Are we looking after our children?

An assessment of two European countries

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Executive Summary

In 2013, the Joint Action Plan for Mental Health and Well-being (JA-MH-WB) was launched as a collaborative effort by the European Union and the 28 Member States. It aims were to build a framework for action mental health policy at the European level and builds on previous work developed under the European Pact for Mental Health and Well-being in 2008 (The Joint Action Plan for Mental Health and Well-being, n,d).

This dissertation examines one area highlighted by the JA-MH-WB: Mental Health & Schools. The scope of this dissertation is limited a) to the Netherlands and Hungary, and b) "schools" are defined as the youth population of 0-18 years whom pass through their respective educational systems. The central question of this dissertation is therefore as follows; 'what are the strengths and weaknesses of the Joint Action Plan for Mental Health and Well-being in the sector 'Mental health and schools' in the Netherlands and Hungary'?

The JA-MH-WB is in response to the significant mental health issue in the EU. The JA-MH-WB presents a series of objectives, which it recommends that the Member States address. It is hampered by a lack of specified goals and the lack of means at EU level to stimulate or enforce Member States to act. This dissertation examines the different organizational approaches taken by the Netherlands and Hungary, considers challenges and how funding, resources and information are disseminated.

Progress seems to have been made in both countries, however, there are few seminal documents available to calibrate actions undertaken. Changes in the status of the mental health of a population will also be difficult to quantify at a national level until many years. The true impact of the JA-MH-WB is expected require several years of continued effort by politicians, government officials and agencies, health care professionals etc. Some of the reported immediate challenges and concerns are presented such as funding and resources. Available data shows that a response to mental health is essential for the economic and social wellbeing of the EU. The JA-MH-WB is a European wide initiative, which similar to other EU Joint Action Plans can be improved through continued energy and focus. Some opportunities for research and improvement to the Plan are presented.

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Glossary

Abbreviation	Definition
ADHD	Attention Deficit Hyperactivity Disorder
AMBZ	Algemene Wet Bijzondere Ziekekosten – Dutch law of special healthcare costs
CBS	Centraal Bureau voor de Statistiek (Dutch National Statistics)
CHAFEA	Consumers, Health, Agriculture and Food Executive Agency
CHE	Current Health Expenditure
DALY's	Disability Adjusted Life Years
DG Sante	Directorate-General for Health and Food Safety
EuroStat	European Statistical Office
ESH	European School of the Hague
EU	European Union
FNV	Federatie Nederlandse Vakbeweging – Dutch Trade Union
GDP	Gross Domestic Product
GGZ	Geestelijke Gezondheidszorg – Dutch mental healthcare
JA-MH-WB	Joint Action Plan for Mental Health and Wellbeing
KSH	Központi Statisztikai Hivatal - Hungarian Central Statistical Office
LSE	London School of Economics
NOS	Nederlandse Omroep Stichting – Dutch National News
NVO	Nederlands Vereniging van Pedagogen en Onderwijskundigen
NVK	Nederlands Vereniging voor

	Kindergeneeskunde - Dutch Society of Pediatrics
NVvP	Nederlands Vereniging voor Psychiatrie - Dutch Society for Psychiatry
OECD	Organisation for Economic Cooperation and Development
SGGZ	Specialistische GGZ – Specialised Dutch mental healthcare
SMART	Specific, Measurable, Attainable, Realistic, and Timely
TFEU	Treaty on the Functioning of the European Union
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNICEF	United Nations Children's Fund
USD	United States Dollars
WHO	World Health Organisation
Wlz	Wet langdurige zorg – law long-term care
Wmo	Wet maatschappelijk ondersteuning – social support law
Zvw	Zorgverzekeringswet – healthcare law

"Mental pain is less dramatic than physical pain, but it is more common and also more hard to bear. The frequent attempt to conceal mental pain increases the burden: it is easier to say; "My tooth is aching" than to say, "My heart is broken."

— C.S. Lewis, The Problem of Pain, 1940

1. Introduction

With the creation of the European Union (EU) in 1992, there was an effort to include healthcare in Europe with Art. 168 of Treaty on the Functioning of European Union (TFEU). The article gave the EU the right to formulate actions about both physical and mental health. Currently the World Health Organization states that around 20% of all children and adolescents globally suffer from mental health issues (Child and adolescent mental health, 2019). It is therefore of huge importance that the EU work together with Member States in order to minimize the risk on European children.

The Joint Action Plan for Mental Health and Wellbeing (JA-MH-WB) was a Plan from 2013 to 2016 funded by the European Agency for Health and Consumers. The objective of the Plan was to contribute to the promotion of mental health and well-being, the prevention of mental disorders and the improvement of care and social inclusion of people with mental disorders in Europe (The Joint Action Plan for Mental Health and Well-being, n,d). The Plan addresses issues related to five areas, one of them being 'Mental health and schools. This dissertation is specifically concerned with mental health of school children between the ages of 0-18.

This dissertation contrasts and compares two countries, the Netherlands and Hungary in the section 'Mental health and schools' as well as analyzes the strengths and weaknesses of the Joint Action Plan in general and in the Member States. The assessment of the impact of the Joint Action Plan ought to be considered in a number of ways. The consequences of the initiatives taken by the Member States about mental health may not be seen within the timeframe of the Joint Action Plan and may only be apparent years later. Health statistics will be taken from 2013 to 2016, however this period may still be too short to bridge a connection between action and result.

The comparison of two countries within the EU is also useful from a number of aspects, such as analyzing the changes in reported health parameters where similar approaches have been taken and secondly to understand the availability of services and infrastructure upon mental health programs. As such, this dissertation is to attain what are the advantages and disadvantage of the Joint Action Plan for Mental Health and Well-being (JA-MH-WB) and whether it managed to attain its goals in the sector of 'Mental health and schools'. As a result the research question that this dissertation will be answering is; 'What are the strengths and weaknesses of The Joint

Action For Mental Health and Wellbeing in the section ‘Mental Health and Schools’ in The Netherlands and Hungary?

2. Methodology

This chapter discusses the methods used to address the research question and highlights the practicality and appropriateness of the methods vetoed from use.

2.1 Use of secondary data

This dissertation relies primarily on secondary data. Secondary data was accessed by extensive desk research and includes a wide range of sources of varying degrees of relevance. Examples, some to be discussed in the Literature Review, are institutions or agencies, such as the World Health Organization (WHO), European agencies (Eurostat), national government agencies (CBS & KSH), academic institutions and independent researchers.

The objective of this research topic is problematic to address through primary research methods. This is due to the fact that the research is primarily an assessment of an initiative undertaken almost four years ago. The lack of a European wide database for mental health makes any research into this topic more complicated as data needs to be sourced from multiple references, mainly national and third-party databases. Whilst there are lobbying groups such as Mental Health Europe and Schools for Health that advocate for positive mental health and well-being in Europe. There is no single "investigation site" which a researcher can "jump into". The topic is a pan-European, national and locational subject, so by default a more distant and holistic assessment is required. Primary research is feasible, however this is would be outside the scope of a bachelor thesis and more suited to a master or postgraduate doctoral degree. Fortunately, there are several advantages of using secondary research for these form of research questions.

According to Saunders, Lewis & Thornhill (2000), secondary research is inexpensive and readily available. With the ready access to multiple data sources and alternative sources, academia vs. social media, governmental agencies vs. independent institutes, a wider and richer range of accessible data is possible, within a very short period of time. Validation of data and information from a wider set of secondary data also allows triangulation and comparisons unavailable from a narrow primary data source. Additionally, secondary data could provide a source of data that has already been peer reviewed, giving the data a level of accreditation and authenticity. In many cases, secondary data research is undertaken as the primary stage of research (the initial

screening) to identify knowledge gaps and refine the research question of a subsequent investigative research topic.

Saunders, Lewis & Thornhill (2000), also states several disadvantages of secondary data and respective approaches. The definitions and aggregations that were collected by other researchers could be inappropriate or have no relevance to the question that is being answered. Additionally, the secondary sources may represent the interpretations of those who produce them and are therefore unable to give an objective view. In other words, the secondary sources may be biased and the combination of these "filtered" data sets will only further skew or distort the information. This challenge is quite valid when dealing with desktop research supported by the Internet search engines. The ability to find a wide enough and relevant set of information could be limited purely by the ability to use the Internet search engines, the search mechanism of the engine itself, the choice of search words or phrases, and whether the information is actually accessible via the web.

To address these challenges, prior to commencing the search, a brainstorming session was undertaken to consider the various agencies that might collect, use or supply this information. The individual agency websites were then assessed to validate that the sources would be considered "trusted". There remains the question of reliability: how to compare a newspaper report to a social media post, a document issued by the one of the offices of the European Union vs. a report from an agency of a government, etc. To address this quandary all sources presented in this dissertation are considered trusted sources and only when the data presented is conflicting each other, these points are highlighted. The sources that were used in this dissertation are taken from governmental sources, non-profit organizations, academia and media. Most statistics and figures were taken from national statistics centers, such as the suicide rates in the Netherlands and Hungary. Any other figures were obtained from independent researchers or from academic papers. Utilizing data from a wide range of trusted sources will provide a comprehensive understanding of the issue, while minimizing individual biases.

2.2 Interviews

The author conducted two interviews for this paper. The JA-MH-WB was under review was from 2013 to 2016, with this research paper written in 2019. Purely from a logistical perspective, the

people directly supporting the Action Plan meet difficult to meet in 2019, the author had approached several mentioned in the Joint Action Plan to no avail. Secondly due to the fact that this dissertation is written about children from the ages 0-18, this brings certain legal dilemmas when trying to collect data in the form of a questionnaire. To address this concern this study relied on interviews from professionals inside the field of education and psychology.

Prior to and at the commencement of each interview, those interviewed were requested to give their consent. The first interviewee consented to being referenced in the appendix but did not wish their name to be used in the main body of work. As a consequence, this dissertation will refer to the first interviewee by their job title. The second interviewee consented to being recorded and their name used in the main body of work.

The first interview conducted was with an orthopedagogician (an orthopedagogician is a healthcare professional who gives assistance to those who have problematic educational situations). This interview was conducted over the phone due to time constraints and geographical location of the interviewee. The orthopedagogue is an accredited member of the Dutch National Society of Orthopedicians (NVO). The orthopedagogue spent just under four years working for YOEP (a child and adolescent psychiatric practice) within the Dutch mental healthcare system (GGZ) primarily working with children with attention deficit hyperactivity disorder (ADHD). They have recently started their own practice. The second interview was conducted in person. Stephanie Kustner is a school psychologist working for the European School of the Hague (ESH). She has spent her career as either a psychologist for primary or secondary education or teaching in her field at various universities the most recent being the Hague University of Applied Sciences and the Leiden Hogeschool.

The interviewees were chosen because of their professional relevance to the scope of the question posed in this dissertation.

Both interviews started by establishing whether they had heard of the JA-MH-WB. The interviews then turned to their experiences in their respective fields in the healthcare sector. Some of the questions asked during the interview were as follows;

- Is there cooperation between different sectors (schools, psychologists, GGZ and any other healthcare providers), and is there a need for more?
- Has the number of children and adolescents with mental health issues increased or stayed the same over the last decade?
- Or have the cases (with children with mental health issues) increased in severity?

The author had in preparation formulated several different possible questions depending on the course of the conversation. The questions asked were tailored to the interviewees' respective fields of expertise and therefore differed slightly in nature. During the course of both interviews other questions were posed in response to the answers given by the interviewee.

The length of both interviews was approximately 30 minutes. The interview with Stephanie Kustner was recorded via audio (*Appendix 3*) and the interview with the orthopedagogician was not, as the interview was conducted over the phone, and has been paraphrased in *Appendix 2.*

2.3 Case studies; Netherlands and Hungary

The author has chosen to use the Netherlands and Hungary as two case studies. The Joint Action Plan for Mental Health and Well-Being is a European wide plan. Studying all the European countries in this plan would be too broad of a scope for a bachelor's dissertation.

The Netherlands was chosen as a subject country because the author resides in the country and is fluent in Dutch. Hungary was chosen because the author was curious to know if there was a difference in healthcare between West and East Europe. Furthermore, Hungary only joined the EU in 2004 compared to the Netherlands which has been part of the European Community and the European Union since inception. In addition, the author's father works in Budapest, speaks Hungarian and would be able or arrange to translate governmental documents if needed.

For the case studies, information was gathered via governmental sources, academia and media outlets. Statistics used were obtained from either the Dutch National Statistics (CBS) or the Hungarian Central Statistical Office (KSH) or from third party independent sources such as the

Organization for Economic Co-operation and Development (OECD) or the World Health Organization (WHO).

2.4 Limitations to the research and the methods taken

There are several limitations to this dissertation. The first has already been stated; that there is an unavailability of certain sources. This is either due to the fact that these sources do not exist or because the data is not available yet, or has not been published. For example, the data for which the OECD and WHO use to formulate their views is only compiled every few years. In the report Health at a Glance: Europe 2018, the OECD used data ranging from 2014 to 2016. As of writing, some of the data for 2016 has not yet been published. Secondly, as this dissertation heavily relies on secondary sources, much of the data used in the secondary sources are form before 2016. This has restricted the amount of data and sources that were available to the author. As well as impacted the conclusions that the author can make about the strengths and weaknesses of the Joint Action Plan as the effects of the JA-MH-WB are unclear. Lastly, the author overestimated the amount of resources available about Hungary. The language barrier was for the author an obstacle, this in additional to the limited research and data available from the KSH limited the conclusions the author could make about the effects of the Joint Action Plan in Hungary.

Furthermore, this is the first time that the author has conducted interviews for research. As a consequence, the interviews, while well prepared, were informal. The author let the conversation flow naturally, building rapport with the interviewee and creating an open conversation. As a result, some of the questions where not posed in the order they were formulated or not asked at all as they had already been discussed during the conversation. Secondly due to time and geographical constraints, no interviews were held with Hungarian healthcare professionals. This has left the research conducted in this dissertation skewed in favour of the Netherlands.

Furthermore, this dissertation only has a limited amount of time available for the size and scope of the research topic. This meant that constraints need to be applied to allow for a meaningful and cohesive document to be constructed. Essentially by default a secondary source approach is the main means to gather information for this dissertation. Using existing statistics obtained by

the government posed no ethical implications for access or data privacy. It is recognized, nonetheless, that the points above could easily be a PhD research topic where some of these limitations overcome.

A final constraint to the research topic is that the duration of this study is a brief look at the status of mental health. The span of this study is insufficient to analyze all the consequences of the actions taken by the Member States. This is due to the fact that whilst local laws, initiatives and actions may have promulgated and reported, it may take several years before there is any impact or a return on the implementation of the Joint Action Plan or its recommendations.

