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Mental Health Prevention in Schools: A Theoretical Framework for Educational Practice in Bavaria

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Introduction

Children and adolescents today are growing up in a world marked by uncertainty and strain: climate crisis, the COVID-19 pandemic, wars, and inflation — a world in a state of continuous stress. In addition, they face their own internal conflicts, which are a natural part of their developmental process.

The number of psychological disorders among children and adolescents increased drastically during the COVID-19 pandemic. Before the pandemic, around one fifth of young people showed psychological abnormalities; during the pandemic, this number rose to about one third (cf. Ravens-Sieberer et al., 2021, pp. 1512–1521). Studies also indicate that anxiety related to climate change increases the risk of developing a mental illness and exacerbates negative psychosocial developments (cf. Vergunst & Berry, 2022, pp. 767–785).

In a press release dated July 13, 2023, the Federal Statistical Office of Germany (Destatis) reported that in 2021, mental illnesses were the most common reason for hospital treatment among 10- to 17-year-olds (cf. Destatis, 2023).

The mental health of students is an increasingly important issue — including in the field of education. It is therefore essential that schools and teachers are informed about preventive measures and know how to apply them effectively.

This paper examines how teachers can contribute to the prevention of mental health disorders in children and adolescents. It provides a theoretical overview of chronic illnesses in youth, the development of mental disorders, and relevant prevention strategies in school contexts. Special attention is given to the role of teachers and the educational system in supporting mental well-being and inclusion.

Chronic Illnesses in Childhood and Adolescence

The following section distinguishes the concepts of "illness" and "health" and explains the chronicity of somatic and mental illnesses.

The term *illness* is broad and lacks a universally accepted definition. According to the online medical database *Pschyrembel* (2022), illness is defined as a "disruption of life processes in organs or the entire organism, resulting in subjectively perceived and/or objectively observable physical, mental, or emotional changes." Illness is thus understood as a disruption.

Health, as defined in the 1948 Constitution of the World Health Organization (WHO), is "one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition" (WHO, 1948, p. 1). It is described as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (WHO, 1948, p. 1).

Health is therefore not merely the absence of illness but a state of positive well-being that extends beyond the disease. This demonstrates that both health and illness are dependent on multiple factors.

Classification systems reflect the current state of medical science and societal approaches to disease. In Europe, the ICD system (International Statistical Classification of Diseases and Health-Related Problems), developed by the WHO, is used. Its 11th revision (ICD-11) was adopted in 2019 and came into effect in 2022, with ongoing annual updates (cf. Fangerau & Franzkowiak, 2022). The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) from the American Psychiatric Association is also used (cf. Frey, 2023, p. 39).

A key distinction in illness classification lies in the onset and progression. Rather than focusing on causes or symptoms, one system categorizes illnesses based on their course: acute versus chronic. Acute illnesses arise suddenly, peak rapidly, and often subside quickly or can be treated effectively. They rarely cause lasting issues. Chronic illnesses, in contrast, develop gradually or episodically and persist over time. They are more difficult to treat, often incurable, and frequently associated with complications and comorbidities (cf. Fangerau & Franzkowiak, 2022).

Chronic diseases are among the most common and economically significant health problems in industrialized countries — and increasingly in lower-income countries (cf. Robert Koch Institute, 2019).

Globally, approximately 12–30% of school-age children are affected by a chronic illness (cf. Damm et al., 2014, pp. 107–116). These illnesses affect various parts of the body — organs, joints, metabolism, and mental health — and include conditions such as diabetes, asthma, epilepsy, congenital metabolic disorders, and depression (cf. Damm, 2022, p. 13). As Damm et al.'s data shows, many chronic illnesses begin during school age.

Children and adolescents with chronic conditions require ongoing medical care, support, and attention, making them a significant concern not only for healthcare systems but also for families and educational institutions.

2.1.1 What Makes a Mental Illness Chronic?

As previously explained, characteristics of chronicity include prolonged — sometimes permanent — complaints and symptoms. Chronic, because most such conditions cannot be cured.

Most common psychiatric disorders tend to become chronic, as they often follow a long-term course. This has been demonstrated by both prospective and retrospective epidemiological studies in recent years. Non-specific initial clinical symptoms and subtle early signs of the impending disorder may appear years or even decades before the first diagnosis and treatment (cf. Klosterkötter & Maier, 2003).

