of 390 separate studies.
- As shown in Figure 1, studies are unevenly distributed across Europe, with most research in Germany, the UK, Denmark and least in Cyprus, Bulgaria, Poland, Iceland, Slovenia and Ireland.
- Despite research strengths in relation to access and use, the existing knowledge base reveals many gaps, especially for certain types of risk, for younger children and for new/mobile platforms.

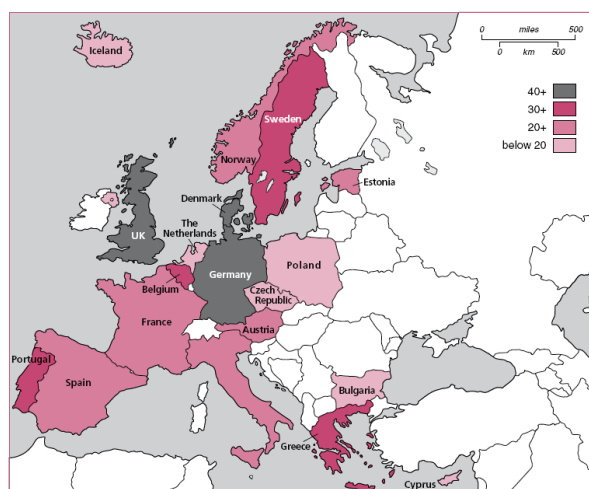


Figure 1: Number of studies identified by country (multicoded)

¹ Staksrud, E., Livingstone, S., Haddon, L., and Ólafsson, K. (2008) *What do we know about children's use of online technologies? 2nd ed*, London: LSE. At www.eukidsonline.net, plus reports on research by country.

Classifying children's online opportunities and risks

- To analyse the available research findings, children's online opportunities and risks were classified according to the child's role in online communication and the substantive themes or values of policy concern (Table 1).
- Despite acknowledged difficulties of definition and overlap, it was clear that there is more research on access and use than on online risks, with risk addressed in up to a third of all studies.
- Few studies include parenting issues, though countries with a good deal of research have more studies about parenting than those with little research overall.
- Research on online risks to children is fairly evenly divided across content, contact and conduct risks overall, though few studies examine online risks in relation to young children.

		Content: Child as recipient	Contact: Child as participant	Conduct: child as actor
OPPORTUNITIES	Education learning and digital literacy	Educational resources	Contact with others who share one's interests	Self-initiated or collaborative learning
	Participation and civic engagement	Global information	Exchange among interest groups	Concrete forms of civic engagement
	Creativity and self-expression	Diversity of resources	Being invited/ inspired to create or participate	User-generated content creation
	Identity and social connection	Advice (personal/ health/ sexual etc)	Social networking, shared experiences with others	Expression of identity
RISKS	Commercial	Advertising, spam, sponsorship	Tracking/ harvesting personal information	Gambling, illegal downloads, hacking
	Aggressive	Violent/ gruesome/ hateful content	Being bullied, harassed or stalked	Bullying or harassing another
	Sexual	Pornographic/harmful sexual content	Meeting strangers, being groomed	Creating/ uploading pornographic material
	Values	Racist, biased info/ advice (eg, drugs)	Self-harm, unwelcome persuasion	Providing advice eg, suicide/ pro-anorexia

Table 1: A classification of online opportunities and risks for children

Contexts of research²

- A range of social and political factors also shape research, including national efforts to support internet diffusion and use, efforts to promote use of the internet in schools, and reactive responses to public concerns. In some countries, especially those which have gained internet access more recently, the EC has set the agenda for research on children and the internet, with national governments often slower to follow.
- Across Europe, the number of universities in a country, itself correlated with population size, is a fair but not a strong predictor of the amount of research on children's internet use. Research is more established in countries which gained widespread access to the internet earlier.
- There is no straightforward or systematic relation between funding source and the amount or type of study conducted across Europe. However, the low levels of research in some countries reflect their reliance on public funding. In most countries, governments and industry are the main funders of research: around half of what they fund goes to research that

² Stald, G. and Haddon, L. (2008) *Cross-cultural contexts of research: factors influencing the study of children and the internet in Europe*, London: LSE. At www.eukidsonline.net, together with reports on research by country.

includes risk issues, and thus they fund a large proportion of the available research on risk. Charities, NGOs, regulators, research councils and the EC fund far fewer studies, though these are very likely to address risk.