2.5 Ethics

Ethics issues for secondary data research can be more complex than one might initially consider. There are responsibilities to the research presented, the original researchers, to the context under which the research was performed. Secondary data sources might have reference to individuals or specific groups, and as such their right to privacy and confidentiality need to be considered. A clear example in this dissertation is the participation of those interviewed and how their wishes are to be honoured. There is also the basic ethical approach of any research that it must be undertaken using a methodologically rigorous manner, which the author follows as steadfastly as possible.

The majority, if not all data shared in this dissertation does not specify any individual, any specific group, location which could allow specific subjects to be identified. The documents have been desensitized from this perspective. Therefore, there is low chance of any ethical issue being created in this manner.

This dissertation presents primary and secondary source data issued by governments and their representative bodies, international institutions, research papers as well as from the media. A key concern from an ethics perspective is to whether this data can be presented side by side as supportive or comparable information. None of these sources present in detail their methodologies and the data filtration/selection processes which they used to reach their conclusions. This lack of transparency can lead to doubt to whether this information can be presented and whether undue weighting on one data source compared to another might lead to unrepresentative conclusions and recommendations. Conversely several of these sources co-

reference each other, which either infers that these sources have already addressed this concern and negated it or everyone has the same problem and does not know what to state. This author argues that since many of these information sources are governmental that some level of regulation has occurred and that the issue of misuse from an ethical perspective or methodological bias has been mitigated.

A further challenge to secondary research and how it handles primary research is the challenge of selectivity. It would be incorrect and inappropriate to present only a limited set of relevant data from a primary resource without mentioning that other similar data is not presented. In this dissertation no filtration of primary source data is undertaken, data is presented as delivered.

Ethics is mentioned above from an access or data privacy perspective, Ethical dilemmas were previously mentioned through the lens of data access and data privacy perspectives, however additional ethical issues are also inherent in the author's own ethical position and intrinsic bias as the author also carried the role of the researcher, therefore questions such as how does one select sources, analyze data, and present the results of the work must also be examined via an ethics perspective. This dissertation has addressed this challenge by ensuring that the Author's opinion is limited to the Analysis, Conclusion and Recommendation sections.

3. Literature Review

This chapter discusses the research obtained through secondary research in order to give the reader a better contextual understanding of the effects, globally and in Europe of mental health issues.

3.1 Modern Mental Health in a Nutshell

This subchapter gives a brief overview of the modern history of mental health.

The subject of physical health and mental health in combination with productivity has been present across the globe probably since the industrial revolution (Plante, 2013). Mental health is a modern concept. Historically mental disorders were seen as symptoms of insanity and in medieval times patients were treated by bloodletting and other 'curative' methods (Plante, 2013). The concept of a healthy worker and a productive worker was a concept that emerged during this time. While during the industrial revolution was focused more on the physical health of the worker than the mental health (Plante, 2013).

From the beginning of the last century, debates considering how health could be linked to civic obligations became common. In many western countries, people were encouraged to consider their collective and communal responsibilities, and soon many aspects of their lives became regulated in the name of public health (Bertelote, 2008). Many ideas permeated across the globe and medical colleges, modern hospitals, and dispensaries appeared. A major role in this dissemination of understanding and civic responsibility was orchestrated and influenced by the media. Nowadays, all sorts of newspapers and journals in a myriad of languages spread the latest thoughts and medical knowledge across the planet (Bertelote, 2008). However, most of the changes made in the name of public health were in response to physical complaints. Mental health, however, was not a priority. Hence there is limited literature about mental health before the industrial revolution.

The Mental Health Foundation in the UK was founded 70 years ago in 1949 ("70 years of the Mental Health Foundation", 2019). Their website states:

"In the 1950s, ignorance about mental health meant that there was extreme stigma and fear surrounding it. People with mental health problems were considered 'lunatics' and 'defective' and were sent off to asylums. 'Insanity' was thought to be incurable and there was no incentive to treat it" (70 years of the Mental Health Foundation", 2019).

This position can be considered as somewhat extreme from a 2019 perspective. An European Mental Health organisation was not founded until 30 years ago with the creation of Mental Health Europe (Who we are, 2020)

In 2015, Mr. Shekar Saxena of the World Health Organization (WHO), at a conference in Santiago highlighted several global problems. For example, the cost of illnesses worldwide (determined by the World Economic Forum) was expected to increase from USD 2.5 trillion in 2010 to USD 6 trillion in 2030. The value of lost lives would increase over this period from USD 8.5 trillion to USD 16.1 trillion. Furthermore, a review of the Global Burden of Disease indicated that since the 1990's mental health and neurological diseases has steadily increased and now were within the top 15 of 306 diseases and illnesses worldwide. One of the final data points that was mentioned during Saxena address was the Disability Adjusted Life Years (DALY's) of people with mental health illnesses (Saxena, 2015).

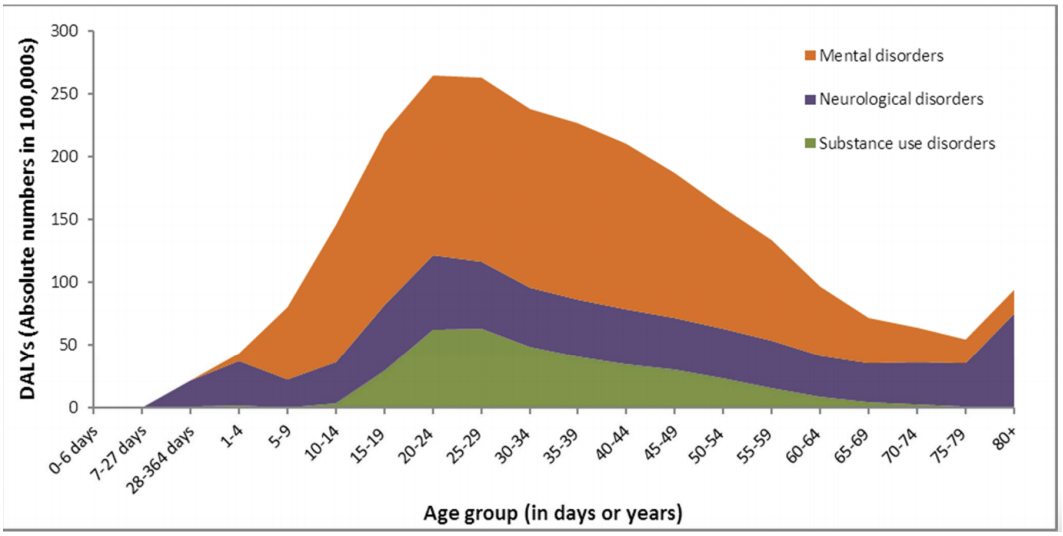

Figure 1. The Potential Life Lost Due to Premature Mortality and the Years of Productive Life Lost Due to Disability in 2010 (Saxena, 2015)

Figure 1, shows the potential life lost due to disability whether it be mental or physical. The potential loss of life and productive years due to mental health issues is coloured in orange. The potential for loss of life and productive years due to mental health issues is already apparent since before the age of four. The recognition of health and especially mental health is therefore a global and current issue. This dissertation now refines its focus to Europe and specific Member States.

3.2 Mental Health in the European Union in a Nutshell

3.2.1 Legal Structures

This subchapter discusses the legal basis on which the EU can make legal acts on healthcare within the EU.

The EU Treaties form the basis of the rule of law within the EU. Every action and law passed in the EU has to have a basis in the EU Treaties. If a policy area in not in a Treaty, then the EU does not have a mandate to make legislation in that area. There are several different forms of EU legal acts. All find their legal basis in the EU treaties. Binding legislation are Directives, Regulations and Decisions. Non-binding legal acts are defined as Recommendations and Opinions. Some of these legal acts are for all EU countries, and some are not (Regulations, Directives and other acts, 2019).

Mental health has been a European policy since its inclusion in the Treaty of Maastricht in 1992. Article 168 of the Treaty on the Functioning of the European Union (TFEU) states that *'Union action, which shall complement national policies, shall be directed towards improving public health, preventing physical and mental illness and diseases'*

Duncan (2002) states that European Union health policy is a paradox. This is due to the fact that the EU was mandated by Art. 168 TFEU to fund health projects on an European level but not given the right to implement directives or regulations that would harmonize public health measures in the EU.

Furthermore, with the implementation of the Treaty of Amsterdam in 1997 the EU was mandated to 'fully respect the member states responsibilities for the organization and delivery of health services and medical care' (Treaty on the Functioning of European Union, 2007). This drastically limited the scope of the European Union to improve health services to European citizens.

The Lisbon Treaty of 2007, reiterated the initiatives and focus of the 1992 Treaty of Maastricht, however, also perpetuates its level of power and influence. Effectively the Treaty has been given the power to have an opinion but not given the power to legislate.

The European Union was able to make legislation under Article 168 TFEU in the areas of cross-border healthcare, pharmaceuticals and medical devices and tobacco. All the laws that the EU has passed can be traced back to the four main principles of the Single Market Act. The Single Market Act of 1993 is an act in which the freedom of movement, people, goods and services is assured. No directives specifically focused on mental health have been passed.

3.2.2 European Health Initiatives

This subchapter discusses the physical and mental health initiatives undertaken in the European Region and by the European Union.

Utilizing Art. 168 TFEU, the EU has also issued various different recommendations since the turn of the century. Examples being;

- 'Prevention of drinking alcohol by young people' (2001)
- 'Prevention of health-related harm associated with drug dependence' (2003)
- 'Prevention of injury and promotion of safety' (2007)
- 'Patient safety, including the prevention and control of healthcare associated infections' (2009)
- 'Action in the field of rare diseases (2009)
- 'Smoke-free environments' (2009)

- 'Seasonal influenza vaccination' (2009) (Examples of Council recommendations to Member States for the purposes of Article 168 - Public Health, European Commission", 2019)

In 2005, the European Commission and the Health and Consumer Protection Directorate-General issued a Green Paper titled '*Improving the mental health of the population: Towards a strategy on mental health for the European Union'.* Green papers are meant to initiate a discussion about a certain topic. The Commission outlines an issue and invites stakeholders to participate and discuss the topic. Recommendations and solutions are given as well (Glossary of summaries, 2019). In this case mental health in the European populace.

As a result of the Green paper in 2005, the European Commission and the 28 Member States participated in a conference in Brussels in 2008 to *'acknowledge the importance and relevance of mental health and well-being for the European Union, its Member States, stakeholders and citizens'* (European Union, Health & Consumer Protection, Directorate - General, 2005). Furthermore, it recognized that mental health is a human right and that it is in the interest of the European Union as a knowledge-based society and economy that its citizens are healthy.

The Pact (2008) has five calls for action.

1. Prevention of Depression and Suicide
2. Mental Health in Youth and Education
3. Mental health in Workplace Settings
4. Mental Health of Older People
5. Combating Stigma and Social Exclusion

The Pact was also an open invitation to various different stakeholders and actors across different sectors and parts of civil society.

In 2013, as a continuation of the Green Paper in 2005 and the European Pact in 2008, the European Union made a Joint Action Plan for Mental Health and Well-being. This Joint Action Plan had five main pillars.

1. Depression, suicide and e-health
2. Community-based approaches
3. Mental health at workplaces
4. Mental health and schools
5. Mental health in all policies

The increasing need to include mental health as one of the main priorities in the public health agenda. The plan states that the *'JA-MH-WB wants to contribute to the promotion of mental health and well-being, the prevention of mental disorders and the improvement of care and social inclusion of people with mental disorders in Europe*' (The Joint Action Plan for Mental Health and Well-being, n,d). This dissertation concentrates on pillar 4: Mental health and schools and look at children aged 0-18. The goal for this pillar was to '*To develop an action framework for cooperation between the health, social and education sector the management of mental disorder prevention and mental health and well-being promotion, including educational attainment, among children and adolescents as part of a commonly endorsed action framework on mental health and well-being in Europe'* (The Joint Action Plan for Mental Health and Well-being, n,d).

The Joint Action Plan for Mental Health and Well-being is funded by the Consumers, Health and Food Executive Agency (CHAFEA) an European agency set up by the European Commission to manage four programmes: health, consumer protection, food safety and the promotion of European agricultural products (The Joint Action Plan for Mental Health and Well-being, n,d). The Joint Action Plan is organized into 5 areas of work (1) Depression, suicide and e-health, 2) Community-based approaches, 3) Mental health at workplaces, 4) Mental health and schools and 5) Mental health in all policies) with 3 transversal working groups in charge of management, dissemination and evaluation. A Steering Committee, compromised of the Coordinators of these working groups were responsible for the implementation of the Joint Action Plan (The Joint Action Plan for Mental Health and Well-being, n,d).

Alongside the JA-MH-WB, the WHO released their seven-year plan on mental health in 2013. This plan included all members of the European Region not just the EU-28.

The WHO European Region plan has 7 objectives:

- *Objective 1: Everyone has an equal opportunity to realize mental well-being throughout their lifespan, particularly those who are most vulnerable or at risk*

- *Objective 2: People with mental health problems are citizens whose human rights are fully valued, respected and promoted*
- *Objective 3: Mental health services are accessible, competent and affordable, available in the community according to need*
- *Objective 4: People are entitled to respectful, safe and effective treatment*
- *Objective 5: Health systems provide good physical and mental health care for all*
- *Objective 6: Mental health systems work in well-coordinated partnership with other sectors*
- *Objective 7: Mental health governance and delivery are driven by good information and knowledge'*

The WHO Plan went into greater detailer on how they were to achieve these objectives proposing several points of actions for WHO European Member States and points of action for the Regional Office (World Health Organization Regional Office for Europe, 2015). The WHO plan also places an emphasis on removing the stigma surrounding mental health issues and the adverse effects it has on accepting mental health and solving the issues surrounding it. Most importantly the WHO Plan spans 7 years, ending in 2020, compared to the Joint Action Plan which only spanned 3 years from 2013-2016. Pescosolido (2008) defines stigma as an attitude that makes a person 'tainted', 'devalued', 'compromised and 'less than fully human'. The paper further stated that the issue of stigma is significant for public health because it is one of the social causes of disease which comprises a person's ability to cope with mental illness, produces stress and exposes them to other disease-producing conditions (Pescosolido, 2008). The JA-MH-WB does not place this emphasis on the need to displace stigma as the WHO plan but rather emphasizes the promotion of mental health issues and the need to establish a collaborative network of stakeholders.

3.3 The cost and economic burden of mental health issues

This subchapter will discuss the economic and social consequences of mental health issues in Europe.

Several studies have been done over the years in order to shed light on the mental health situation in the European Union. The London School of Economics (LSE) published a paper in 2008 about the economics behind mental health e.g. how health systems are financed, how much

funds are allocated yearly to mental health, the cost and the potential loss of productivity and income loss due to unresolved mental health issues (See Figure 3).