This confirms that it is generally not appropriate to speak of mental illnesses as either chronic or non-chronic, since such disorders rarely emerge acutely or disappear abruptly. For this reason, this paper will use the term “mental illness” to include the concept of chronicity for simplicity.

The ICD-11 defines chronicity not by a fixed time threshold, but rather by the pattern and duration of symptoms. The focus lies on the clinical relevance of the condition and its impact on the individual's functioning (cf. World Health Organization WHO, 2023).

2.2 Development of Mental Illnesses in Childhood and Adolescence

Mental illnesses rarely arise from a single cause. Rather, they typically result from a complex interplay of biological, psychological, and social factors. The following model illustrates the interaction between these three dimensions. In addition, the crucial concept of resilience and biopsychosocial risk and protective factors are introduced.

2.2.1 The Vulnerability-Stress Model

The transdiagnostic *vulnerability-stress model* is a psychological framework that explains the development of mental disorders as a dynamic interaction between biological, psychological, and social factors. It also considers developmental aspects, such as influences from developmental psychology and developmental biology.

The model posits that a mental disorder develops when stress and specific burdens are added to an individual’s *vulnerability* — that is, a predisposition or susceptibility. Elevated vulnerability alone does not lead to a disorder (cf. Wittchen et al., 2020, pp. 24f.).

Vulnerabilities stem from both individual (e.g., genetic, neurobiological, or traumatic) and social factors (e.g., family structure, education, or socioeconomic status). These risk factors interact dynamically and, when coupled with acute stress, can exceed a psychological threshold — triggering mental health problems. Factors like resilience or impulse control can either mitigate or exacerbate this vulnerability (cf. Wittchen et al., 2020, pp. 24f.).

