WELL-BEING AND MENTAL HEALTH OF EUROPEAN YOUTH

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WELL-BEING AND MENTAL HEALTH

In the field of youth policy, the terms of *well-being* and *mental health* are often used interchangeably when addressing the state of today's youth. The research and policy developments regarding both these concepts, however, have followed quite separate paths. This paper will discuss both these concepts as outcomes, the various determinants and policy challenges. The paper should contribute to a meaningful discussion about the most relevant consequences in the European youth strategy.

The interest in the idea and the conceptualization of well-being exists since the 1940s, but has increased in the past decades. The concept has been discovered not just as an *individual* asset, but also as a quality of societies, as the following definition of UNICEF demonstrates (1):

> The true measure of a nation's standing is how well it attends to its children – their health and safety, their material security, their education and socialization, and their sense of being loved, valued, and included in the families and societies into which they are born.

Furthermore, the concept of child and youth well-being was defined as an attribute of the *future* of societies, as is illustrated by this early quote by Bradshaw (2):

> "In any society, the state of our children should be of primary concern – their well-being is not only an indication of a society's moral worth, they are human capital, the most important resource for its national future'

Despite the importance of the concept of well-being, the field is fragmented and lacks taxonomy (3). Definitions and operationalisations of child well-being may be data-driven or theory-driven, represent the current state of a child (well-being) or the future success as an adult (well-becoming), can focus on strengths as well as deficits (4), use objective measures (such as poverty indicators) or subjective measures (such as happiness or life satisfaction) (5).

Despite these inconsistencies, the concept of well-being roughly covers a similar content as the concept of health, as defined by the still prevailing definition of the World Health Organization in 1946: *"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"* (6). In 1984 the WHO delivered a specific definition of mental health: *Mental*
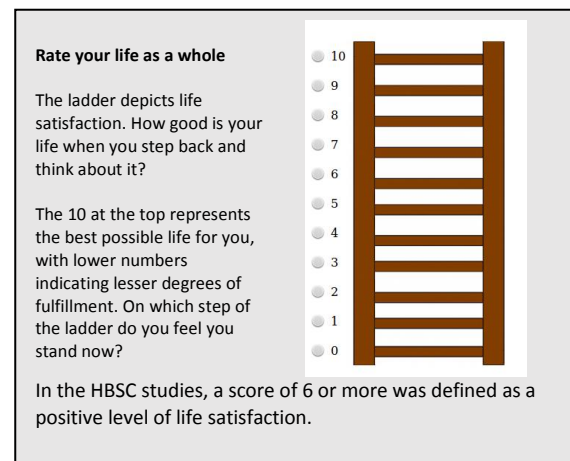
health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community (7). The Mental Health Action Plan 2013-2020 adds: *"With respect to children, an emphasis is placed on the developmental aspects, for instance, having a positive sense of identity, the ability to manage thoughts, emotions, as well as to build social relationships, and the aptitude to learn and to acquire an education, ultimately enabling their full active participation in society"* (8).

The definitions of well-being and mental health share a lot of common content: the well-being definitions approaching this content from a social perspective, the mental health definition from an individual perspective. Subjective well-being and mental health are strongly linked: health influences well-being and subjective well-being influences health and life expectancy (9).

YOUTH WELL-BEING AND MENTAL HEALTH IN EUROPE

Youth well-being

In 2007, UNICEF commissioned a report on indicators of well-being. A multidimensional approach was taken, rooted in the international standards agreed for children in the United Nations Convention on the Rights of the Child (10). Child wellbeing was established on 6 dimensions: material well-being, health and safety, education, behaviours and risks, housing and environment and subjective well-being. The indicators were derived from national registrations and also from the *Health Behaviour in School-aged Children study* (11), an international study carried out in collaboration with WHO Europe. The HBSC self-report research among young adolescents included questions about life satisfaction (such as the Cantril ladder, box 1). The score on this ladder is one of the components of the *subjective* well-being measure in the UNICEF report cards.

Rate your life as a whole

The ladder depicts life satisfaction. How good is your life when you step back and think about it?