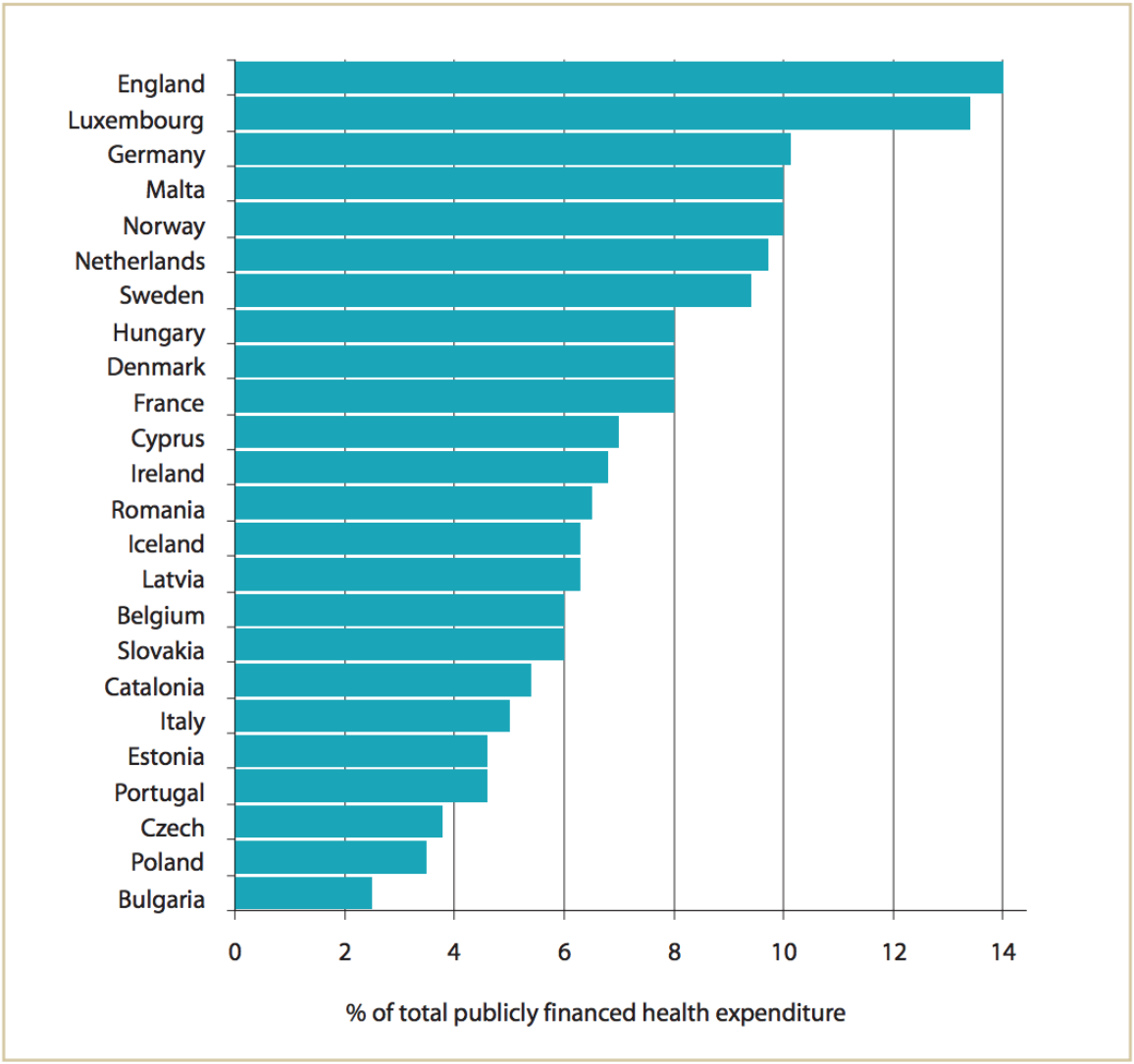

Figure 2. The Percentage of Public Health Expenditure Designated for Mental Health (MHEEN Network, 2008)

Figure 2 above shows a huge difference in mental health expenditure in the European Union. This data ought not to be used to suggest that those living in the Netherlands are far unhealthier than those living in Hungary, it also suggests that the funding priority to mental healthcare does not seem to be the priority (MHEEN Network, 2018). It should be mentioned that both the

Netherlands and Hungary appear, compared to other European countries, above 8% of their healthcare budget on mental healthcare. Possibly the wrong metric is being used to present the focus on mental health however, this graph does show a tremendous percentage difference in spending on European citizens.

In 2011, Wittenchen and his colleagues published a paper about the size and burden of mental disorders in Europe in 2010 (Wittechen et al. 2011). They estimated that 38.2% of the EU population suffers from a mental disorder. The paper further calculated based on age and comorbidity that this roughly corresponds to 164.8 million people. In 2010, the European Union had a population of 502.2 million people in 2010 (EuroStat, 2018). The paper further states that the '*most frequent disorders are anxiety disorders (14.0%), insomnia (7.0%), major depression (6.9%), somatoform (6.3%), alcohol and drug dependence (>4%), ADHD (5%) in the young, and dementia (1-30%, depending on age)*' (Wittechen et al. 2011). The paper concludes that over a third of the European Union suffers from one type of mental disorder. They further state that the true size and burden of mental health issues in the EU has been significantly underestimated in the past. Wittenchen recommended a substantial increase in funding for basic, clinical and public health research in order to provide better care for the prevention and treatment of mental health.

Over the years, several different mental health projects have been funded in the EU and worldwide. In 2016, the final year of the Joint Action Plan for Mental-Health and Well-being, Haza et al, published a study on the research health programmes funded by the EU in the period 2007-2013. Of the projects funded only 0.8% were specifically dedicated to mental health and another 0.7% being only partially related to mental health. In total they received 1.4% of the available funding which equates to €607.1 million (Haza et al, 2016). Across EU countries, there were huge variations in funding. The study done by Haza et al, (2016) concluded that the EU funding for mental health research did not match the current needs.

3.3.1 Direct and Indirect costs

This chapter will discuss the direct and indirect costs of mental health issues, considering differences between The Netherlands and Hungary.

In the 2005 Green Paper on Mental Health, the European Commission calculated that mental illnesses cost the EU an estimated 3%-4% of total GDP (close to Euro 20 million), mainly through lost productivity. Trautmann, Rehm and Wittchen (2016) stated that *'the cost of mental disorders*

in a defined population can be quantified as lost economic output by estimating the projected impact of mental disorders on GDP. The major idea behind this approach is that economic growth depends on labor and capital, both of which can be negatively influenced by disease'. The study went on further to lament that the true economic cost of mental illnesses could only be estimated indirectly because DALY's are calculated based on somatic diseases.

Gustavanson et al (2012) estimated that the costs in 2010 of mental disorders totaled at €798 billion. They further concluded that:

''Direct costs constitute the majority of costs (37% direct healthcare costs and 23% direct non-medical costs) whereas the remaining 40% were indirect costs associated with patients' production losses. On average, the estimated cost per person with a disorder of the brain in Europe ranged between €285 for headache and €30,000 for neuromuscular disorders. The European per capita cost of disorders of the brain was €1550 on average but varied by country. The cost (in billion €PPP 2010) of the disorders of the brain included in this study was as follows: addiction: €65.7; anxiety disorders: €74.4; brain tumor: €5.2; child/adolescent disorders: €21.3; dementia: €105.2; eating disorders: €0.8; epilepsy: €13.8; headache: €43.5; mental retardation: €43.3; mood disorders: €113.4; multiple sclerosis: €14.6; neuromuscular disorders: €7.7; Parkinson's disease: €13.9; personality disorders: €27.3; psychotic disorders: €93.9; sleep disorders: €35.4; somatoform disorder: €21.2; stroke: €64.1; traumatic brain injury: €33.0.''

The total cost of mental illnesses as a percentage of GDP has increased since the publication of the Green Paper in 2005. The OECD currently places it at over 4% of GDP totaling, at over 600 million Euros across the EU-28 in 2015 (OECD, 2018).

	Total costs		Direct costs				Indirect costs	
			On health systems		On social benefits		On the labour market	
	in million EUR	% of GDP	in million EUR	% of GDP	in million EUR	% of GDP	in million EUR	% of GDP
EU28	**607 074**	**4.10**	**194 139**	**1.31**	**169 939**	**1.15**	**242 995**	**1.64**
Austria	14 930	4.33	4 686	1.36	3 902	1.13	6 342	1.84
Belgium	20 740	5.05	5 447	1.33	5 845	1.42	9 448	2.30
Bulgaria	1 067	2.36	448	0.99	299	0.66	320	0.71
Croatia	1 785	4.01	525	1.18	537	1.21	724	1.63
Cyprus	569	3.21	203	1.14	144	0.81	223	1.25
Czech Republic	4 132	2.45	1 727	1.02	1 046	0.62	1 360	0.81
Denmark	14 627	5.38	3 431	1.26	5 563	2.05	5 633	2.07
Estonia	572	2.81	210	1.03	167	0.82	196	0.96
Finland	11 140	5.32	2 576	1.23	3 884	1.85	4 681	2.23
France	81 345	3.71	29 337	1.34	26 437	1.20	25 570	1.17
Germany	146 536	4.81	43 421	1.43	40 939	1.35	62 177	2.04
Greece	5 311	3.01	2 241	1.27	1 440	0.82	1 630	0.92
Hungary	3 454	3.12	1 417	1.28	703	0.64	1 333	1.20
Ireland	8 299	3.17	2 232	0.85	1 891	0.72	4 176	1.59
Italy	54 487	3.30	20 221	1.22	15 787	0.96	18 478	1.12
Latvia	789	3.24	270	1.11	169	0.70	350	1.44
Lithuania	990	2.64	372	0.99	266	0.71	352	0.94
Luxembourg	1 634	3.14	413	0.79	701	1.35	520	1.00
Malta	314	3.29	132	1.38	40	0.42	142	1.50
Netherlands	34 969	5.12	8 534	1.25	11 069	1.62	15 367	2.25
Poland	12 952	3.01	5 113	1.19	3 235	0.75	4 604	1.07
Portugal	6 580	3.66	2 048	1.14	1 652	0.92	2 880	1.60
Romania	3 400	2.12	1 510	0.94	737	0.46	1 153	0.72
Slovak Republic	2 061	2.61	655	0.83	599	0.76	807	1.02
Slovenia	1 602	4.13	507	1.31	308	0.79	786	2.02
Spain	45 058	4.17	14 415	1.33	12 318	1.14	18 325	1.70
Sweden	21 677	4.83	5 696	1.27	7 558	1.68	8 423	1.88
United Kingdom	106 024	4.07	36 353	1.40	22 704	0.87	46 967	1.80
Iceland	753	4.93	201	1.31	265	1.73	288	1.88
Norway	17 299	4.97	4 965	1.43	6 384	1.83	5 950	1.71
Switzerland	21 679	3.54	5 769	0.94	7 023	1.15	8 888	1.45

Figure 3. Estimates of Total Costs (Direct and Indirect) of Mental Health Problems in EU Countries, in millions EU as a share of GDP in 2015 (OECD, 2018)

As previously explained, it is very difficult to accurately calculate the true economic cost of mental health illnesses. Luckily, in 2018, the OECD did publish 'Health at a Glance: Europe 2018', which included a table (*Figure 3*) with the estimated costs. The table is divided into direct and indirect costs. According to Boccuzzi (2003), *'direct costs usually represent the costs associated with medical resource utilization'*, this means any medical treatments and the consequence of them. Boccuzzi further states that indirect costs are *'expenses incurred from the cessation or reduction of work productivity as a result of morbidity or mortality'* (Boccuzzi, 2003). According to the OECD, the total indirect and direct costs of mental health problems in 2015, in the Netherlands were 5,12% of GDP compared to 3,17% of GDP in Hungary. The main difference being the indirect costs. Unfortunately, the issue with indirect costs is that it is hard to distinguish where the money is going.

McDaid, Park and Wahlbeck (2019) state in their study that there are several economic arguments for preventative action for avoiding ill mental health. They made the case that preventative care should be available even before the birth of the child. Studies have shown that bad maternal mental health is linked to adverse effects in the child's mental health. Furthermore, preventative maternal healthcare not only helps the child in utero but also promotes better postnatal care in mothers ensuring a better social and emotional environment (Ashby, Scott & Lakatos, 2016). McDaid, Park and Wahlbeck (2019) continue this argument with young children and adolescents stating that preventative action in the form of targeted programs will have a return from 1.80 USD to 3,30USD for every 1 dollar spent .

3.4 Children and Adolescents

This chapter discusses why the author chose the pillar Mental Health and Schools and gives an overview of the number of children suffering from a mental illness in Europe.

One of the pillars of the Joint Action Plan for Mental Health and Well-being is Mental Health in Schools. The author choose this pillar because of similar or related personal experience with this topic.

The WHO states that worldwide around 20% of all children and adolescents suffer from or experienced mental disorders (Child and adolescent mental health, 2020). Of those children affected Kessler et al, (2007) state that 50% of all mental illnesses begin or have begun by age 14 and that by age 20 this number goes up 75%. Kessler's point is reinforced by the research presented by the OECD and summarized in the graph below (*Figure 4*). The most common mental health illness affecting children and adolescents are behavioral disorders such as ADHD, autism, anxiety and depression (Green et al., 2005). In addition 50% of all adult mental disorders could be traced back to issues in childhood or adolescence (Kapoćs &Balázs, 2017).