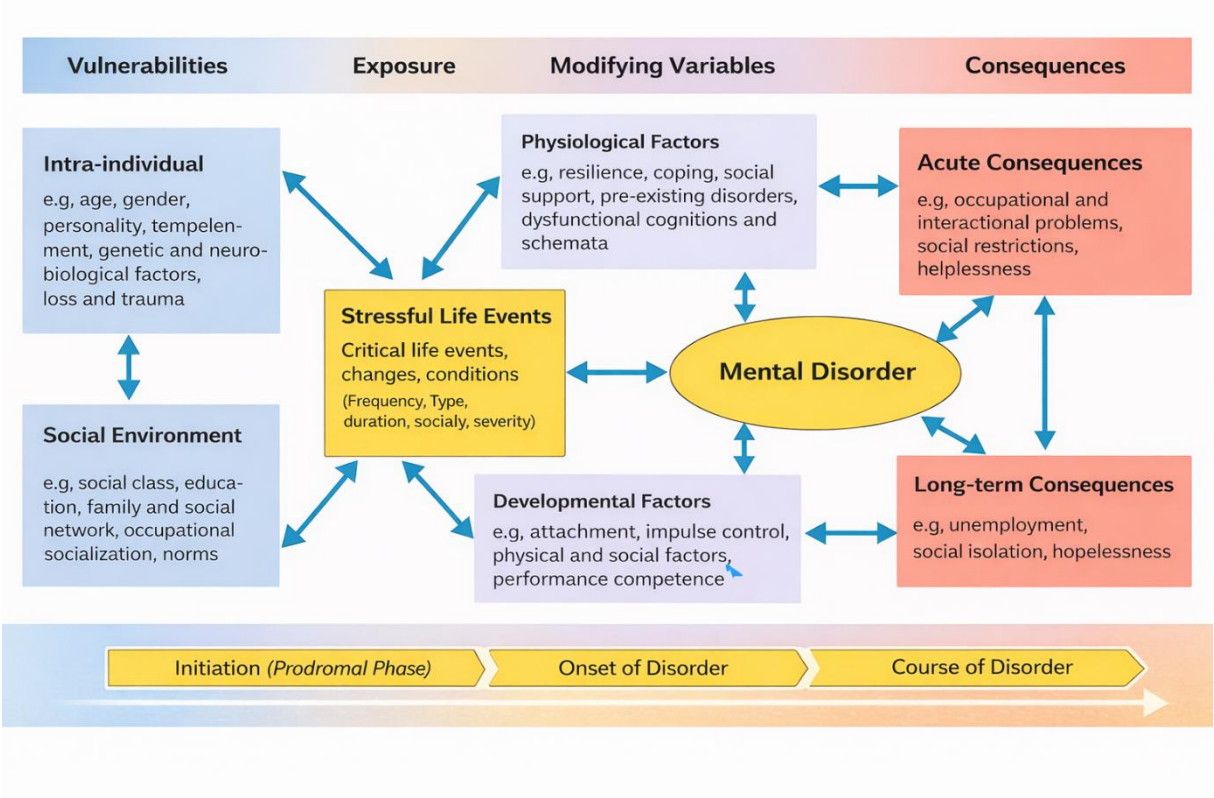

Fig. 1. Vulnerability Stress Model of Mental Disorders (Wittchen et al., 2020, p.25).

2.2.2 Resilience

While vulnerability increases an individual's susceptibility to risk factors, *resilience* develops through a process in which positive outcomes occur despite the presence of multiple risks.

Resilience refers to a person's ability to adapt and respond proactively in the face of severe stress or adversity. Resilient individuals can successfully adjust and cope with challenges, even when confronted with negative events, risk factors, or heightened vulnerability (cf. Wittchen et al., 2020, p. 26).

Strong, trusting relationships within the family and positive peer integration are core elements of robust resilience. Resilience may be seen both as an outcome of successful adaptation despite adverse circumstances and as a dynamic process between the individual and their environment that adapts to varying developmental stages and demands (cf. Wittchen et al., 2020, p. 26).

According to Zolkoski and Bullock, resilient children tend to possess strong social skills, self-regulation, problem-solving abilities, critical awareness, autonomy, self-efficacy, confidence, and goal orientation (2012, pp. 2295–2303).

2.2.3 Biopsychosocial Risk and Protective Factors

When dealing with stressful life situations, a distinction is made between *risk factors* and *protective factors*. Risk factors are variables that increase the likelihood of negative outcomes, while protective factors reduce the probability that such outcomes will occur (cf. Wittchen et al., 2020, p. 25). Risk factors are influences that heighten the chance of developing a mental disorder (cf. Heinrichs & Lohaus, 2020, p. 20).

Risk factors for mental illness may arise prenatally (e.g., genetic defects, substance exposure), perinatally (e.g., birth complications), or postnatally through psychosocial stressors. These early biological influences can shape a child's vulnerability trajectory and are relevant for understanding mental health risks in school-aged populations (cf. Heinrichs & Lohaus, 2020, pp. 21–22).

Postnatal psychosocial risk factors are increasingly prominent. One key factor is *early childhood regulation disorders*, which may result from biological, psychological, or social causes. These difficulties form a foundation for emotional and social competence development and for parent-child interaction, thereby presenting a major risk for later mental illness (cf. Heinrichs & Lohaus, 2020, pp. 22f.).

Additional postnatal risk factors include the quality of attachment to caregivers, parenting behavior, peer socialization, and broader cultural influences (cf. Heinrichs & Lohaus, 2020, pp. 23ff.).

On the other hand, *protective factors* can buffer the negative effects of risk factors and thus lower the probability of developing a mental illness. These too can be prenatal or postnatal. Genetic personality traits, such as intelligence or temperament, may support positive development in children raised in high-risk socioeconomic environments (cf. Heinrichs & Lohaus, 2020, pp. 28f.).

Postnatal protective factors include secure relationships with parents and peers, positive parenting practices, and a stable, non-threatening social environment (cf. Heinrichs & Lohaus, 2020, pp. 29f.).

Importantly, children and adolescents from disadvantaged families often lack the same protective factors as their peers from more privileged backgrounds — for example, in terms of financial resources. An analysis by the German health insurer DAK-Gesundheit found that adolescents from low-income families are less likely to be diagnosed and treated for mental disorders than those from wealthier households. Children from affluent families are more likely to receive treatment for mental illness. These findings

suggest a high number of unreported cases of mental illness among children and adolescents in Germany (cf. DAK-Gesundheit, 2023).

2.3 Preventive Approaches to Mental Illnesses in Childhood and Adolescence

This chapter addresses preventive strategies for dealing with mental illnesses in children and adolescents. It defines the concept of *prevention* and presents possible preventive actions and interventions in school settings.