- In countries with higher use of the internet among children, media coverage plays a key role in focusing the research agenda on safety and awareness issues. By far the majority of press coverage on children and the internet is concerned with risks rather than opportunities: nearly two-thirds of all stories referred to risks, whereas less than a fifth referred to opportunities.

Key research findings

- Children's use of the internet continues to grow, and at least as many parents are now also online. Gender inequalities seem to be disappearing but socio-economic inequalities persist in most countries.
- The rank ordering of online risks experienced is similar across European countries, with giving out personal information figuring as the most common risky behaviour; meeting an online contact offline is much less common but it remains the most dangerous risk
- Children from lower status homes are more exposed to risk online. Boys are more likely to encounter (or create) conduct risks and with girls more affected by content and contact risks.
- There is a positive correlation between use and risk: Northern European countries tend to be 'high use, high risk'; Southern European countries tend to be 'low use, low risk'; and Eastern European countries tend to be 'new use, new risk'.

Changes in the profile of children online³

- Eurobarometer surveys conducted in 2005 and 2008 by the Safer Internet Programme show that children's use of the internet continues to grow. In 2005, 70% of 6-17 year olds in the EU25 used the internet. By 2008, this rose to 75% on average, though there was little or no increase in use among teenagers. The most striking rise has been among younger children – by 2008, 60% of 6-10 year olds were online. However, most research available focuses on teenagers rather than young children.
- Greater increases in internet use are evident in recent entrants to the EU in Central and Eastern Europe. In other words, countries where use was low in 2005 have seen the greatest increases in recent years, partly because many countries have already approached 'saturation'. However, most research available focuses on countries where the internet is already well-established rather than on countries new to the internet.
- A further striking change from 2005 to 2008 is that as many parents are now online as children, reversing the previous trend for teenagers especially to outstrip adults in terms of internet use, although children may still 'lead' in amount/quality of use. In 2008, 85% of the parents of 6-17 year olds had ever used the internet, a significant increase from the 66% online in 2005. In 2005 more children were online than their parents, but no longer. Indeed, across the EU27, only 9% of 6-17 year olds are online while their parents are not.
- There is, therefore, decreasing evidence that children are the 'digital natives', because parents are 'catching up' with teenagers (and were already 'ahead' of younger children). Only in Estonia, Poland, Slovenia, Malta, Hungary, Lithuania, Slovakia, Portugal and Romania are (slightly) more children online than parents – all countries where the internet is a relatively recent arrival.
- The analysis of internet use by age shows that use increases with each year the child gets older and plateaus by the age of 10-11. In 2005, this plateau was not reached till 12-13. Long-standing gender inequalities may be disappearing, though socio-economic inequalities persist in most countries. Since most research, especially non-academic research, is quantitative, this is better at revealing the frequency and distribution of children's activities across the population than at understanding children's own experiences or perspectives in context.

³ Hasebrink, U., Livingstone, S., Haddon, L., & Olafsson, K. (Eds.) (2009) *Comparing Children's Online Opportunities and Risks across Europe* (2nd edition). At www.eukidsonline.net, plus national reports of findings in each country.

- There is a substantial body of evidence regarding children’s online usage, followed by their online interests and activities. Fewer studies in each country consider their learning, skills, frustrations, search strategies, creative activities, civic engagement or coping and safety practices. At present, there is too little cross-nationally comparable evidence regarding the take-up of online opportunities to permit cross-national European comparisons.