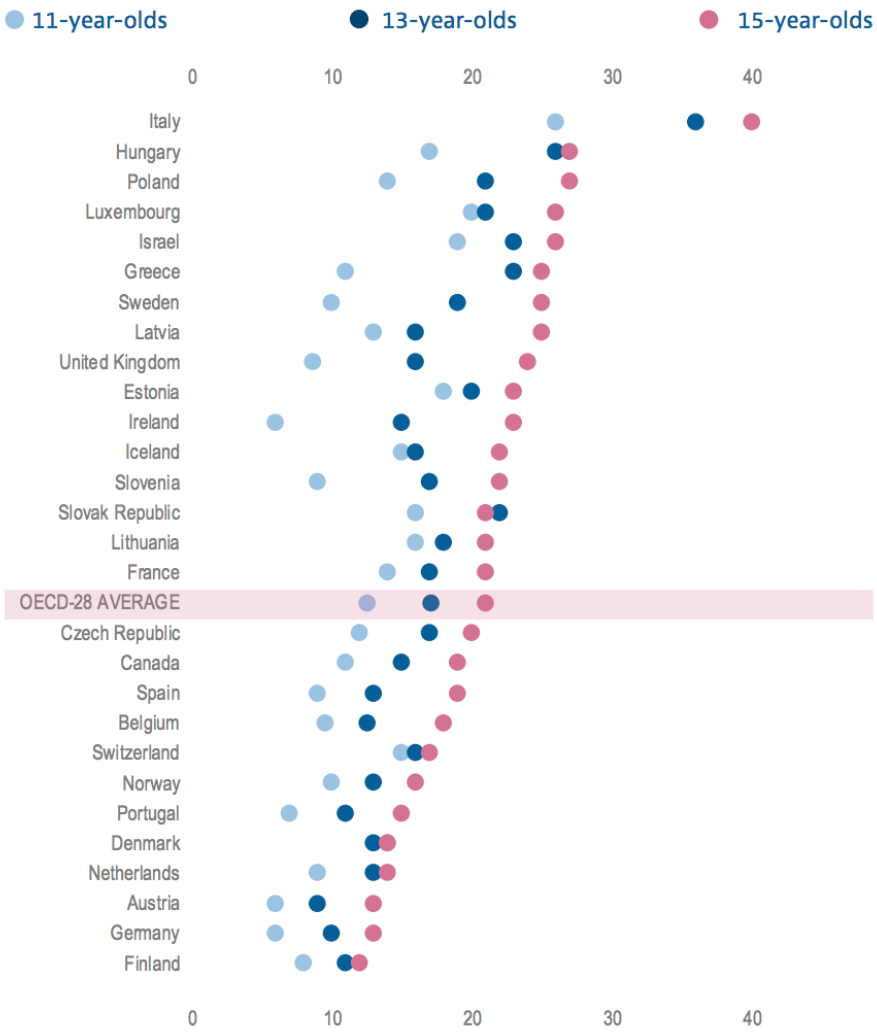

Figure 4. The percentage of children feeling low more than once increases sharply with age (OECD, 2018)

In 2008, Belfer published a paper that used data from the WHO Atlas which in mapped out the gaps in policies in mental health in children. He concluded that while the data consistently states that 20% of children and adolescents globally suffer from mental health issues. Belfer stated a high level of consistency could not be said about policies dealing with mental health. Children and adolescents in low-income countries lacked (potentially), any form of mental health policy, policy development, failed to provide services, lacked continued care and/or had a barrier to any care (Belfer, 2008).

According to the WHO in the European Region, there are high and increasing levels of mental health issues in children and adolescents (Child and adolescent mental health, 2019).

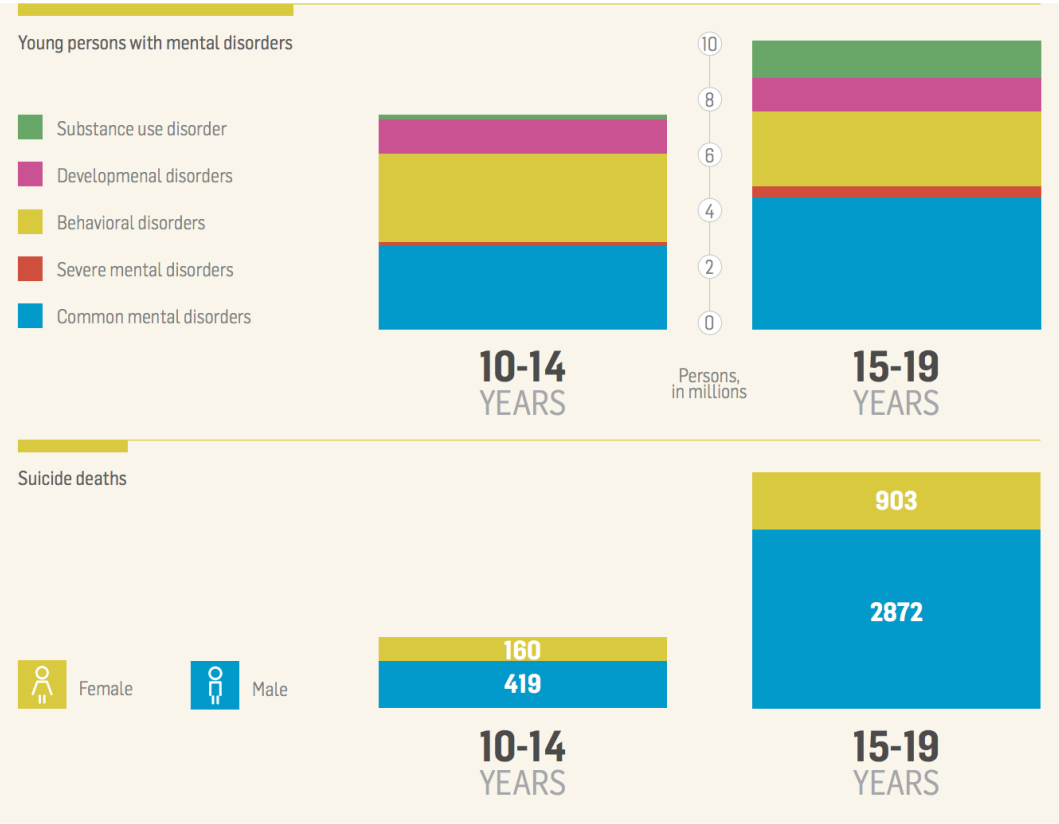

Figure 5. Distribution of Mental Disorders and Suicide by Age Group and Gender in the WHO European Region, 2005 (World Health Organization Regional Office for Europe, 2018)

Figure 5 presents mental disorders as a function of age and gender. It also classifies the various forms of mental illness suffered. Common mental disorders such as ADHD, autism, dyslexia were the majority of the illness. With this subgroup increasing with age common mental disorders increased. In addition substance abuse exponentially increased as adolescents become closer to legal drinking and smoking age. Across the European Region, the statistics presented highlighted that boys had a greater tendency to commit suicide than girls.

According to EuroStat, there are currently around 510 million people living in the European Union. Approximately, around 167 million of them are under eighteen (EuroStat, 2017). The WHO has stated, some 20% of all children and adolescents will be affected by a mental illness

(Child and adolescent mental health, 2019), in other words, 33,4 million children and adolescents are affected by mental health disorders.

4. Case Studies

This chapter discusses the two case studies chosen by the author: the Netherlands and Hungary. This chapter discusses the prevalence of mental health issues in children and adolescents in these two countries. It further looks at the steps taken during the years 2013-2016 to develop an action framework for cooperation and action between different sectors for the prevention of mental health issues and the promotion of mental well-being and if these steps were sufficient and felt by healthcare professionals.

4.1 The Netherlands

This section presents an overview of the mental health situation in the Netherlands. In 2013, the Netherlands had a GDP of 827,476 million USD. By the end of the Joint Action Plan in 2016, this number was 890,399 million USD (*Table 1*).

Table 1. Total GDP (in millions USD) of Hungary and the Netherlands from 2013 to 2016 (OECD, 2019)

Location	2013	2014	2015	2016
Hungary	242 362	252 631	262 494	271 845
Netherlands	827 476	830 318	852 113	890 399

In *Figure 6*, presents the percentage per GDP spent in the Netherlands on healthcare reported by the World Health Organization. In 2013, the percentagethis was 10,6%, by 2016 this percentage was 10,3% (World Health Organisation, 2019). In 2008, the Centrale Bureau van Statistiek (CBS), the Dutch National Statistical Office reported that the Netherlands spent just over 72 billion euro on healthcare totaling 12,5% of its gross domestic product (CBS, 2016). This percentage differs greatly with the percentages reported by the World Health Organization, however, it is possible certain items have been included/excluded from the respective calculations.

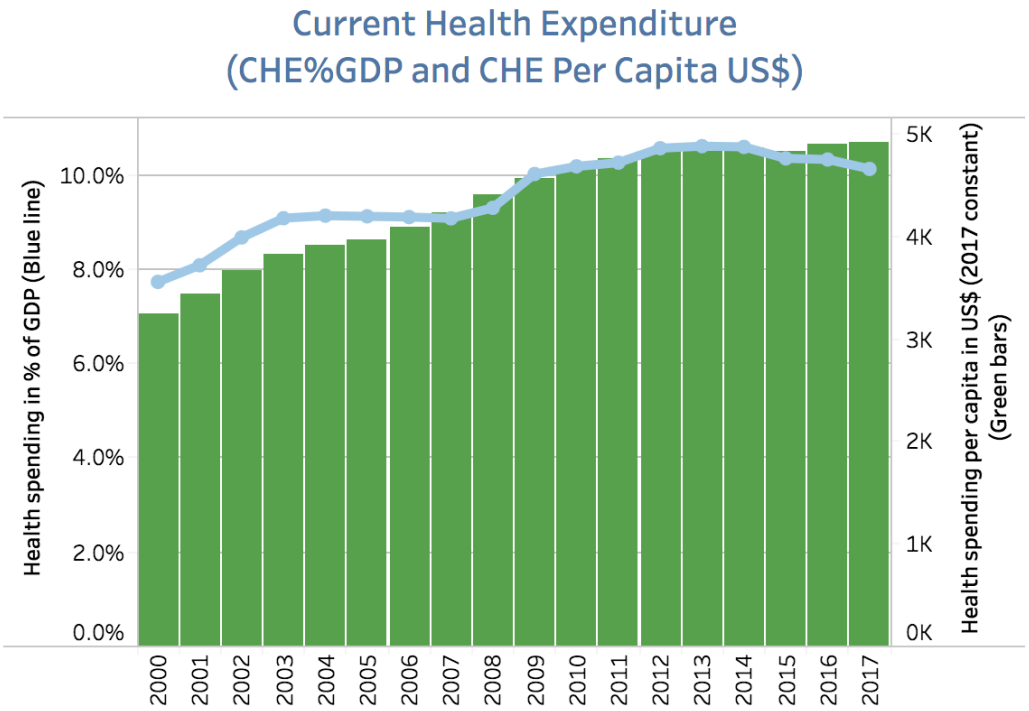

Figure 6. The health expenditure of the Netherlands in % of GDP and the health spending per capita in USD (World Health Organisation, 2019)

The Netherlands had a population of 16,779,575 million people in 2013 (CBS, 2019). This number had slightly increased to 16,979,120 million people in 2016 (CBS, 2019). The OECD stated in their report 'Health at a Glance' in 2018 (which used predominately data from 2016), that the Netherlands had one of the highest level of mental health issues out of all EU countries (with a rate of 18,6% of the population) (OECD, 2018).

The graph (*Figure 7*) below highlights some of the mental health statistics of the Netherlands from 2005-2017. In general a slight increase from 18% to 20% was observed. Specific changes were seen in hyperactivity which are close to 30% of children affected.

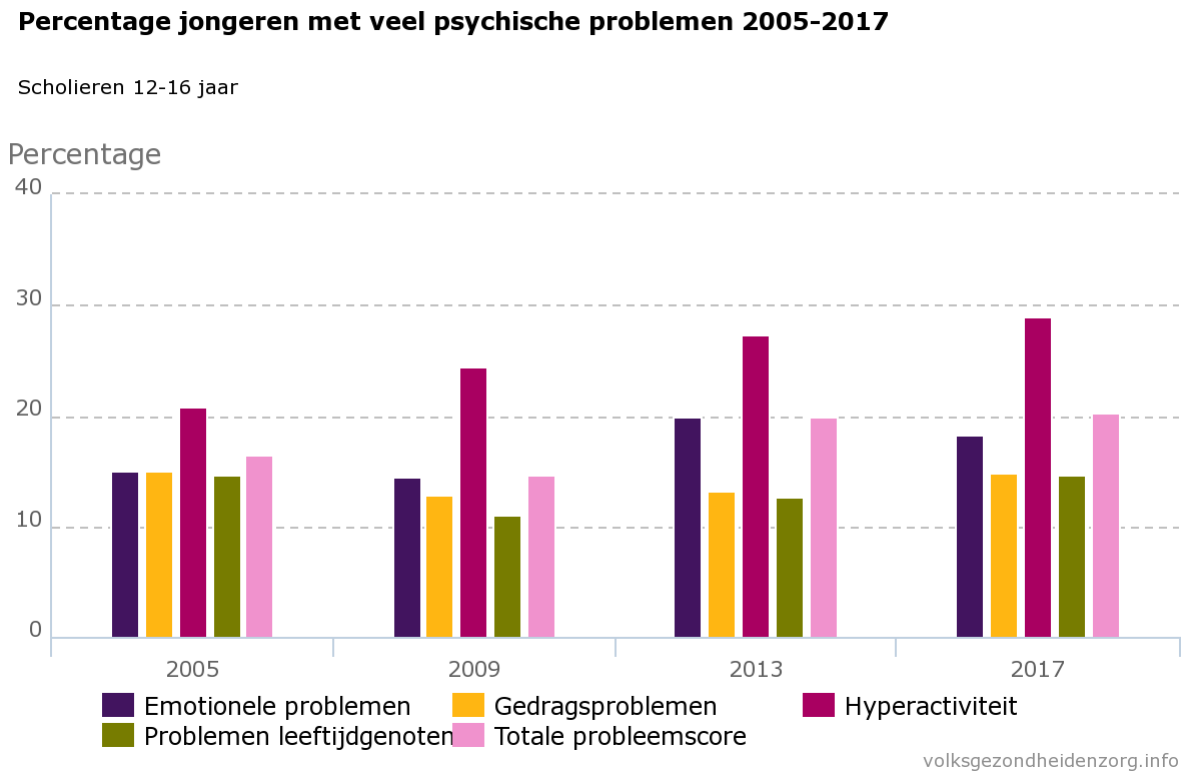

Figure 7. Percentage of youth (ages 12-16) with mental illnesses 2005-2017 (Volksgezondheidenzorg, 2019)

In the Netherland, mental healthcare is provided through the Dutch mental healthcare (Geestelijke gezondheidszorg - GGZ) (Kuijper, 2014). There is the basic GGZ and the specialized GGZ, called the SGGZ. For children and adolescents under 18, there is the jeugd-GGZ (Kuijper, 2014). On the 1st of January 2015, the Netherlands reformed the law special healthcare costs (Algemene Wet Bijzondere Ziekekosten or AWBZ). The tasks and responsibilities that fell previously under the AWBZ were now split between the law long-term care (Wet langdurige zorg – Wlz), the social support law (Wet maatschappelijk ondersteuning – Wmo), the healthcare law (Zorgverzekeringswet – Zvw) and the newly minted youth law (Jeugdwet) (Kuijper, 2014).

The most notable change was the decentralization of the healthcare for Dutch youths. The new law stated that municipalities would be responsible for the organization, quality and accessibility of healthcare for under 18-year-old (Kuijper, 2014). Inevitably this proposed reorganization was met with a lot of challenge. The Dutch National News (NOS) reported that the proposed law was met with skepticism as early as 2013. Abvokabo FNV (now just FNV), the Dutch Trade Union conducted a survey of stakeholders that concluded that 79% (of people who participated in the

survey) of people did not believe the municipalities were ready for the responsibility ('Jeugdwet leidt tot problemen', 2013). The same survey also highlighted that respondents feared that the quality of care would be differ per municipality ('Jeugdwet leidt tot problemen', 2013).