The 10 at the top represents the best possible life for you, with lower numbers indicating lesser degrees of fulfillment. On which step of the ladder do you feel you stand now?

In the HBSC studies, a score of 6 or more was defined as a positive level of life satisfaction.

BOX 1: MEASURING LIFE SATISFACTION: THE CANTRIL LADDER (24)

Two years later, OECD derived similar constructs but focused on policy amenable indicators, and compared these to policies and public spending patterns in OECD member countries. The OECD indicators did not include either subjective wellbeing or the child's relationship with parents. The follow-up on the initial report card by UNICEF took place in 2013. Figure 1 represents the outcomes on the overall well-being score, clustered in quintile groups. Figure 1 draws a picture on the distribution of well-being across Europe that is quite consistently found in the different frameworks: Nordic countries scoring high on overall well-being, south-eastern European and Baltic countries scoring low.
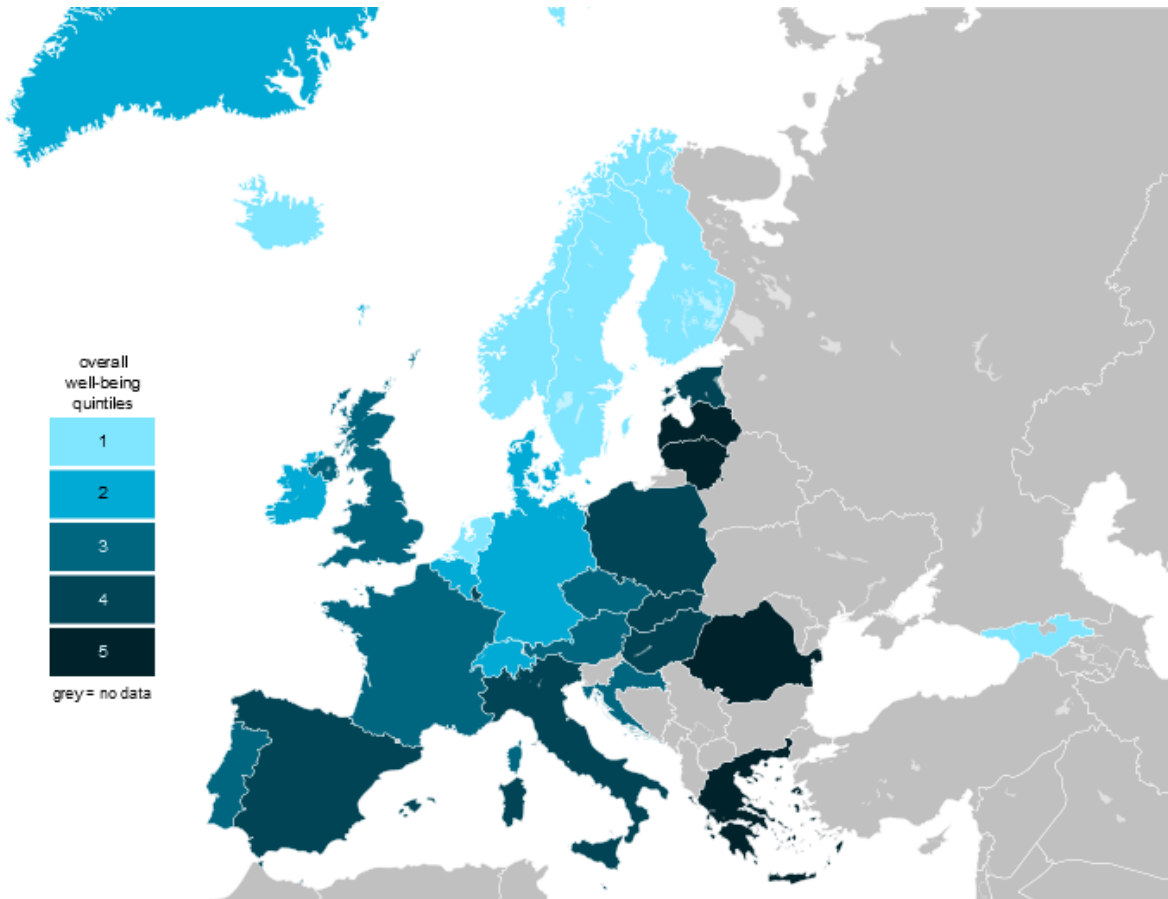
FIG 1: CHILD AND YOUTH WELL-BEING IN EUROPE ACCORDING TO UNICEF FRAMEWORK IN RC11 (25)

Youth mental health

Although mental health and mental disorders are not opposites, and mental health is not just the absence of mental disorder, the prevalence of disorders should tell us something about the average mental health status of a country.