Comparing online risks to children

- Across Europe, notwithstanding considerable cross-national variation, the available findings suggest that for online teenagers, the rank ordering of risks experienced is fairly similar in each country. Giving out personal information is the most common risky behaviour followed by encountering pornography online. And then seeing violent or hateful content. Being bullied (i.e. ‘cyber-bullied’) comes fourth, then receiving unwanted sexual comments, while meeting an online contact offline appears the least common though arguably the most dangerous risk.
- In several countries, there is evidence that around 15%-20% of online teens report a degree of distress or of feeling uncomfortable or threatened online. This provides some indication, arguably, of the proportion of teenagers for whom risk poses a degree of harm.
- Even though higher status parents are more likely than those of lower status to provide their children with access to the internet, it seems that the children from lower status homes are more exposed to risk online.
- There are also gender differences in risk, with boys apparently more likely to encounter (or create) conduct risks and with girls more affected by content and contact risks.
- Last, it appears that older teenagers encounter more online risks than younger children, though the question of how younger children cope with online risk remains little researched.
- Countries were classified by degree of children’s internet use and degree of risk online. The classification of countries as ‘high risk’ (i.e. above the European average), ‘medium risk’ (i.e. around the European average) or ‘low risk’ (i.e. below the European average) is a relative judgement based on findings in the available studies reviewed. This suggested a positive correlation between use and risk whereby Northern European countries tend to be “high use, high risk”; Southern European countries tend to be “low use, low risk”; and Eastern European countries tend to be “new use, new risk” (Table 2).

Table 2: A classification of countries by children’s internet use and online risk

Online risk	Children’s internet use		
	Low (< 65%)	Medium (65%-85%)	High (> 85%)
Low	Cyprus Italy	France Germany	
Medium	Greece	Austria Belgium Ireland Portugal Spain	Denmark Sweden
High		Bulgaria Czech Republic	Estonia Iceland Netherlands Norway Poland Slovenia UK

Coping with risk

- There is little consensus on what it means to ‘cope’ with or ‘be resilient’ to online risk, nor much expertise in measuring this. Children’s responses to online risk appear to range from ignoring the problem to checking website reliability or reporting it online, telling a friend or (rarely) a parent or, for some, exacerbating the problem by forwarding on or responding with hostility. These are not yet systematically studied and nor is their effectiveness evaluated.
- Generally, it seems that children’s internet-related skills increase with age. Such skills are likely to include children’s abilities to protect themselves from online risks although, perhaps surprisingly, this has been little examined. However, there are difficulties measuring internet-related skills as yet, and little available comparable research on children’s attitudes to the internet. For example, boys often claim higher skill levels than girls, but this remains to be

tested objectively, and little is known of how children evaluate websites, determine what is trustworthy, cope with what is problematic and respond to what is dangerous.

- There are cross-national differences in coping, it seems. Children's perceived ability to cope with online risk (as reported by parents in different countries, based on the 2005 Eurobarometer survey) reveals that high ability to cope is claimed for children in Austria, Belgium, Cyprus, Denmark, France, Germany, and the UK; low ability to cope is claimed in Bulgaria, Estonia, Greece, Portugal and Spain (intermediate countries are Czech Republic, Ireland, Poland, Slovenia and Sweden).