The Jeugd-GGZ falls under the Jeugdwet, therefore decentralized in 2015. The Eerste Kamer (Senate) debated in 2014 whether it would be the right decision to decentralize the jeugd-GGZ. Former Christen-Unie senate leader Roel Kuiper remarked that *'the question is who will be at the gate; the professionals or the municipalities?'* ('Senaat twijfelt over Jeugd-ggz', 2014). The conclusion being to go forward with the proposed changes.

In 2018, the CBS presented data collected of youth between 12 and 25 years from 2015-2017 in a report titled *'1 in 12 youths are mentally unwell'* (Rijksinstituut voor Volksgezondheid en Milieu, 2019). It also compared the same data from 2005-2007 (*Figure 8*). The CBS did not cluster the same age groups as Joint Action Plan, so there is a proportion under 12 years missing and an additional 7 years above.

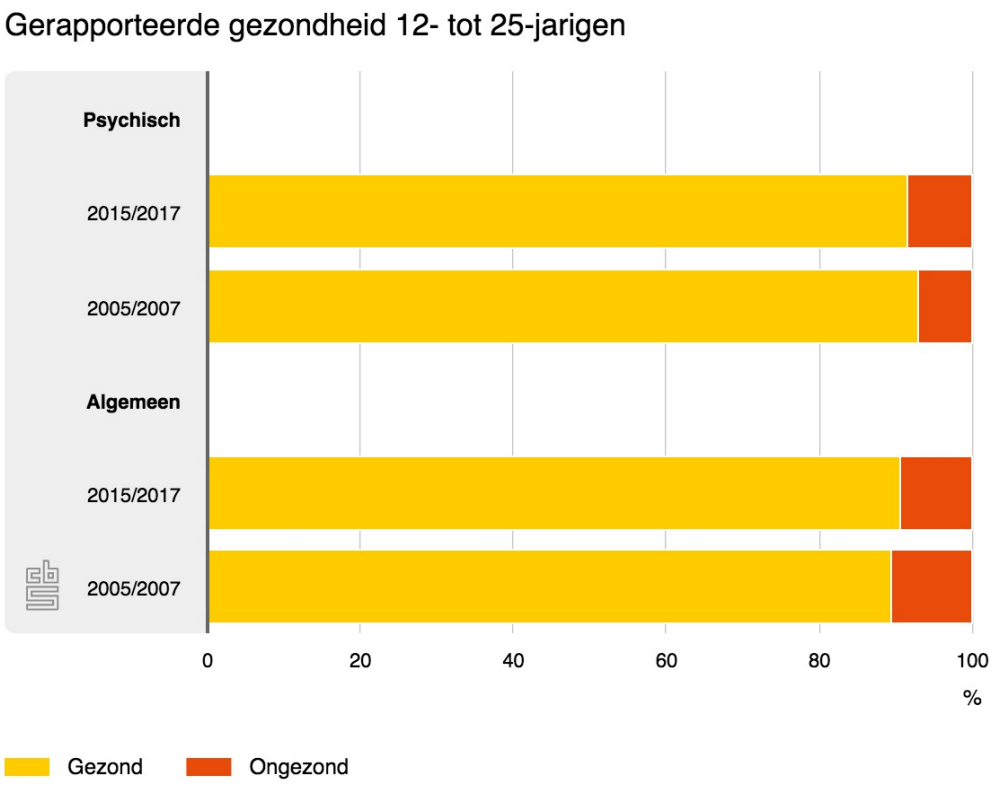

Figure 8. General and mental health of 12 to 25 year olds, 2005-2007 and 2015-2017 (CBS, 2018)

Figure 8 shows that in 2005-2007, 6,9% of youths reported to be mentally unwell. This percentage rose to 8,3% in the period 2015-2017 (CBS, 2018). It is unknown whether the decentralization of the jeugd-GGZ played a role in this rise. A third of those who reported to be mentally unwell where suffering from depression (37,4%) (See *Figure 9*) (CBS, 2018). The report further stated that youth who had indicated to feel mentally unwell were more likely to a) suffer from more than one illnesses and b) have depression in combination with migraines, headaches and allergies (CBS, 2018). In fact almost 70% of all mental health issues fell in these two categories.

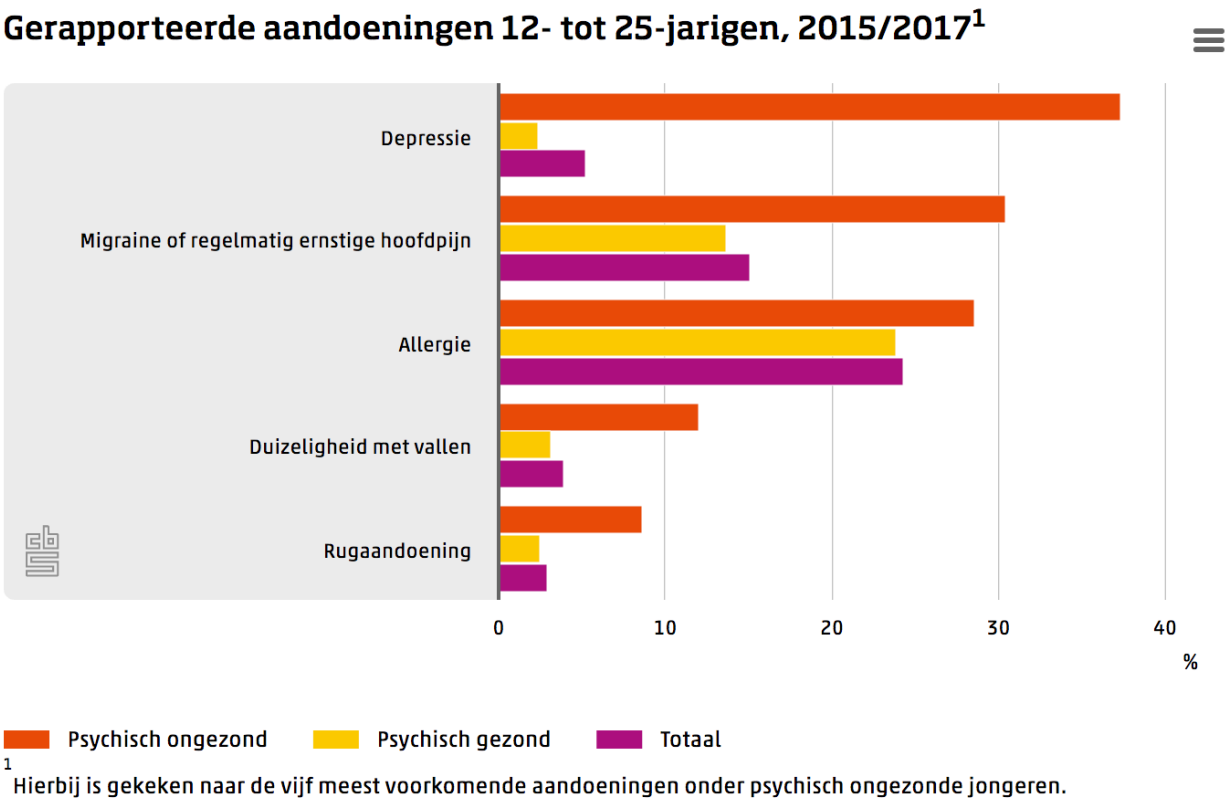

Figure 9. Reported illness of youth aged between 12-25 in the period 2015-2017 (CBS, 2018)

While the number of youths (male and female) that were reported to be feeling mentally unwell, the number of suicides in the similar age group has remained stable (*Table 2*). In total there were 1857 suicides in 2013 (CBS, 2019). 36 were men under 20 and 22 were women under 20. In

2016, this number dropped to 30 in men and 18 in women (CBS, 2019). No information has been provided to indicate whether the changes (albeit small) are due to any particular programme or purely a statistical variance.

Table 2. Total suicide rates in the Netherlands and the suicide rates due to mental illnesses in men and women under 20 years of age (CBS, 2019)

			Geslacht	Perioden																
Onderwerp			Totaal mannen en vrouwen						Mannen						Vrouwen					
Leeftijd			2000	2010	2013	2016	2017	2018	2000	2010	2013	2016	2017	2018	2000	2010	2013	2016	2017	2018
Totaal zelfdoding	Totaal alle leeftijden	aantal	1 500	1 600	1 857	1 893	1 917	1 829	999	1 124	1 308	1 279	1 304	1 176	501	476	549	614	613	653
	Jonger dan 20 jaar	aantal	48	55	58	48	81	51	40	42	36	30	50	30	8	13	22	18	31	21

The consequences of the decentralization of the jeudg-GGZ are already visible. In the beginning of this year, the Dutch Society for Psychiatry (Nederlands Vereniging voor Psychiatrie – NVvP) and the Dutch Society of Pediatrics (Nederlands Vereniging voor Kindergeneeskunde – NVK) sent an open letter to the Tweede Kamer (Dutch House of Representatives) stating that children with illnesses such as anxiety disorders, autism, ADHD and other psychoses are being seen by a medical professional too late ('NVvP en NVK pleiten voor aanpassingen jeugdhulp", 2019). The group primarily affected is between high level emergency and later care. Károly Illy, the chairmen of the NVK stated that 'these children in some municipalities are stuck between a rock and a hard place' (Kinderen met complexe psychische problemen moeten sneller hulp krijgen'", 2019). Pediatricians and child psychologists are of the opinion that only qualified professionals should be at the 'frontline' (Kinderen met complexe psychische problemen moeten sneller hulp krijgen'", 2019).

Furthermore Kieskamp (2019) stated that two thirds of municipalities in the Netherlands are experience a funding shortage of at least 20%, with one in five municipalities experiencing shortages up to 40%.

On the 8th of November 2019, the Healthcare and Youth Inspectorate published a report on the youth healthcare (of which the jeugd-GGZ is a part). The report stated that the government was not fulfilling its duty to adequately protect and provide care for the Dutch youth (Inspectie Gezondheidszorg en Jeugd, 2019). They cited three main points: i) a shortage of qualified

healthcare professionals; ii) insufficient 24/7 immediately deployable, appropriate assistance; and iii) insufficient financial support to the municipalities to provide basic care (Inspectie Gezondheidszorg en Jeugd, 2019).

4.1.1 Interviews

The author held two interviews (see Appendix 2 and 3 for transcripts). Both interviews were held with Dutch healthcare professionals working with children and adolescents. The first interview was held with an orthopedagogue who worked in the SGGZ for YOEP, a child and adolescent psychiatric practice. The orthopedagogue worked primarily with children and adolescents suffering from ADHD. They were unfamiliar with the Joint Action Plan for Mental Health and Well-being and lamented over the work pressure within the SGGZ. They felt like they were always "playing catch-up". Eventually they left the SGGZ in 2018 to start up they own practice citing an unhealthy work life balance and increasing work pressure as one of the leading causes of leaving the public health sector.

When further questioned about the cooperation that the Joint Action Plan put an emphasis on to foster in national healthcare services. The orthopedagogue stated that the SGGZ already heavily relies on cooperation from different sectors. Secondly they didn't think more cooperation was needed to alleviate the pressure on the mental health sector but rather advocated for mandated school programs that taught children and adolescents the tools (e.g. tools taught in therapy) to deal with difficult situations. They referred to school programs in Scandinavia where the emphasis is put on personal development and teaching children how to cope with a multitude of external stimuli (such as social media).

The second interview was with Stephanie Kustner, a school psychologist currently working for the European School of the Hague. Stephanie has spent her entire career either working as a school psychologist in primary and secondary schools in the Netherlands and abroad or as a lecturer at various Applied Science Universities in the Netherlands (HBO). Kustner, like the orthopedagogue was unfamiliar with the Joint Action Plan for Mental Health and Well-being. Stephanie was critical of the decentralization of the jeugd-GGZ in 2015. Stating that municipalities have no idea what that they are doing and that quality of care could be

compromised as municipalities could potentially work with the cheapest providers. She further cited that the high level of bureaucracy in the Dutch mental healthcare system (jeudg-GGZ) was one of the biggest issues. Not money or the lack of personnel but the sheer number of hoops that healthcare professionals had to jump through. What was further interesting was that during the interview Kustner remarked on the fact that while this was a European School, and accredited as such, the inspection for the accreditation did not ask to speak with the support staff during their inspection.

4.2 Hungary

An overview of Hungary is presented taking a high level economic view. In 2013, Hungary had a GDP of 242,362 million USD. This number increased to 271,845 USD million in 2016. In the figure below the total GDP is compared with the Netherlands from 2013 to 2016.

Table 3. Total GDP (millions) of Hungary and the Netherlands from 2013 tp 2016 (OECD, 2019)

Location	2013	2014	2015	2016
Hungary	242 362	252 631	262 494	271 845
Netherlands	827 476	830 318	852 113	890 399

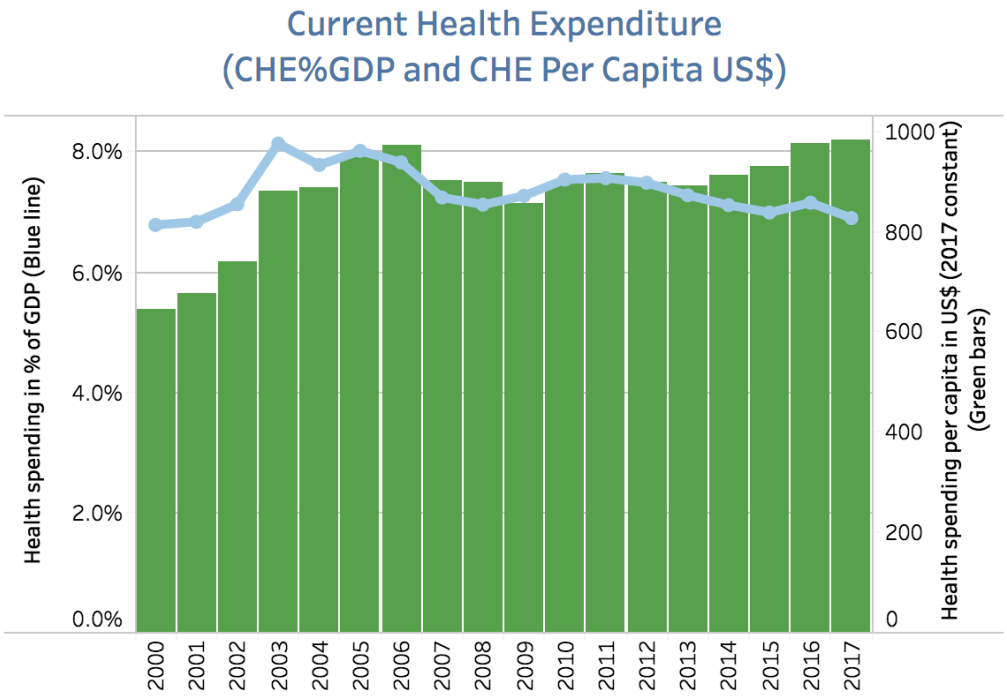

Figure 10. The health expenditure of Hungary in % of GDP and the health spending per capita in USD (World Health Organisation, 2019)

The health expenditure (CHE) as a percentage of GDP of Hungary in 2013 was 7,3%. This parameter has remained within roughly 0.5 percentage points since 2000 (World Health Organization, 2019). So even though spending per capita increased the health spending in % of GDP remained virtually unchanged.