Unfortunately, there are no prevalence studies on mental health that deliver a broad view of the occurrence of psychiatric disorders in children and adolescents in European countries. A summary by Achenbach and colleagues (13) of adequate studies using the instruments Development and Well-Being Assessment (DAWBA) or Diagnostic Interview Schedule for Children (DISC), only comprised 3 and 1 European country prevalence(s) respectively. The ESEMeD /MHEDEA study, a cross-national prevalence study among adults aged 18 years and older using a version of the CIDI (Composite International Diagnostic Interview) comprises too few young adults to make solid statements about international differences in prevalences.

Table 1. Strengths and Difficulties Questionnaire (SDQ): % deviant scores in 11 European Societies	
Austria	13.2
Czech Republic	20.7
France	18.6
Germany	10.0
Hungary	17.9
Netherlands	10.4
Poland	14.7
Spain	15.1
Sweden	12.8
Switzerland	10.0
United Kingdom	23.6
Source: (12)	

On a scale level of measurement, there are various instruments that operationalize mental health. The EU youth report includes only data on mental health ("psychological distress") of 12 countries from the Mental Health Inventory (MHI-5), a 5-item self-report questionnaire. A more substantial measure, the Strength and Difficulties Questionnaire (SDQ) assesses five dimensions of psychological functioning: conduct problems, emotional symptoms, hyperactivity, peer problems, and prosocial behaviour. Table 1 depicts the percentages of deviant total difficulties scores from self-report SDQs completed by 12- to 18-year-olds in school or in telephone interviews in 11 European countries.

The comparison of psychiatric diagnoses or dimensions of psychological functioning across countries is troublesome because the ratings can be performed by different informants: professionals, parents, and teachers or by self-report. These reports remain culturally specific and dependant on for instance the view on normality by the respondent.