Parental mediation of children online

- The 2008 Eurobarometer survey found that, parents of 6-17 year olds in the EU27 were rather or very worried about their child seeing sexually/violently explicit images (65%), being a victim of online grooming (60%), getting information about self-harm, suicide or anorexia (55%), being bullied online by other children (54%), becoming isolated from other people (53%) and giving out personal/private information online (47%). A quarter of parents worry about all of these risks. And parents worry more about girls and about younger children (though, as was seen above, boys and teenagers encounter as many or more risks online).
- Cross-national differences are also evident, largely related to the degree of internet diffusion: if fewer children are online in a country, parents are more (not less) worried. Notably, parents in France, Portugal, Spain, and Greece (all countries where children's internet use is lower) are far more worried than parents in high use countries like Denmark and Sweden.
- Further, parents who are themselves online are less worried than those who are not. Getting parents online is therefore likely to produce a good means of reducing anxiety as they will then learn about the online experience and improve their online management skills.
- As with most media, now including the internet, parents report various strategies for mediating their children's online activities. These include, first, imposing rules and restrictions; second, social approaches – watching, sharing, talking about the internet with their children; and third, using technical tools such as filtering, monitoring. Generally, parents prefer to talk to their child about what they do online and to stay nearby when their child is online - for younger children, because parents wish to share their experiences, for older teenagers because parents think rules do not work or are inappropriate for their age, and for all children because parents wish to trust their child and treat them with respect. Nonetheless, a substantial proportion reports using each of the available strategies.
- The 2008 Eurobarometer survey reveals that cultural values matter. The lower levels of worry and of mediation among Nordic parents, despite their high internet use, may be due to more laissez faire attitudes regarding the internet or greater confidence in their children. Parents in Denmark and Sweden claim to mediate their children's internet use much less than parents in Germany, Greece, Ireland, Italy, Portugal, Spain and the UK. So too do parents in Estonia and the Czech Republic, but this may rather reflect a relative lack of parental knowledge of the internet. Overall, analysis of the 2008 Eurobarometer suggests that if parents are internet users, they report more mediation of their child's internet use; non-using parents mediate less.

Policy recommendations – maximising opportunities⁴

- The degree of internet diffusion influences children's access and use. In countries where access has become commonplace, it appears that gender and SES differences across households are reducing. However, these differences (or inequalities) remain significant, especially where access cannot (yet) be taken for granted.
- E-inclusion policies should target countries where children's internet use is relatively low (Italy, Greece, Cyprus), along with certain population segments (less well-off households, parents who are not online) if the remaining 25% of EU children are to get online.
- English language proficiency tends to be higher in Northern Europe, where both use and risks tend to be average or high. It is possible that greater access to English language content

⁴ de Haan, J. & Livingstone, S. (2009) *EU Kids Online: Policy and Research Recommendations*. At www.eukidsonline.net

increases both opportunities and risks. Nonetheless, in small language (e.g. Czech Republic, Slovenia, Greece), it is likely that children's opportunities will be enhanced by greater provision of online content.

- There are some indications that the presence of a strong public service broadcaster or other public content provider(s) for children plays a role in encouraging online opportunities and, also, in avoiding online risks.
- The overwhelming focus of media coverage on online risks rather than opportunities may increase parental anxiety. Since there is a correlation between national levels of parental internet use and parental anxiety about children's internet use, the combination of low parental use and media panics may exacerbate parental anxiety in some countries.
- Little is known of how peer culture mediates children's internet use, though previous research has pointed to cross-national variations in the balance of family and peers as children grow older, to the constraints on friendships in cultures where outside play is highly restricted, and on the growth of media-rich bedrooms in individualised cultures.
- Balancing empowerment and protection is crucial, since increasing online access and use tends to increase online risks. Conversely, strategies to decrease risks can restrict children's online opportunities, possibly undermining children's rights or restricting their learning to cope with a degree of risk.
- Balancing these competing goals requires a mix of regulation, media literacy and improved interface design. Positive online provision is also important: there are growing indications that such provision, if valued by children, directly benefits their development and reduces online risks by encouraging valuable and valued activities.
- Greater internet use is associated with higher levels of education, so educational achievement may be expected to increase the extent and sophistication of internet use. However, gaps in ICT provision and insufficient/ outdated provision of ICT in schools should be addressed, and media education should be recognised and resourced as a core element of school curricula and infrastructure.