2.3.1 Definition of "Prevention"

Prevention generally refers to the implementation of measures aimed at preventing or mitigating undesirable conditions. "Disease prevention includes all measures aimed at avoiding, reducing/mitigating, or delaying the onset of (health) disorders" (Franzkowiak, 2022).

Caplan's prevention model distinguishes between *primary*, *secondary*, and *tertiary* prevention (cf. Caplan, 1964).

- **Primary prevention** targets individuals who do not currently exhibit symptoms of a disorder. Its main goal is to reduce risk factors associated with the potential development of illness. By eliminating root causes, behavioral risk factors, and environmental conditions, the incidence of illness within a population can be decreased.
- **Secondary prevention** focuses on the early detection of disorders. It aims to correct developmental issues at an early stage. However, not every mental illness presents clear and identifiable symptoms, which can make early intervention difficult — otherwise, lifestyle changes might be initiated.
- **Tertiary prevention** aims to reduce the suffering caused by an ongoing illness and to minimize further consequences of the disorder. The goal is to prevent chronicity or relapses. Alongside treatment, tailored rehabilitation is crucial (cf. Franzkowiak, 2022).

Unlike therapy, prevention targets a broader range of potential conditions, rather than focusing on one specific disorder. Its goal is broad impact (cf. Leppin, 2018, p. 43).

According to Rosenbrock and Michel (2007), the key objectives of prevention include:

- Preventing, mitigating, or delaying *morbidity* (disease incidence) and *mortality* (death rates) within a given population, and reducing the resulting loss of well-being and social participation.
- Preventing, reducing, and/or delaying *direct healthcare costs* related to treatment, rehabilitation, and insurance.

- Preventing, reducing, and/or delaying *indirect costs* such as reduced productivity or limitations in volunteer engagement. The aim is to maintain the economic and social potential of the population.
- Viewing health investments as key to human capital: without functional labor capacity, economic productivity declines, leading to stagnation (cf. Rosenbrock & Michel, 2007, pp. 3ff.).

Since the risk of developing a mental illness is highest during the first four decades of life, it is essential to implement suitable preventive measures starting in childhood (cf. Bühring, 2018).

2.3.2 Preventive Measures School Contexts

In Bavaria's *LehrplanPLUS* (curriculum framework), the cross-disciplinary educational goal of health promotion aims to foster "active health prevention, addiction prevention, and the development of a healthy lifestyle based on physical, mental, social, ecological, and spiritual balance" (ISB, 2024).

Germany offers a wide range of programs intended to prevent problem behaviors and associated mental health disorders. These initiatives cover areas such as parenting and family education, support for children and adolescents, as well as professional development for teachers.

When selecting appropriate preventive strategies, it is essential to differentiate between target groups. In schools, primary prevention can be subdivided into *universal*, *selective*, and *indicated* prevention:

- **Universal prevention** targets the entire population, such as all students in a school or class.
- **Selective prevention** focuses on individuals or groups at elevated risk.
- **Indicated prevention** addresses those already showing early symptoms of a disorder (cf. Heinrichs & Lohaus, 2020, pp. 81f.).

For example:

- A universal prevention program could target a specific age group with depression-prevention modules, as depression is widespread in Germany and warrants broad counteraction.
- If, for instance, girls at a particular school show increased risk for eating disorders due to academic pressure, a selective intervention may be initiated for that subgroup.

- Indicated prevention might be applied to students who are already showing symptoms — such as social withdrawal or low self-esteem — potentially signaling an emerging eating disorder (cf. Heinrichs & Lohaus, 2020, pp. 81f.).

A comprehensive meta-analysis on school-based prevention (Durlak et al., 2011, pp. 405–432) shows that both the establishment of positive and safe learning environments and the promotion of social-emotional skills are fundamental strategies in school prevention programs.

A key component in creating a supportive learning environment is *classroom management*. Effective classroom leadership not only supports productive learning but also enables the early detection and support of students showing behavioral or emotional difficulties (cf. Toman, 2017, p. 1). In the context of mental health, this means that teachers can identify warning signs early and provide structure that contributes to a stable school experience.

The targeted promotion of *social-emotional competencies* aims to counteract potential problem behaviors (cf. Hillenbrand, 2012, p. 32). Flaschberger et al. (2013, pp. 1–24) summarized the effectiveness of various school-based preventive interventions based on nine international systematic reviews. These reviews examined the promotion of mental health and the prevention and early intervention of anxiety and depression symptoms in school settings.

