



CAMHEE

CHILD AND ADOLESCENT MENTAL HEALTH IN EUROPE: INFRASTRUCTURES, POLICY AND PROGRAMMES



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An introduction to the country profiles

This report presents an overview of the situation of child mental health policies and practices across 15 European countries/regions: Belgium, Bulgaria, Estonia, Finland, Germany (Heidelberg), Greece, Hungary, Latvia, Lithuania, Norway, Poland, Romania, Slovenia, Spain (Catalonia), and the United Kingdom (England).

The country stories presented in this report have been prepared by the partners of the CAMHEE project who are key experts on child mental health in their respective countries. For the preparation of this report, the partners of each of 15 countries.

have involved stakeholders in their countries to collect information about available policies, programmes, workforce and infrastructures for mental health promotion, mental disorder prevention and care in childhood and adolescence.

This document is not an official and exhaustive account, but rather a snapshot of the current situation and a first attempt to collect comparable baseline information on the general situation in the field of child mental health policies and practices across countries and regions within the enlarged European Union. This process, initiated by the CAMHEE project, and supported by the European Commission, will hopefully act as an impetus and have a positive impact on development of effective child and adolescent mental health policies and practices across Europe.

One of main goals of CAMHEE project was to provide new opportunities for the newer EU Member states to move towards evidence-based CAMH policies and a modern culture of management and evaluation of activities within the CAMH field. The design of the project brought together state agencies, academic centres and NGOs from both "old" and "new" EU Member States, so that creative networking and "cross-fertilization" between different partners could facilitate mutual learning, addressing challenges and identifying new opportunities. The significance of this process of networking within the CAMHEE project and its results was increased through synergy with new developments in EU Mental health agenda, especially with the launch of the European Pact on Mental Health and Well-being.

The results of this exercise, as well as the process of dialogue, raising awareness and networking between partners in 15 countries, revealed many gaps in different levels which need to be filled with evidence-based practices for the promotion of mental health and prevention of mental disorders in childhood and adolescence. These gaps – such as lack of evidence-based CAMH policies, lack of political will to implement existing policies and programmes, low level of investment in modern culture of evaluation and monitoring of policies and services and lack of sustainable preventive programmes – need to be addressed in all EU countries. New EU Member states need to demonstrate a clear political will and to invest in child mental health in ways based on evidence and European values.

On behalf of CAMHEE project leadership, I would like to thank all partners who contributed to this report.

Dainius Puras
Scientific leader of CAMHEE project

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

Prepared by Vanesa Carral, Fleur Braddick, Eva Jané-Llopis and Rachel Jenkins

1. INTRODUCTION

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

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

The CAMHEE Country Profiles have been developed with the intention of beginning the process of analysing the situation regarding CAMH in participating countries and identifying obstacles and opportunities to develop evidence-based and multi-sectoral national CAMH policies within the enlarged EU. While it is understood that the situation analyses compiled in the country stories can never be exhaustive and will represent mainly the perspectives of the multiple stakeholders consulted by the authors for each country, this work aims to comprise a thorough first step in the improvement of baseline information and knowledge in mental health and to contribute to the development of a comprehensive approach to mental health promotion (MHP) and mental disorder prevention (MDP) for children and adolescents. The basis and starting point for the CAMHEE Country Profiles were the 1st and 2nd editions of the IMHPA Country stories¹, developed under the IMHPA project, which analysed and presented the situation for MHP and MDP in the general population across 30 European member states.

Child mental health policies are stimulated by the interaction of knowledge, public awareness, social mobilisation and advocacy. They are also influenced by other contextual issues such as historic and existing health, social and educational policy and services. The need to develop policy on child mental health has, sadly, been widely neglected, but is now recognised as a crucial first step in the development of accessible and effective services for children². As well as policy, detailed strategic action plans, identification of entry points and levers for change are all crucial. A strong supporting infrastructure and facilitators for change, as well as regular audit and review will be needed at the ground level to enable practice to effectively represent the policy behind it.