Policy recommendations – minimising risks

- There are good grounds to strengthen regulatory frameworks across Europe, especially in some countries, since substantial proportions of children are encountering content, contact and conduct risks, and since many children and parents lack the tools and skills by which they can prevent or manage such exposure.
- Self-regulatory provision in improving children's safety online is to be welcomed and supported, although it is not always transparent or independently evaluated. Children can only be supported in managing the online environment if this is substantially regulated - by law enforcement, interface and website design, search processes, content and service providers, online safety resources, etc – just as they can only be taught to cross a road on which drivers and driving are carefully regulated.
- Where national internet access is greater, self regulation by the industry, including provision of safety information provided by ISPs to complement that provided by government and NGOs, appears also greater. The opposite – low levels of self-regulation in some countries resulting in less safety information – is also true. Additionally, countries which appear to take a liberal approach to state regulation (Bulgaria, Estonia) appear to be high risk for children online.
- Priorities for future awareness-raising should concentrate on countries identified by research as high risk (Estonia, the Netherlands, Norway, Poland, Slovenia, the UK); on countries which have rapidly and recently adopted the internet, where access appears to exceed skills and cultural adjustment (Bulgaria, Estonia, Greece, Poland, Portugal); and on countries where children's use exceeds parents' use (Hungary, Malta, Poland, Romania).
- Awareness-raising priorities should focus on younger children; on strategies to encourage coping after exposure to risk; on addressing girls and boys differently; and on targeting less privileged families, schools and neighbourhoods. Awareness-raising should encompass new risks as these emerge, especially on mobile platforms and via peer-to-peer content and services.

- Policy must move beyond the division between child victims and adult perpetrators. Some children perpetrate online risks, whether from malice, playfulness or mere accident; those who tend to experience online risks may generate further risks; those who create risks may also be victims; and those who are vulnerable online may lack adequate social support offline.
- Although no-one doubts that parents are responsible for their children's safety, evidence suggests that they should not be relied upon as many are unaware or unable to mediate their children's online activities. Rules and restrictions do not fit well with the ethos of modern parenting, especially in some countries, and it is unclear that parental strategies are effective in reducing children's exposure to risk or increasing their resilience to cope.
- Given the growing impetus behind media literacy initiatives, it is timely to evaluate their effectiveness in increasing children's critical knowledge of the online environment. The changing demands of a complex technological, commercial and, increasingly, user-generated environment sets limits on children's media literacy, hence the importance of co-and self-regulation to support children's media literacy.

Research recommendations

There are some significant gaps in the evidence base. Research priorities include:

- younger children, especially in relation to risk and coping, though continually updated research on teenagers is also important;
- emerging contents (especially 'web 2.0') and services (especially if accessed via mobile, gaming or other platforms);
- understanding children's developing skills of navigation and search, content interpretation and critical evaluation;
- new and challenging risks, such as self-harm, suicide, pro-anorexia, drugs, hate/racism, gambling, addiction, illegal downloading, and commercial risks (sponsorship, embedded or viral marketing, use of personal data, GPS tracking);
- how children (and parents) do and should respond to online risk;
- how to identify particularly vulnerable or 'at risk' children within the general population;
- evaluations of the effectiveness of technical solutions, parental mediation, media literacy, other awareness and safety measures, both in terms of the ease of implementation and more importantly in terms of their impact on risk reduction; this may vary for different groups of children in different cultural contexts.

To advance this agenda, and since methods of researching children, the online environment, and countries in comparative perspective are all demanding, EU Kids Online produced two reports on methodology - a literature review and a best practice research guide, plus additional online resources to guide researchers. All are available at www.eukidsonline.net, along with project reports and further publications.⁵

⁵ Lobe, B., Livingstone, S., Ólafsson, K., Simões, J. (2008) *Best Practice Research Guide: How to Research Children and Online Technologies in Comparative Perspective*. At www.eukidsonline.net, plus a range of good practice resources.

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