The evidence strongly suggests that school-based programs are especially effective when they operate on multiple levels, involve the students' social environment (e.g., families), and are implemented over extended periods using diverse and differentiated methods. *Universal programs* tend to be more effective than those targeting only specific groups (cf. Flaschberger et al., 2013, p. 5).

A vignette-based study by Naumann et al. (2023) further illustrates that teachers can play a key role in identifying mental disorders early. In the study, teachers were asked to interpret and diagnose mental health conditions based on various case vignettes. The results showed that teachers had a strong ability to recognize disorders, though there is still room for improvement in naming and classifying moderate conditions. These findings highlight the importance of teacher training in mental health prevention.

Prevention Projects for Mental Illness in Children and Adolescents in the School Context

Projects "ich bin alles" and "ich bin alles @Schule"

The evidence-based project *"ich bin alles @Schule"* was launched in November 2023 by the Department of Child and Adolescent Psychiatry, Psychosomatics and Psychotherapy at the LMU University Hospital Munich, in collaboration with the Beisheim Foundation (cf.

LMU Klinikum & Beisheim Stiftung, 2023). It is based on the earlier project *“ich bin alles”*, which provides information and resources for healthy, psychologically stressed, and depressed children and adolescents, as well as their parents and caregivers (cf. LMU Klinikum & Beisheim Stiftung, 2021).

This digital information portal is a universal prevention initiative aimed at promoting the mental health and well-being of children and adolescents. It offers teachers the opportunity to understand potential causes of mental illnesses such as depression and to acquire knowledge about student mental health in order to apply practical preventive measures in the classroom. In addition, *“ich bin alles @Schule”* seeks to combat stigma surrounding mental illness and foster a judgment-free space for addressing issues like depression.

The website is structured around the categories *“perceive,” “understand,” “communicate,” “encourage and strengthen,”* and *“support.”* This framework gives teachers a comprehensive overview — from initial observations of symptoms to concrete intervention and prevention strategies (cf. LMU Klinikum & Beisheim Stiftung, 2023). Both platforms provide accessible support and promote awareness of mental health and prevention through clearly structured content.

Projects “Verrückt? Na und!” and “Unsere ‘verrückten’ Familien!” for Secondary and Primary Schools

The evidence-based project *“Verrückt? Na und!”* from the association *Irrsinnig Menschlich* is a universal prevention program that promotes mental health and reduces the stigma associated with mental illness. It targets students from grade 8 and up.

The project is centered around dedicated school days with a highly personal approach to promoting and preventing mental health challenges. On these days, students and teachers engage in open dialogue about mental illness and available support services. Each class is accompanied by two experts from the association: one person with lived experience of mental illness shares their personal story and answers questions, while a second person provides professional background knowledge. This second expert works in psychosocial care or specializes in prevention and mental health promotion.

Topics such as mental health crises and warning signs are explored through discussions, group work, and role plays. Students learn where and how to seek help. An open, safe space for questions and dialogue is central to the day’s success.

The goal is to create an authentic and empathetic experience that fosters self-awareness and strengthens the class community.

The program also offers training sessions for teachers and informational events for parents and guardians (cf. Irrsinnig Menschlich e.V., n.d.).

The related project *"Unsere 'verrückten' Familien!"* carries the slogan *"Mentally fit in primary school"*. It introduces students from grade 3 onwards to the topic of mental health challenges within families. This initiative also takes place during a dedicated school day. The centerpiece is a large illustrated scene (*Wimmelbild*) depicting various family crises. The aim is to raise awareness, provide children with guidance on where to seek help, and offer emotional relief (cf. Irrsinnig Menschlich e.V., n.d.).

These two projects help bring mental health into the social mainstream, equip young people with knowledge and strategies for dealing with psychological stress, and create an environment where open dialogue about mental health is possible.

Universal, school-based programs play a vital role in preventing mental illness among school-age children. However, these are not one-time interventions — prevention is an ongoing process. Therefore, refresher sessions and the combination with selective programs are necessary to provide more tailored approaches.

2.3.3 Practical Measures in the School Context

In addition to prevention, *intervention* in the school environment plays a crucial role in addressing mental health disorders in children and adolescents. Although the focus of this thesis lies on prevention, this section briefly discusses intervention as well.