This restraint is less applicable to *suicide statistics*. Predominantly, suicide statistics have been collected by a homogeneous group of informants (coroners) for almost a century. Figure 2 represents the quintile categorization of countries based on their suicide rates in 15-19 yr.-old inhabitants. Again, the Baltic states seem to score less fortunate in this respect, but surprisingly, joined by some of the Nordic countries.
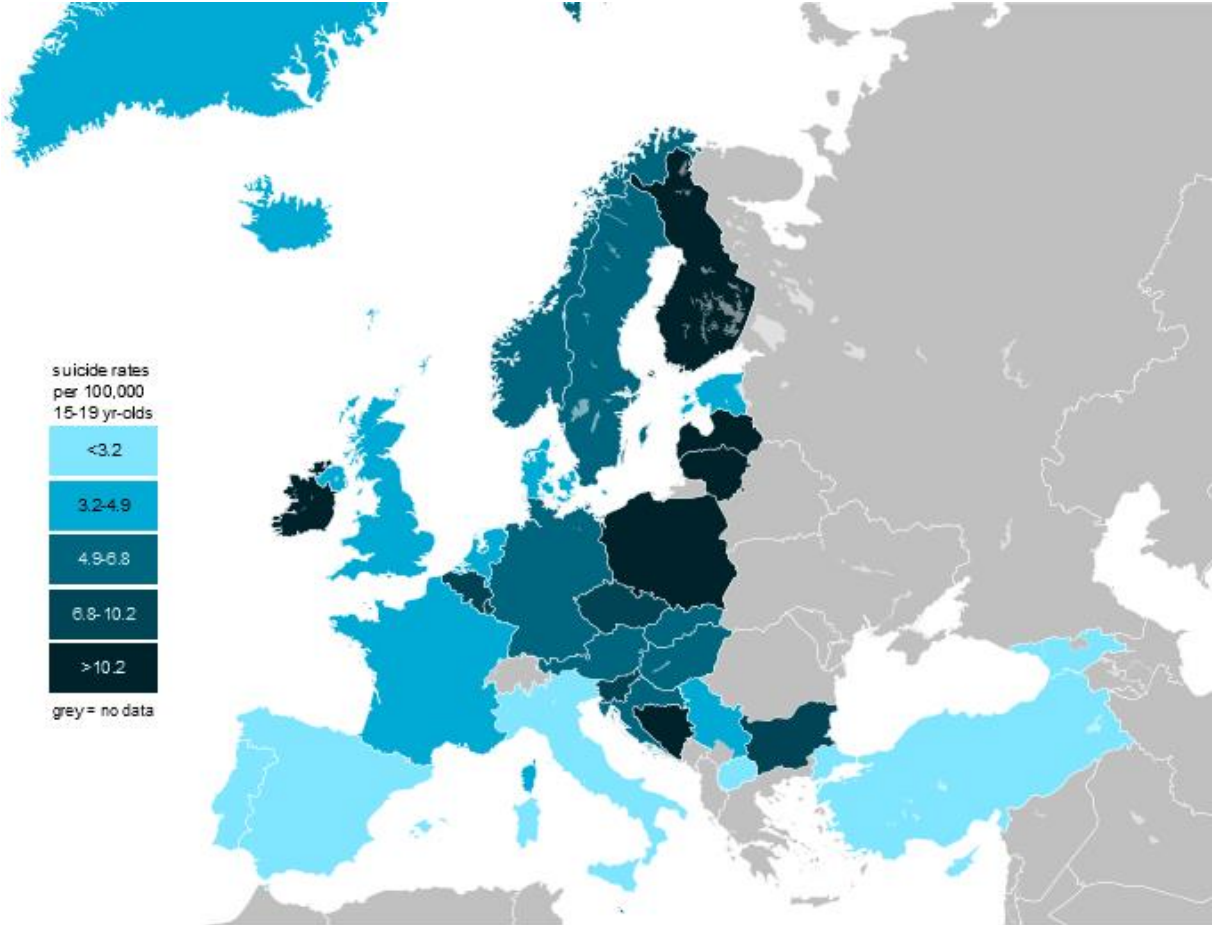

FIG 2: SUICIDE RATES OF 15-19 YR-OLDS IN EUROPEAN COUNTRIES, 2012 (26)

De Wilde, Richardson and Bradshaw (14) analysed this phenomenon (on data from Innocenti Report Card 7) to discover that especially educational well-being correlated with suicide rates: the higher the educational well-being (i.e., school participation and school performance) in a European country, the higher the suicide rates in that country.

FACTORS THAT INFLUENCE WELL-BEING AND MENTAL HEALTH

What are factors that can account for the differences in well-being and mental health of young people in European countries? We'll distinguish factors in different contexts: the societal context and the social context of peers, schools, and families.

SOCIETY

The economic status of a nation matters. There is a positive relationship between the overall child well-being in the EU and GDP per capita. Also, countries that spend above average on families and children in-kind services have higher levels of child well-being (15) .

Common mental disorders are more frequent in disadvantaged populations. A major determinant for mental health is social inequality. In 2014, the WHO summarized social determinants of mental health, underlining that social inequalities are associated with increased risk of many common mental disorders and that giving every child the best possible start will generate the greatest societal and mental health benefits (16).

The 2008 consensus paper of the European Communities (17) concludes that mental health and well-being are essential to positive growth and development. Deprivation, poverty and inequalities in youth increase poor mental health, which in turn leads to poorer outcomes in later life.

Investments in enhanced leisure opportunities could create contexts for improving well-being, especially for youth populations from low-income families (18).

PEER RELATIONS, SCHOOL AND FAMILY

The social networks of children and adolescents are needed to develop positive peer relationships and friendships. They are important for performing developmental tasks. Adolescents who participate in social networks are found to have better perceived health and sense of well-being (19). The relationships with friends appear independently and robustly related to happiness and life satisfaction, both directly and through their impact on health (20).