By 2013, Hungary had a population of around 9.893 million people (Population, 2018). The OECD reported in 2018, using data from 2016, that Hungary out of all the EU countries had a lower average of people being affected by mental illness (15,4%) (OECD, 2018). According to UNICEF data in 2013 there were around 2,3 million people under 18 (UNICEF, 2013). Kapoćs and Balázs (2017) stated that 15,8% of children aged 4-17 in Hungary had a mental illness. Assuming that there was not a large change in population demographics between 2013 and 2017, an estimate of some 363,400 children could be inferred had some form of mental health issue.

In the last twenty years, Hungary has acknowledged the need for better mental health care. Since 2003, they have implemented several different policies that deal explicitly or in some form with child and adolescent psychiatry.

These plans were:

- National Program of the Decade of Health (2003)
- Our Children Our Treasures – National Infant and Child Health Program (2005)
- Semmelweis' Plan for Saving the Health System – Revitalization and Treatment (2011)
- Health Hungary (2014) (Health Secretary of Ministry of National Resources, 2015)

In 2003, in the age group 16-24 suicide caused by illegal alcohol and drug consumption was one of the main health concerns. Compared to 1994, when Hungary had a suicide rate of 49,9 out of a 100,000 people (total population), by 2003 the number decreased by a third (World Health Organization , 2008). Even though further reductions have been reported the suicide rate still remains above the EU average of 20 per 100,000, currentlt at 29/100,000 (World Health Organization, 2008). The suicide rates for children 0-10 could not be found. However in 2004, the suicide rates in the age group 10-17 was higher for boys (World Health Organization, 2008). There were 1.6/100,000 deaths for boys in the age group 10-14. This increased to 5,8/100,000 in the age group 15-17. The suicide rates for girls was significantly lower, with 0,7/100,000 in the age group 10-14 and 3.3/100,000 (World Health Organization, 2008). The World Health Organization makes a note that statistical data for attempted suicides are not available but that this number is believed to be significantly higher than executed attempts.

The National Program of the Decade of Health was implemented not only to tackle the high suicide rate but also to improve the general health of Hungarian citizens (Hungarian Parliament, 2003). The chapter on mental health had 7 key objectives:

1) Downsize general prejudices and misconceptions related to mental illnesses and mental health disorders

2) Primary prevention of mental disorders by health education and promotion

3) Early detection and treatment of psychiatric disorders by sensitizing primary health care providers

4) Develop community mental health programs and improve structures and functions of the psychiatric in-patient care

5) Reduce the suicide rate of children and adolescents at least by 20%

6) Reduction of the general suicide rate to the 20/100,000 level

7) Increase the number of registered depression patients at least by 30%.

No literature (in English) has been found presenting the results of this programme.

The 'Our Children Our Treasure – National Infant and Child Health Program was created in 2005 in collaboration with government, NGO's, national health institutes and universities (Ministery of Health, 2005). This program was created on the recommendation of the WHO Regional Office for Europe who gave a high priority to child and adolescent health in 2003. In 2008, the World Health Organization published a case study that commended Hungary for the 2005 policy as Hungary was among the first European countries to adopt a fully national child and adolescent health plan (World Health Organization, 2008). However the paper also pointed several issues. Most notably the financial sustainability of the policy and the need for a more precise action plan with roles and responsibilities.

The study conducted by LSE in 2008 (MHEEN Network, 2008) noted that the health care facilities in Hungary were outdated and that there was a huge exodus of Hungarian healthcare professionals to other EU countries due to their accession into the EU in 2004. The status of these facilities being a result of communist national policies over the 1990's (Kapoćs and Balázs, 2017).

In 2008, Hungary had a below average EU life expectancy and healthy life expectancy. Additionally, mental and behavioral disorders were the third and sixth leading causes of morbidity. Dlouhy (2014) stated that community psychiatry which is one of the WHO fundamental elements of mental health initiatives (The Policy: Our Children Our Treasure – National Infant and Child Health Program was created on the basis of the recommendation of the WHO) was during these years in its infancy in Hungary. He further stated "that Hungary is in a double-bind dilemma. One hand Hungary tries to satisfy and conform to European expectations while on the other the constraints of existing structures, established operational mechanisms and economic constraints often frustrate policies and policy procedures" (Dlouhy, 2014).

The Semmelweis' Plan for Saving the Health System – Revitalization and Treatment of 2011, was issued after consultation with 114 national institutes (Health Secretary of Ministry of National Resources, 2011). Due to financial cuts in the 2000's psychiatric inpatients capacities decreased by 24%, becoming the smallest in the European Union (Kapoćs and Balázs, 2017).

The Semmelweis' Plan put an emphasis on child and adolescent psychiatry. The goals for increasing the mental health in children and adolescents were:

1) Increasing the number of psychiatry specialists, clinical psychologists, specialized licensed nurses, educational advisors and behavioral experts

2) Establishing a nationwide network of school psychologists

3) Increasing capacities of inpatient facilities with high security wards

4) establishing pediatric mental health centers in the seven administrative regions of the country with specialized multi-disciplinary teams (child psychiatrists, psychologists, special educational advisors, speech therapists, social workers, child protection employees, family therapists, and psychotherapists)

5) Setting up emergency units for patients after suicide attempts and in crisis situations

6) Increasing the number of rehabilitation beds for patients suffering from schizophrenia, autism, eating disorders, etc.

7) Developing outpatient care and rehabilitation network concerning also illegal drug addict residents in the homes of the National Children and Adolescent Protection Agency.

The last mental health policy was issued in 2014; Healthy Hungary (Health Secretary of Ministry of National Resources, 2015). It is a plan that spans 6 years, from 2014 to 2020 (Health Secretary of Ministry of National Resources, 2015). This policy was based on the Semmelweis's Plan, only it updated some priorities and objectives. The main new priority being that they wanted to improve the general mental health status in Hungary, decreasing general mental illness statistics by at least 10%.

Studies in Hungary showed that 2 out of 10 children suffered from a mental health issue (Kapoćs and Balázs, 2017). Furthermore Hungarian adolescents smoke and drink around 20% more than the European average (this number is more or less equivalent in boys and girls) (Kapoćs and Balázs, 2017). The initiation into alcohol and drug use can be young, with reports showing that children in Hungary have started smoking at 10 years of age (Kapoćs and Balázs, 2017).

Similar to the previous plan, no literature (in English) has been found evaluating the impact of the Semmelweis plan. A short search for papers in Hungarian, also did not surface any publicly available research papers or official (governmental) public reports.

5.0 Analysis

This chapter will discuss the strengths and weaknesses of the Joint Action Plan for Mental Health and Well-being by conducting a SWOT analysis.

5.1 Joint Action Plan for Mental Health and Well-being

Strengths	Weaknesses
1. Acknowledges that mental ill-health is an issue 2. Covers multiple sectors 3. Three year duration	1. Ineffective 2. No/weak legal basis 3. No concrete points of action
Opportunities	**Threats**
1. Moral accountability 2. SMART targets 3. Communication campaign for healthcare professionals	1. Costs the EU 798 billions Euros 2. DALY's

Table 4. SWOT analysis of the Joint Action Plan in general

The main strength of the JA-MH-WB is that it acknowledges the increasing prevalence of mental health issues in European society. As far back as in 1992 with the Treaty of Maastricht (Art. 168) an emphasis was placed on improving physical health and mental health (Treaty on the Functioning of the European Union, 2007). The EU continued this trend by writing a Green Paper on mental health in 2005 which was further expanded to a European Pact in 2008. The Joint Action plan was created *to contribute to the promotion of mental health and well-being, the prevention of mental disorders and the improvement of care and social inclusion of people with mental disorders in Europe*' (The Joint Action Plan for Mental Health and Well-being, n,d). This shows that the EU was aware of the issue and had taken an initiative. The Plan in the section 'Mental Health and Schools' placed an emphasis on the cooperation between national institutions. Taking into account the various sectors that are needed to properly support the growth of a child and adolescent.

Another strength is that this plan is diverse in its efforts, taking a multidisciplinary approach by emphasizing the workplace, schools, e-health and policy making. It was also recognized that this issue required several years of support, therefore the plan duration was 3 years. This duration ought to allow the stakeholders ample time to understand this issue in each Member State and to promote the cooperation between different sectors in society.

The main weakness of the Joint Action Plan for Mental Health and Well-being is considered to be its ineffectiveness. While the JA-MH-WB shed light on the issue of mental health and the threats that it poses to European society it did not resolve any of the underlying issues. This source of this problem is derived from the Treaty of Amsterdam (Treaty on the Functioning of European Union, 2007). The Treaty of Amsterdam drastically limited the scope of Art. 168 by stating that the EU had to *'fully respect the member states responsibilities for the organization and delivery of health services and medical care'* (Treaty on the Functioning of European Union, 2007). Essentially the EU has the right to have an opinion on the state of mental health and healthcare in general in its Member States, however it has no legal basis to recommend or enforce any changes.

The Steering Committee is responsible for the implementation of the JA-MH-WB and as such is acknowledged as attempting to generate an economic and ethical driven Plan to improve the status of EU citizens (The Joint Action Plan for Mental Health and Well-being, n,d). The research undertaken has however not revealed any attempt to project manage the plan, influence the Member States. The ineffectiveness of the plan is argued, a result of lack of concentrated focus to motivate and hold accountable Member States.

Converting the plan and its objectives into measurable and observable targets is the basis of any project. The JA-MH-WB being more a statement of intent by a political body lacks specificity. Cynically it could be argued that any plan issued by a political body, composed of 27 Member States, always lacks specificity because of the multiple semantic compromises required to allow a document to be issued. On the other hand when a subject such as mental health is making a sizeable and long term negative effect on the wellbeing of all Member States, the author argues that clearer goal setting would be beneficial. This could be done by setting more Specific, Measurable, Achievable, Realistic and Timely goals (SMART). This would not only clarify the intention of Joint Action Plan but also gives the Member States a quantifiable challenge. The

author knows that the EU does not have the power to mandate any change due to art. 168 TFEU, however Member States can be held accountable by the EU to fund reports on mental health and by showing Member States the progress (or the non-progress) they have made dealing with this issue.

Another opportunity for any further Joint Action Plans related to this issue would be to finance a communication campaign for healthcare professionals. The would be to inform healthcare professionals of the intentions of the European Union.

The biggest threats of this Joint Action Plan is the DALY's and the mounting costs of indirect and direct cost of mental health issues on Member States.

5.2 Netherlands

Strength	Weaknesses
1. Plan in place 2. Centralized financing 3. Media knowledge of issue 4. Trained healthcare practioners 5. CBS database 6. Multiple ministery reports	1. Plan unknown by practioners 2. Insufficient financing 3. Media focused on failures 4. Insufficient healthcare practitioners 5. Additional health parameters are absent 6. Impact of JA-MH-WB unknown 7. Decentralization of jeugdzorg
Opportunities	**Threats**
1. Increased communication between authorities and practitioners 2. Focused and increased financing 3. Positive publications 4. Additional qualified staff	1. Continued decrease in funding 2. Decrease in quality of care 3. Decrease in commitment by state and municipalities 4. Insufficient qualified healthcare staff

Table 5. SWOT analysis of the Netherlands

The Netherlands already has a focused mental health care for youths in place; the jeugd-GGZ. This is a specific healthcare that is tailored for children and adolescents who suffer from mental health issues (Kuijper, 2014). In addition, the Netherlands has trained healthcare professionals who can manage the issues that these children and adolescents have. The CBS and the Ministry for Health, Well-being and Sports have multiple data sources and publish several reports on the state of child and adolescent mental healthcare (CBS, 2018; CBS, 2019; Rijksinstituut voor Volksgezondheid en Milieu, 2019) . In the last years, after the ending of the Joint Action Plan, the Dutch media outlets, such as the NOS, have published several articles about the state of mental health care for children and adolescents (Kinderen met complexe psychische problemen moeten sneller hulp krijgen'", 2019). This shows a growing awareness in the general population about the seriousness of mental health and its effects.

(")

The Joint Action Plan was unfortunately unknown to the healthcare professionals that the author interviewed. Whilst a larger group ought to be surveyed this feedback could indicate that the Joint Action Plan was not communicated at the 'front-lines'. In addition, news outlets have reported the financing for the jeugdzorg and the jeugd-GGZ was inadequate (Kieskamp, 2019). The author suggests that if two thirds of all municipalities are experiencing financing problems then i) the quality of care and ii) available resources, that the children and adolescents are receiving may be under challenge or insufficient. The decentralization in 2015, was supposed to place the best care closer to the children. However this has not worked out in that way, with the Youth and Health Inspectorate reporting in 2019 that the government was not doing enough to support municipalities in their duty to care for at-risk child and adolescents (Inspectie Gezondheidszorg en Jeugd, 2019).

The Netherlands needs more focused strategic financing and potentially increased funding. This would help municipalities provide high standards of care and could potentially alleviate the extended duration waiting lists now common throughout the jeugd-GGZ. Kustner made the remark that increasing funding is not the solution but rather the removal of the bureaucratic systems that healthcare workers have to overcome. This change would save time and money leading to more afflicted individuals being helped in time.

The most immediate and potentially biggest threat to the mental well-being of children and adolescents in the Netherlands is a further decrease in funding. This would have a knock-on effect. Not only could the standard of care in the jeugd-GGZ decline, but one could argue that just like the orthopedagogue, more healthcare professionals could leave the public sector for private practive meaning that children and adolescent with parents who lack the sufficient funds to pay for private care would be more at-risk then children and adolescent those parents are able to pay.