At the center of any intervention is the affected student — in relation to their parents, family, peers, school, and themselves. These are all factors that shape the individual's daily experience. Indicated programs are designed specifically for students who already show clinical symptoms of a mental disorder (cf. Flaschberger et al., 2013, p. 9).

To intervene effectively, teachers must first have the ability to observe and identify issues in everyday classroom and school situations — whether during lessons or recess. Consulting with colleagues, school leadership, school psychologists, school social workers, or mobile special education services is immensely valuable, as an objective external perspective is often essential for accurate assessment.

Another key step is initiating dialogue — both with the affected student and with their legal guardians. These conversations help to better understand the background and possible causes of the issue.

The final step is the *advisory process*. In this stage, the teacher recommends further action — for example, scheduling a consultation with a child and adolescent psychotherapist. If there is an imminent risk of self-harm or danger to others (e.g. in cases of suspected child endangerment), teachers are legally required to contact the youth welfare office or police immediately (cf. Frey et al., 2023, pp. 30f.).

2.4 Schooling of Students with Mental Illnesses

This section addresses the educational inclusion and schooling of students diagnosed with mental illnesses.

The UN *Convention on the Rights of Persons with Disabilities* (CRPD) clearly states in Article 24, paragraph 2, that *all* children — including those with mental illnesses — must have access to education. This includes the right to pursue successful academic and vocational pathways (cf. Federal Government Commissioner for Matters relating to Persons with Disabilities, 2018, p. 21).

In Germany, compulsory education is anchored in the Basic Law: *"The entire school system shall be under the supervision of the state"* (Art. 7(1) GG). This allows each federal state to define and enforce compulsory education through its own legislation.

In Bavaria, every student is required to attend school for twelve years: a combination of full-time compulsory education and compulsory vocational schooling (cf. BayEUG Art. 35).

According to Article 36 of the Bavarian Education Act (*BayEUG*), this obligation can also be fulfilled by attending a *school for sick children*, thus ensuring the schooling of students with mental illnesses.

The following subsections distinguish between *regular schooling*, *hospital schools*, and *child and adolescent psychiatry*.

2.4.1 Regular Schooling

According to Schulte-Körne, approximately 1.1 million students in Germany were already affected by a mental illness in the 2014/15 school year (2016). These numbers have increased further due to the COVID-19 pandemic, as confirmed by the COPSY study, which observed a decline in quality of life and a rise in mental health symptoms (cf. Ravens-Sieberer et al., 2021, pp. 1512–1521).

These growing figures show that students with mental illnesses are present in general education schools across the country and that such schools play a critical role in both prevention and early detection.

School is no longer solely a place for learning. It has become a social space that must act preventively and responsively to the growing mental health needs of students (cf. Frey et al., 2023, p. 30).

This applies equally to special needs schools, which also fall under the umbrella of general education and thus belong to the scope of "regular schooling" (cf. Federal Ministry of Education and Research, 2024).

There are several support mechanisms for students with mental illness:

- **Compensation for disadvantages** (Nachteilsausgleich) under §33 of the Bavarian School Regulations (BaySchO): e.g., extended time during exams or the use of assistive technologies. These measures aim to level the playing field for students without mentioning the adaptations in report cards.
- **Exemptions from performance assessments** (*Notenschutz*) under §34 BaySchO: Students are excused from specific performance requirements when participation is not feasible — for instance, exemption from physical education for students with mental health conditions.
- **Individual support measures** under §32 BaySchO: These allow for personalized instruction, such as differentiated assignments or modified break schedules, tailored to the needs of the student. These measures apply across all types of schools in Bavaria (cf. BaySchO §§32–34).

However, this inclusion in mainstream schools is overwhelming for many teachers. According to the School Barometer, three-quarters of surveyed teachers feel overburdened by the demands of inclusive education (cf. Robert Bosch Stiftung, 2024, p. 30). Only 9% feel their university training adequately prepared them for inclusive classrooms, and about three-quarters believe that special schools are more suitable for students with (special) educational needs (cf. Forsa, 2023, p. 39).

2.4.2 Hospital Schools

Article 41 of the Bavarian School Regulations (BaySchO):

"School-age children who, due to illness, are required to stay for extended periods in facilities where schools or classes for sick children have been established must attend these schools or classes — provided there are no medical reasons preventing it."