The current era provides an intensified communication between peers through social media that influences the development as well as the safety of social relations. Bullying through social media may affect both well-being and mental health among children and adolescents (21). Schools have an important role in supporting young people's wellbeing and in acting as buffers against negative outcomes. They are playing field of many preventive interventions that promote well-being in youth.

The family can equip young people to deal with stressful situations, buffering them against the adverse consequences of several negative influences. Young people who can communicate with parents are more likely to report a range of positive health outcomes, such as higher life satisfaction and fewer physical and psychological complaints (19). Caring for the mental health of parents is

essential in prevention and adverse mental health outcomes for their children. Parental distress influences children's life satisfaction (22).

Promoting children's well-being requires an integrated policy approach. It addresses a topic where social policy and health policy should meet and strive at the same goals. The instruments they have may be quite different, the objective should not be; youth is indeed the human capital. The following challenges are instrumental to achieve a higher level of youth well-being and e better mental health for European youth:

Strive for an integrated approach

The promotion of well-being of children and youth implies the improvement of living conditions, safety, health, social engagement, education and work. In all these fields governmental responsibilities exist. Policies should be directed towards improving the qualities of these aspects and reducing inequalities within the country.

To arrive at an integrated (or *holistic*) approach, universal services (such as schools, child care and youth work) should work closely together with preventive services (or primary youth care services), such as child health care, general social work, parenting support. These preventive services aim to detect problems at an early stage, to intervene at an early stage, to coordinate support and to refer children and families specialized services, such as mental health care facilities. A further integrated approach should develop between the in many countries independently operating services for young people and for adults.

Strive for appropriate care

The WHO European Mental health Action Plan, endorsed by the states of the European Region, comprised statements on the right on mental health for everyone, the rights of people with mental health problems (whose human rights should be fully valued, protected and promoted), the accessibility and affordability of mental health services and the quality of these services (8). Well-being includes optimal participation in school or work, not hindered by mental health issues.

As such, specialised mental health care is not by definition appropriate care. In some places, an increase in medicalisation seems to result from flaws in the care referral system (where only certain types of care are subsidized), or from a growing demand of specialist care by parents or teachers. Of course, children and youth who need support should receive that, but they should not receive too much. Everyday behavioural and emotional problems should not automatically lead to referral to care professionals. This implies an empowerment of community and family support capabilities to address problems that do need attention, but not (expensive) specialised care. It also needs a close

The Netherlands: participation and demedicalisation

The past years an increasing number of youth made use of youth (mental health) care services, whereas the proof of a deteriorating state of mental health during the same period is absent.

Current Dutch policy is strongly focused on fostering self-sufficiency among members of the public and reducing government support. The government is seeking solutions that involve demedicalisation, disengagement with the care system, and normalization of mental and behavioural problems.

working relationship between community, education and care.

Strive for well-being in general

Well-being, and in the latest definition, mental health as well, is not merely the absence of trouble. it is important to focus on how to optimize strengths so that children can develop to their full potential and cope with challenging experiences. Communities, families and schools have a great responsibility to provide for the possibilities for youth to do so. Youth participation in education, culture, sport and employment should be a cornerstone of youth policy. This may invoke the need to change from a problem-oriented policy approach to a non-problem oriented youth policy (development of 'positive youth policy') aimed at all children and young people and not only at young people with problems or young people at risk.

Do what works

Choose treatments, educational programs, support methods and policy strategies that provide insight into the quality, feasibility and effectiveness. In this way, professionals, researchers, quality officers, policy makers and financers know to what extent an intervention is considered to work and/or is feasible. Connecting science to practice and policy is essential in this respect.

Monitor progress and induce learning

There is still a serious shortage of cross-country comparable information on mental health and well-being. The same applies to the quality of services and local policies that intervene on these outcomes. We suggest that a measure-learn cycle on this phenomenon does not really exist on a European level, let alone on a national level. To this end, researchers, policy makers, statistical bureaus and mental health practitioners need to join hands. Quoting Richardson (23): "Governments should update policies and programmes for children, learning lessons where they can from comparable countries that are working on the same issues. These policies and programmes need to be rigorously evaluated to see whether they enhance child well-being".

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