5.3 Hungary

Strengths	Weaknesses
1. Centralized healthcare 2. Recognition of issue 3. Focused youth plans 4. Qualified healthcare workers	1. Insufficient and aged infrastructure 2. Low levels of healthcare expenditure 3. Data quality challenged 4. Low level of mental health support in rural areas 5. Population spread over wide area
Opportunities	**Threats**
1. Modernise infrastructure 2. More healthcare resources 3. Additional funding 4. Improved data quality	1. Prevalence of alcohol and drug abuse 2. Insufficient in-patient care 3. Exodus of trained healthcare professionals

Table 6. SWOT analysis of Hungary

Even before the publication of the Green Paper in 2005 Hungary had acknowledged the issue of mental health in children and adolescents. The National Program of the Decade of Health was published in 2003 and had a clear goal to reduce the suicide rate of children and adolescents, as well as improve the general mental health of all Hungarians (Hungarian Parliament, 2003). Since then there have been several plans such as the Our Treasure Our Children Plan in 2005, the Semmelweis's Plan in 2011 and the Health Hungary in 2014 (Ministry of Health, 2005; Health Secretary of Ministry of National Resources, 2011; Health Secretary of Ministry of National Resources, 2014). All these plans emphasized the promotion of mental well-being in children and adolescents.

In contrast to the Netherlands, the Hungarian healthcare system is centralized. It is supported by qualified healthcare professionals.

In the 1990's Hungary was under Soviet influence and its infrastructure was and remains influenced by that era (Kapoćs and Balázs, 2017). One of its major weakness has thus been its aged and insufficient facilities and infrastructure. In general hospitals are in poor condition without modern equipment and largely concentrated in the main cities, such as Budapest, Debrecen, Miskolc, etc. Due to these limitations Hungary only provides limited mental health

care to people living in rural areas. The ability to reach its population is also harder because whilst its population is some 50% of the Netherlands, Hungary is a much larger country.

An opportunity for Hungary would be to modernize the existing infrastructure, build facilities in rural areas and invest in more qualified healthcare professionals. There are, for example in Budapest, many private clinics nowadays with modern facilities. This investment would provide both better care for those people living in rural areas and potentially alleviate the pressure of services provided in larger cities. Improved infrastructure would also provide rural areas with better access to a wider range of health services and potentially attract other businesses. These opportunities could be realized via increased funding, tax incentives or other means.

According to Kapócs and Balázs (2017) the quality of data describing the Hungarian healthcare plans is not always reliable. It is in Hungary's own interest to have more reliable data for similar reasons as presented in the discussion about the Netherlands. Improvements in data quality are cheap and can be immediate. For example, employees whom are recording invalid data for either personal reasons or to "protect other interests", can be incentivized in many ways (e.g. small financial bonuses) to record the correct data to properly reflect the current status.

There are several threats to Hungary's mental healthcare. First, the prevalence of alcohol and drug abuse amongst children and adolescent is still high (Kapoćs and Balázs, 2017) . For many years the Hungarian government has made improvements, however, it is still a major concern. Secondly the high suicide rate is still a huge issue. Hungary has stated in several of its healthcare plans that it would like to reach the level of 20/100,000 suicides (World Health Organiization, 2008). Currently the national average hangs around 29/100,000 suicides (World Health Organization, 2008). This is a huge change since in 1994 the suicide rate was close to 49,9/100,000 people (World Health Organization, 2008). As a result of long-term low funding in the Hungarian health sector, the country has one of the lowest numbers of in-patient beds in Europe. If this number continues to decrease it will further reduce its ability to provide effective health care to its citizens. The exodus in 2004 of trained Hungarian healthcare professionals influenced by better conditions elsewhere which could be reignited if lack of funding and support prevails.

6. Conclusions

This dissertation reviews a relatively controversial subject, the mental health of our society through the prism of youth from 0-18 years old. At a worldwide level, this issue is clearly shown to concern every country on the globe according to the WHO. This dissertation unfortunately shows that mental health has been and remains a concern at a worldwide level. Currently available global data highlights that around 20% of all children and adolescents suffer from mental ill-health (Child and adolescent mental health, 2019). The Joint Action Plan is the most recent culmination of years of EU initiatives (2005 Green Paper and the European Pact in 2008). It highlights that the EU has recognized the growing concern of the effects of mental health issues on society.

Overall recent mental health statistics indicate that there is a slight increase in children and adolescents affected by ill mental health (Child and adolescent mental health, 2019) . Whilst these statistics are presented by reputable data sources, it is not always clear to whether exactly the same methodology or classification is used to allow a comparison of data, say from WHO or the OECD. This means that, at least within this dissertation, gross trends rather than absolute figures are considered more important. Furthermore, the parameters set by the Joint Action Plan (0-18) are not always the typical data collected during primary research studies thus making it difficult to assess the impact of the Joint Action Plan. An additional constraint to this dissertation is the complexity of mental health. It has a very broad scope and within this dissertation only a few of the parameters could be discussed. A simple example of a data quality challenge is the apparent grouping of all mental health problems under one “umbrella” parameter, makes differentiation between neurological problems and those created through social, cultural or educational events very difficult.

Hungary and the Netherlands have approached the challenge of mental health differently. The Netherlands has decentralized supplying mental health care to its municipalities whilst Hungary has centralized management under its Ministry of Health. There is insufficient data published to assess their respective successes and failures over the period of the Joint Plan, however, neither systems have announced any immediate benefits from one or other approach. With further evaluation or data collection, it may be able to prove that one approach is the optimal approach,

however, currently it seems that neither is able to address the issue at hand. Both systems are experiencing challenges. A good specific example in the Netherlands is the recent large numbers of complaints regarding mental health support. A similar negative example in Hungary is the small number of in-patient beds and a concentration of care located in larger cities in Hungary. An assessment of published suicides rates, for many the most indicative data point, for mental health, shows plateauing figures in both the Netherlands and Hungary. This data point on its own could suggest that the Joint Plan has had no impact as recent available data mirrors historic data. Conversely it can be argued that those driven to suicide have had a long term negative history, which would mean that changes assigned to the Joint Plan may not be seen for decades. This view point might have some weight as Hungary has seen its suicide rates drop over decades.

Kustner and the orthopedagogue pointed out additional funding may not be the solution to both the issues in the Netherlands and Hungary (or even at an European level). Kustner advocates for less bureaucracy whilst the orthopedagogue advocates for targeted programs in primary and secondary schools that teach children and adolescent to learn tools in order cope with increasing demands and pressures of today's society. In essence their arguments are towards focused funding in a strategic manner with currently available finances. If additional financing is required then these monies could be requested based on the successes achieved with the funding to date. A quick comparison of the absolute levels of funding towards mental health between the Netherlands and Hungary show a striking difference, however, both countries seem to be struggling to address the challenge. This high level comparison may add weight to the Interviewees argument, although in Hungary insufficient funding did lead to many qualified health care professionals emigrating to other EU countries. There is therefore a minimum level of funding required to maintain a qualified work force and provide the necessary facilities to treat the afflicted.

Hungary is about twice the size as the Netherlands and almost half the population. It is therefore relatively easy to understand why today Hungary is concerned that it has insufficient resources and aged infrastructure to address the issue. Any additional funds that could be allocated to the Hungarian healthcare sector should be going to increase healthcare services in more rural areas and alleviate the pressure on hospitals and clinics in larger cities. It is easy to conclude that Hungary has a bigger logistical challenge than the Netherlands probably compounded by the need for ancillary support facilities such as civil works, transport infrastructure etc.

The interviews that the author conducted showed that communication from EU and Governmental level, such as policies, plans etc. had not reached the "working level". Both interviewees were unaware of the Joint Action Plan. It would be expected that an important initiative of this sort would receive enough attention and discussion at all levels of the health industry, local and national government. It is very common in doctor and dentist clinics to see important informational flyers on many different topics, what prevents mental health communications being issued in the same manner? It is the author's opinion that there is a lack of communication between the authorities and the healthcare professionals.

One fundamental conclusion that the author would have liked to reach would have been the impact of the Joint Action Plan. Ideally a seminal report would have been issued with a baseline assessment prior to the plan, the results at the end of the programme and key learnings from the initiatives and programmes undertaken. No such paper or report has been found during this research, only partial reports underlying the issues in certain areas in only a handful of Member States was available. This situation has required the Author to present a view of "work in progress".

It is quite clear that mental health problems are a major economic and social issue. It is also obvious that these problems have been present for many years and that there is an open understanding that the current forecast is that with population growth, social and cultural pressures that there may be further growth in mental health issues. It is also apparent that this is a multi-facetted challenge which means that many mental health issues are short term, self-managed whilst only a small proportion may result in personal tragedies of wasted lives.

This dissertation recognizes that the data used here may not all align with the parameters set out by the Joint Action Plan. This is because not all the research that was used uses the same parameters of 0-18 years but may split the age groups differently or classified in alternate structures. This data classification problem, however, does not mitigate or alleviate the problem posed by mental health and the objective of the Joint Action Plan. In essence, we have a very complex and complicated problem which will necessitate continued and dedicated effort across society. This effort the author hopes will allow everyone in society to live a full and prosperous life.

7. Recommendations

This dissertation has only touched the surface of many aspects of the initiatives to address mental health in Europe, Netherlands and in Hungary. Undoubtedly a longer duration study with engagement with the many stakeholders involved in healthcare would allow for a deeper understanding of the issues and be able to define many more practical and detailed recommendations. From the work undertaken it is very clear that many of the data gaps, data coherence, lack of baseline data and fundamental primary research, a post graduate doctoral research programme is recommended. This dissertation can be used in some regards as a starting point and to help define its scope.

The Author also highlights that mental health is a multifacetted, complex and complicated subject. This condition means that it is difficult to undertake a single form of research or a single definitive work, which may lead to a universal "cure" or programme that fits all needs in all Member States. The Author therefore suggests that the Joint Plan allows for national, cultural and societal differences and motivations. A recommendation would be for tailor made programmes to address the specific needs of each Member State.

There will undoubtedly be common needs and problems to address across the EU. This dissertation has identified that learnings and knowledge sharing is crucial. With the easy access to the Internet across the EU and the expansion of broadband networks the EU Commission could set up and facilitate knowledge networks for healthcare professionals. By doing so, the current distance between policy makers, healthcare professionals and academic support would be minimised and information would be current.

To overcome the issue of healthcare professionals permanently moving to other parts of the EU or stepping out of the public care to private, the EU and Member states could invest in a cross border education and financing plan. The objectives of the plan would be to rotate professionals across the EU to locations which would benefit from their expertise without such individuals being financially penalised. In other words a cross EU standard terms and conditions for professionals with incentive based bonuses to rotate into "difficult" or rural locations on a temporary basis.

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Appendices

Appendix 1 - Student Ethics Form

Student Ethics Form

European Studies
Student Ethics Form

Your name: Madelon King

Supervisor: Ms. Krijtenburg

Instructions/checklist
Before completing this form you should read the APA Ethics Code (http://www.apa.org/ethics/code/index.aspx). If you are planning research with human subjects you should also look at the sample consent form available in the Final Project and Dissertation Guide.

a. [Read section 3 that your supervisor will have to sign. Make sure that you cover all these issues in section 1.
b. Complete sections 1 and, if you are using human subjects, section 2, of this form, and sign it.
c. Ask your project supervisor to read these sections (and the draft consent form if you have one) and sign the form.
d. Append this signed form as an appendix to your dissertation.

Section 1. Project Outline (to be completed by student)

(i) **Title of Project:** Are we looking after our children? *An assessment of two European countries*

(ii) Aims of project:

This dissertation seeks to know the effects of the Joint Action Plan for Mental Health and Well-being by answering the question 'What are the strengths and weaknesses of The Joint Action For Mental Health and Wellbeing in the section 'Mental Health and Schools' in The Netherlands and Hungary?

(iii) Will you involve other people in your project – e.g. via formal or informal interviews, group discussions, questionnaires, internet surveys etc. (Note: if you are using data that has already been collected by another researcher – e.g. recordings or transcripts of conversations given to you by your supervisor, you should answer 'NO' to this question.)

YES

If no: you should now sign the statement below and return the form to your supervisor. You have completed this form.

This project is not designed to include research with human subjects . I understand that I do not have ethical clearance to interview people (formally or informally) about the topic of my research, to carry out internet research (e.g. on chat rooms or discussion boards) or in any other way to use people as subjects in my research.

Student's signature _____ date _____

If yes: you should complete the rest of this form.

Section 2 Complete this section only if you answered YES to question (iii) above.

(i) What will the participants have to do? (v. brief outline of procedure):

Participants will be asked a series of questions based on their expertise in their respective professional fields. Furthermore I will be asking if they are familiar with the Joint Action Plan for Mental Health and Well-being. Additionally I will be asking questions pertaining to their expertise in mental health sector and see if this aligns with the goals set out in the Joint Action Plan.

(ii) What sort of people will the participants be and how will they be recruited?

I will be interviewing healthcare professionals and they will be recruited via email, LinkedIn and via other personal contacts.

(iii) What sort stimuli or materials will your participants be exposed to, tick the appropriate boxes and then state what they are in the space below?

Questionnaires[ ]; Pictures[ ]; Sounds [ ]; Words[X]; Other[ ].

I will be interviewing the participants and asking them questions based on their experience in their respective fields and any questions that pertain to my research in order to give a better perspective of the issue.

(iv) Consent: Informed consent must be obtained for all participants before they take part in your project. Either verbally or by means of an informed consent form you should state what participants will be doing, drawing attention to anything they could conceivably object to subsequently. You should also state how they can withdraw from the study at any time and the measures you are taking to ensure the confidentiality of data. A standard informed consent form is available in the Dissertation Manual.

Verbal consent was obtained from both interviewees. One interviewee wished to be unnamed in the main body of text but allowed their name to be used in the appendix.

(vi) What procedures will you follow in order to guarantee the confidentiality of participants' data? Personal data (name, addresses etc.) should not be stored in such a way that they can be associated with the participant's data.

The author will deleted any audiofiles and notes taken.

Student's signature: ..... **date:** 5th January 2020

Supervisor's signature (if satisfied with the proposed procedures): ..... **date:** 5th January 2020

Appendix 2

Interview with Simone Verhage, an orthopedagoge.

Simone gave consent for her name to be mentioned in the appendices but wished to be excluded from the main body of text.

Method

The interview with Simone Verhage took place over the phone. This conversation was not recorded. This was due to time and geographical constraints. The conversation took place in Dutch. The questions asked and the answers the author received are translated from notes taken during the course of the interview.

1. Are you familiar with the Joint Action Mental Health plan?
2. The Joint Action plan is about cooperation, do you think there is such need?
3. You have worked in the SGGZ with YOEP. How was that?
    a. Was there an increase in children and adolescent with mental health problems?
    b. Was there an increase of severity of the cases that you saw?
4. May I ask why you left the SGGZ?
    a. What were your reasons for creating BijSIMOON?
5. What were the responsibilities and tasks that you had within the SGGZ?
6. How can the cooperation between school/psychologist and GGZ in the Netherlands and any other health service be improved?
7. Do you have any ideas how?