This applies not only to children with mental illnesses but also to those with physical conditions. Since the revision of the Bavarian Education Act (BayEUG) in 1982, hospital schools have been separated from the special education system and are now recognized as their own distinct type of school. They act as a bridge between the student, their family, the clinic, and their home school (*Stammschule*) (cf. Bavarian State Ministry of Education and Cultural Affairs, 2024).

These schools are regulated by the *Krankenhausschulordnung* (KraSO), the school ordinance specific to hospital education. Hospital schools serve students who, due to illness, are receiving treatment in hospitals or similar institutions. Instruction generally follows the curriculum of the student's regular school, with adaptations to account for illness-related limitations (cf. BayEUG Art. 23).

This allows students to maintain a sense of daily structure and preserve familiar routines from before their illness, supporting the healing process and facilitating recovery.

Students with mental illnesses are often absent from school for long periods or repeatedly within a school year. Therefore, stable educational support and effective interdisciplinary collaboration between the home school, classroom teachers, school psychologists, and the hospital school are essential (cf. Bavarian State Institute for Education and Cultural Affairs, 2024).

Given the severity of these students' psychological distress, teaching in hospital schools comes with particular pedagogical challenges. These students are usually in a crisis situation — their emotional suffering is central, and teaching must be adapted accordingly (cf. Wertgen, 2012, pp. 67f.).

2.4.3 Child and Adolescent Psychiatry

Child and adolescent psychiatry is a medical specialty that focuses on the diagnosis, treatment, prevention, and rehabilitation of mental disorders in individuals up to the age of 18 — and in some special cases, up to age 21 (cf. Frey, 2023, p. 3).

Depending on the treatment plan, psychiatric care is provided in three forms: *outpatient*, *day-patient (partial hospitalization)*, or *inpatient (full hospitalization)*:

- **Outpatient treatment** is the least disruptive to a young person's daily life and allows quick, low-threshold access to a multiprofessional care team. It often includes preventive components (cf. Mörtl, 1989, p. 100).
- **Day-patient (partial) treatment** means the child or adolescent receives therapeutic care during the day but returns home in the evening. This format enables the integration of home dynamics into therapy and can offer a sense of stability (cf. Myschker & Stein, 2018, pp. 42ff.).
- **Inpatient treatment** involves 24-hour care. In cases of acute self-harm or harm to others, young patients may be admitted to a locked ward. In contrast, treatment on an open ward is voluntary (cf. Frey, 2023, p. 8).

During both partial and full hospitalization, students continue their education in a **psychiatric clinic school**. Because students come from all types of schools, the teaching staff is highly heterogeneous and must continuously engage with the psychiatric context of their learners.

The core responsibilities of the clinic school include ongoing communication with:

- medical and therapeutic professionals at the clinic,
- the students' legal guardians, and
- the students' home schools.

A major focus of the clinic school is *reintegration*. As “temporary schools,” they aim to support successful rehabilitation and prepare students for their return to regular schooling (cf. Frey et al., 2023, pp. 29ff.).

2.5 Interim Conclusion and Outlook

The growing prevalence of mental health disorders among children and adolescents presents a pressing societal and educational challenge. As outlined in this theoretical analysis, mental illnesses are often chronic in nature, shaped by a complex interplay of biological, psychological, and social factors. While vulnerability and risk factors can significantly increase the likelihood of developing a disorder, protective factors such as resilience, strong relationships, and stable environments can buffer these risks and promote mental well-being.

Schools play a central role in the early detection and prevention of mental health disorders. Teachers, as key figures in students’ daily lives, are in a unique position to observe early warning signs and respond with appropriate preventive strategies. Universal, selective, and indicated approaches to prevention — when implemented systematically and sustainably — can create a supportive school environment that promotes not only academic success but also emotional and psychological resilience.

Current prevention programs such as *"ich bin alles @Schule"* or *"Verrückt? Na und!"* demonstrate the importance of accessible, stigma-free resources and highlight the value of interdisciplinary collaboration. Nevertheless, effective implementation depends on adequate training, structural support, and ongoing professional development for educators.

In conclusion, preventive mental health strategies in schools must be understood as a continuous, multifaceted process. While structural and systemic challenges remain, the school context offers significant potential to foster the mental well-being of young people and counteract the long-term consequences of psychological distress. A sustained investment in prevention is therefore not only a health imperative but also an essential contribution to educational equity and social participation.

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