Transcript (paraphrased)

Q: Are you familiar with the Joint Action Mental Health plan?

Simone: No, I suspect that this is a political plan. It's not something that I come in contact with.

We then spoke about the goal and objectives of the Joint Action Plan. The author asked Simone whether more cooperation is needed.

Q: The Joint Action plan is about cooperation, do you think there is such need?

Simone: More cooperation is always good. However at YOEP we already work closely with schools. We need to have the same vision and have our heads in the game in order to help the child. Cooperation is crucial in my line of work.

Q: May I ask why you left the SGGZ?

Simone: I left because of the increasing work pressure. I couldn't find the right balance anymore. Our days are long and hard, but there never any break or a 'breather'.

Madelon: What this because there was an increase in patients?

Simone: Not necessarily, YOEP deals primarily with children and adolescents who have ADHD. There is always a waiting list, but there are also only so many hours in the day. So all the time you have you want to spend it helping. But there is never any relief. It's always busy. You're always playing catch-up. To make matters worse there is no money, or less money coming from the government.

Madelon: So you didn't feel like you have enough time to help?

Simone: Yes and no, the media likes to state that bureaucracy swamps us. And that is partly true, however the administrative tasks are necessary to a degree. We need to have reports on who we see and treat. Not only for our own administration but also for future references. If the work is sloppy the first time round, we only create more work for ourselves.

Q*: Was there support from your supervisors?*
Simone: No not really, we were very much left alone. Personally I didn't have enough supervision. Furthermore there wasn't a lot of understanding about the pressure that a job at the SGGZ entails.

Q: Did the quality of care you could provide suffer because of these pressures?

Simone: No, you put all your available energy in helping these children. It just means that there isn't a lot of energy for you.

Q: Do you think we need more cooperation and transparency in the healthcare sector? Is a plan like the Joint Action Plan with the emphasis on cooperation going to help? Do you have any ideas?

Simone: I don't think cooperation (or lack of cooperation) is the issue. Rather that children and adolescents are exposed to so many different external stimuli, like social media that some are more susceptible to. I think that we should target primary and secondary schools and teach them how to cope with these things. Teach them tool, like we do in therapy to cope with the ways of the world. In Scandinavia, I think in Denmark, they already have programmes like these in primary schools. They teach children how to position themselves in life. I think that this the bigger issue currently.

Appendix 3

Interview with Stephanie Kustner – school psychologist at the European School.

Method

The interview with Stephanie took place at the European School on the 4th of December at 13:00. The interview was semi- structured. Verbal consent was obtained to use Stephanie's name and answers in this dissertation.

The questions that were prepared for this interview are stated below:

1. Are you familiar with the Joint Action Mental Health plan?
2. The European School of The Hague is an accredited Dutch school; do you receive support from the Dutch Health services?
    a. You have worked, as an educator at HBO and in schools, was there a difference in theory and practice?
3. You worked in both, the primary and secondary schools. How different are the two levels of education in terms of support for mental health professionals?
    a. What kind of awareness is there at school?
    b. Do they promote
    c. How does this work at ESH
4. The Joint Action plan is about cooperation, do you think there is such need?
5. The Joint Action plan is about cooperation, do you think there is such need?
6. How can the cooperation between school/psychologist and GGZ in the Netherlands and any other health service be improved?
7. Do you have any ideas how?

These questions where loosely followed. As this was one of the authors first interviews, they felt it was more important to establish a rapport with the interviewee and have the conversation flow organically. As a result the questions where not asked in a particular order but what felt natural at the time. The main questions are in italics.

Transcript from voice recorder

Madelon: Thank you so much for doing this. I gave a little bit of information about I am looking and my dissertation is about the Joint Action Plan for Mental Health and Well-being. So it's an EU-project. It's not a policy because the EU doesn't have any say over healthcare. But they wanted to have broader idea of the problem in Europe and then also to foster more cooperation between national health services and European-wide health services.

Q: Are you familiar with this plan?

Stephanie: Not at all.

Q: I know that the European School is an accredited Dutch school. Do you receive support from the government from the Dutch health services?

Stephanie: Yes. We do. We have a school doctor under the GGD, we have a school nurse, we have a social worker that is attached to the school. These services are all subsidized by the Dutch government. The nurse and doctor are fully subsidized, and the social worker is partially subsidized

Q: Do you think, the support you receive is sufficient as far as mental health is concerned?

Stephanie: I think we received similar as to what any other Dutch School receives, as far as for school situation I think this is sufficient because I am of the opinion that as soon as it is a real psychiatric problem this doesn't belong in a school situation, it belongs in the GGZ. We do all the work of the 'toeleiding' but we don't do diagnoses here at school. And we are in fact further along than a regular Dutch school because you wouldn't have a school psychologist working at the school, you would get it via the 'samenwerkingsverband' and get a referral through there. Because we are so multinationalistic, we have to deal with so many different languages we do have that. So we are in fact one step further.

Q: I see that have worked as an educator at HBO level teaching psychology and as school psychologist. Is there a difference in support for mental health and is there a difference between teaching theory and seeing it in practice?

Stephanie: I think that is the advantage of having a foot in both places. Which is exactly why I like doing it. I taught at the Haagse Hogeschool and I also teach in Leiden and I continue to do it because having the both is the best way of doing it. What you do see is that students get a rose-colored view on how the system works.

Q: How so?

Stephanie: If we use 'passend onderwijs' and the Jeugdzorg. Students will say we have 'passend onderwijs now that's really good!' No, it's a nightmare. Because the reality of it is that they don't get the frustrations of waiting lists or the bureaucracy. That does not get translated to them at all. Because in their books it's the theory. And the theory doesn't include the bureaucracy. It should. So as an instructor having the practice you say it; 'Find a crisis place, crisis bed on a Friday, good luck'

Madelon: I talked with an orthopedagoge about this. She said that the waiting list is the worst thing for children and adolescents with any kind issue.

Stephanie: We have lots of children with parenting problems where it would be really helpful if we had a social worker. We a have a social worker, and she will go and do the first intake with the family and then getting someone in there (the GGZ). I cannot name one single agency in The Hague that I would recommend.

Madelon: That is sad to hear.

Q: Could there be something done at European level, or on Dutch level?

Stephanie: The Netherlands swings backwards and forwards on a pendulum. First everything had to be medicalized and then it all has to go the 'gemeente'. The gemeentes have no idea what they're doing. Jeugdzorg en Passend onderwijs; they go to the lowest 'aanbieder' and that is not

always a good person to deal with for these issues. If somebody can see a kid tomorrow, then I question the quality of the care that they are putting in.

Q: Is it not ideal system that the kid is seen immediately with adequate care?

Stephanie: Yes absolutely. Then you need people who understand what the problem is, they have to understand the background, the history and the medical aspect of it, and when you have all these different agencies, they need to be checked, spot checks, like they do anywhere else.

Q: Do you think this because of a lack of money and lack of personnel?

Stephanie: Yes. It's a combination. There is a bureaucracy. And if you're going to talking about the European Union, that's a whole other type of bureaucracy. I thought that Holland was bad, but since working at the European School, you add on to that the European system. I have not been involved with going down to Brussels for meetings and so on, but before we can change anything in our curriculum or add things. For example a topic like safeguarding, or our use of the Meld Code: So if we see that we have in our safeguarding a number of cases that involves, shall we say, sexually interested behavior, then you can think 'when do we start teaching children that?' If you are in a normal Dutch School they talk about 'lentekriebels' in group 1.

Madelon: Yes, when you're 4.

Stephanie: Exactly. You start from the very very beginning. We (at the European School) don't do that until P5, which is right before they go to High School.

Madelon: Really?

Stephanie: Yes, because that's the European curriculum. So if you say we would like to change that or we want to add something. We have to first come up with a proposal. We all have to agree upon that (and that's a miracle in of itself), and then you have to take it to Brussels. And, they have to agree on it too.

Q: So the bureaucracy of the educational system of the European school is also reflected in the mental health system?

Stephanie: Yeah, I would say bureaucracy is a bigger problem than money or knowledge. I think you can get money and I think you can get qualified people but if they have to go through all of these loops, that is the issue.

Madelon: I had a chat with another professional in education and mental health. From her I learned, that it is not so much the bureaucracy. That for her this was not the biggest issue, it was the fact that she was not given enough time to go through the hoops. For example, you refer someone to the GGZ, she is the one who would pick it up the case and to do all the diagnoses and the reports. Everything has to be documented well, which of course it necessary, were she to send the child on to another healthcare professional. However there was always another child, there's always another teenager, there was never a breather.

Stephanie: I think if you could get rid of the bureaucracy, you could move quicker. I will also be starting up again, at the clinic where I was working at; they are starting with children now. And we have a child and youth psychiatrist who is gone out of the Dutch system because of exactly this reason. She has tried and tried and said this is enough; I am not doing this anymore.
So, then the public sector is losing good people because they are not willing to do this anymore. The only people who are able to get help are the ones who can afford it.

Madelon: Yeah and that is not really how the Dutch system is set is set up for.

Stephanie: No, but that's what they're forcing, when the waiting list is 4 months and that's on a good day.

Madelon: Do you see it getting better the older they get?

Stephanie: The children?

Madelon: No the waiting list, so if a child is young is the waiting list longer?

Stephanie: The waiting list are long everywhere. If you want to get them into to a multi-disciplinary team, which is what you're aiming for. So whether it Use, Curion or Delftland - well I have to say I have not tried Delftland lately. All of them have waiting lists, all of them. Then the question, particularly with our target group, what kind of testing they can do?

Q: Since you have worked in both primary and secondary schools and a Dutch system. You currently work in a primary school. Do you see a difference in the two levels of education in terms of supports of mental health and raising awareness of mental health issues?

Stephanie: The school I worked at, was a VSO (Voortgezet Speciaal Onderwijs) so it was already with specialized education for cluster 4, it was already with kids that had diagnoses, every kid had a caseworker.

Q: How does it work out at the European School?

Stephanie: I'm in my second year here, I still have no 'takenpakket' I have a 'functiebeschrijving' rom Rijnlands Lyceum, that is absolutely not what I do. It is something that they just picked off the internet, and says this is what a school psychology does, and I'm still waiting for a sit down to go over what exactly they want me to do in the time that I'm here.

Q: So, what have you been doing?
Stephanie: What I want.

[Laughter]

I have also a new department head, this is my second year and this is my second department head. I have spent a period without a department head. So I had no one above me.

Madelon: That's unusual.

Stephanie: That it is not unusual at all, it's shocking but it's not unusual. So, what were the things that I was hired for? They needed someone outsourcing everything to HCO (Haagse

Centrum voor Onderwijsadvies) and it was costing them a huge amount of money so they wanted someone in house to do the work. I wanted to build up internships, with the Haagse Hogeschool. They were interested in that as well. I wanted to do some prevention with the parents. Then there are the usual observations and IQ tests, those are my primary functions.

Madelon: You basically choose to do that.

Stephanie: Yes. But its also the question of you see things that need to change or you see things in a policy that should change. For example, we have an anti-bullying policy. All schools require an anti-bullying policy. We use a protocol or policy, which is not necessarily a good one. So, you say why are we using that? Well, we have been always using that or someone took a course on that. Then you say, maybe we need to rethink that? We need to look at something that is evidence based and that is actually is proven to work? nd not just because we've been using that and it works really well - in your opinion - And everybody does it differently, is anybody trained in it?

Those sorts of things are the things I think of as the job of a school psychologist. To bring these issues to light. But then I report them.

Madelon: And there is no one to pick it up?

Stephanie: We have senior management and middle management. We have lots of managers, but that's the bureaucracy within the school. Who picks it up and what do they do with it?

Q: Have you felt that you make recommendations to further the health of the child and this has not been picked up?

Stephanie: Absolutely.

Q: There is a need for more listening really, within the system?

Stephanie: What is quite interesting is, that we were literally just two or three weeks ago, we had our accreditation, as a European School, they visited all different classes and they didn't ask

to meet with support. They met with a new support coordinator, who had been in the position for not even a month and they didn't ask to meet with me. They did ask to meet with anybody else, they did not ask any questions about that.

Madelon: You've already talked about your ideas how to change this, which is less bureaucracy.

Stephanie: Yes, that will be the first step.

[Laughter]

Q: Do you have any other ideas that could help?

Stephanie: Just a whole accreditation cycle and checking things, having checks and balances that's the biggest problem. We don't have checks and balances. We do things that are supposed to work in the Dutch system on that regard, and on needs based. But you need to think ahead; you need to attack before the need takes place.

We can do anti-bullying, or we can use the no blame method for the bullying, but then it already has taken place. If we have a more positive sphere at the beginning, then we don't have the bullying to start off with.

Q: Reflecting on your career span, do you think there is an increase in children's and adolescent mental health issues? Has the caseload gone worse?

Stephanie: I don't think that it is so different from 20 years ago. When I look at the cases that I saw in the States, when I was first starting out, it is still the same stuff you've got here. There is a variety of things, ADHD, autistic issues always stay at a certain level. You have your parenting issues. Which at primary schools this is a much bigger thing. I know everybody is going to say that bullying has gotten worse, but I don't think it's gotten worse, maybe people are more aware of it?

Madelon: So, there are more numbers because people are more aware of it?

Stephanie: Yes, and lots of things are called bullying that are necessarily not bullying,

[Laughter]

Stephanie: Cyberbullying is new, but I don't think that that's any different; it's just a different way of doing the same thing. I don't think it's so terribly different.

Madelon: There have been reports that say that in Western Europe, anxiety levels in children are higher. Do you think that this is because people are more aware of mental health issues or do you think that that was always prevalent?

Stephanie: I think people had a more logical way of dealing with it. The big differences are the level of support. I mean you used to have mothers staying at home all the time, and now you don't.

Yeah the kids here, I can see that they're getting anxious, more than kids maybe 20 years ago, although I wasn't at an international setting then. And this target group is just very highly stressed. Super high achievers, everybody has to do their best, be the best. One of the differences is that 20 years ago, you had to be the best, but at least your parents would sit down together with you and did homework with you. But now parents are doing 16 other things and on the phone all the time, and maybe there is a nanny, are there isn't,

Madelon: So society has really changed

Stephanie: Yes, I think it that regard yes, but there is always been a little nervous kids, you just sort of dealt with it.

Madelon: Those are basically all my questions.

End of interview

After the end of the interview, the author had one last follow up question. This correspondence was via email:

Madelon: Thank you so much for sitting down with me last week. I just have one follow up question. You mentioned that the biggest challenge to your work was the bureaucracy, of not only the Netherlands but also the EU. I was wondering if, in your opinion, this has gotten worse in the last decade, especially with the decentralization of the jeugdzorg in 2015?

Stephanie: With regards to getting children and families' help (outside of the private sector) yes, it's gotten much worse.