The overall objectives in developing these CAMHEE Country Profiles are 1) to monitor and map, as far as possible within the scope of this exercise, available infrastructures, policies and programmes for CAMH across the 15 partner countries involved in the CAMHEE network; 2) to analyse these aspects of CAMH at the European level in order to begin to identify gaps and support recommendations for policy and infrastructure development for CAMH; 3) to develop and produce detailed Country Profiles, focusing on CAMH, for 15 European countries.

Process to prepare the CAMHEE Country Profiles

Partners of the CAMHEE Project (Annex 1) accepted the responsibility to act as focal points for the initiative in each country. It was agreed that information on CAMH would be collected through identifying available documents and through consulting, and whenever possible involving, key stakeholders and experts who could provide information.

The starting point was a questionnaire developed with the aim of systematically collecting information on

¹Jané-Llopis, E. & Anderson, P. (Eds). (2006). Mental health promotion and mental disorder prevention across European Member States: a collection of country stories. Luxembourg: European Communities. http://www.gencat.cat/salut/imhpa/Du32/html/en/dir1662/dd11714/country_stories.pdf ²Harper, G & Çetin, FÇ. Child and adolescent mental health policy: Promise to provision. (2008). *Int Rev Psychiatry*, 20 (3): 217-224.

infrastructures, policies and programmes for child and adolescent mental health at the country or regional level. The CAMHEE Project Country Profiles Questionnaire: "Infrastructure, Policies and Practices in Child and Adolescents' Mental Health" is a tool with 8 sections designed to collect key national or regional data on indicators for infrastructures and action for mental health and prevention/promotion for children and adolescents. This questionnaire, based on the previous IMHPA European Mental Health Module questionnaire³, was developed specifically to collect standardised data from a variety of different European countries, including supporting instructions and a glossary of terms⁴.

With support from the EC, the CAMHEE partners created national expert groups, or country coalitions, whose task was to confer and complete the questionnaire for their country or region. The partners were encouraged to include a variety of professionals and multi-sectoral stakeholders in the country coalitions. The make-up of these groups varies across countries, however a sample list of different stakeholders to be included in country coalitions could be: Policy makers; Mental Health Specialists; Social services; Educators; Traditional/alternative healers; Consumers (children and adolescents) and their representatives (ombudsmen, minister); Families and carers; NGOs; Academics – psychiatry, public health, education, anthropology, social sciences.

A variety of methods were used to analyse the data collected, including document analysis; secondary data analysis and critical discussions in the expert group. The data was then synthesised and analysed using SPSS and qualitative appraisal to arrive at a European overview. Simultaneously, CAMHEE country partners developed their

country profiles according to a standard structure.

The European Member States with partners involved in the CAMHEE project, whose country profiles are represented here are: Belgium, Bulgaria, Estonia, Finland, Germany (region: Heidelberg), Greece, Hungary, Latvia, Lithuania, Norway, Poland, Romania, Slovenia, Spain (region: Catalonia), UK (England).

The selection of information included and the programmes and policies described should not be interpreted as the only available sources of action in these countries, nor should they be considered necessarily evidence-based or recommended action. This report was not intended to be a completely exhaustive or evaluative exercise, but rather the first stage in an ongoing process to identify resources, infrastructures and support for the well-being of children and adolescents, which will, hopefully, be extended and updated in the future.

2. What we know about children and adolescents and their mental health

2.1. Prevalence of mental disorders in children and adolescents

The aim of this section is to give an overview of the information available for the monitoring and assessment of trends in children's and adolescents' mental health (CAMH). In this overview, special attention is given to the nature of the data collected, and its comparability across countries. It has been estimated that about 10 to 20% of children and adolescents suffer from mental health problems worldwide⁵, but it has also been noted elsewhere, that large differences in prevalence estimates between countries exists.^{6,7}

The importance of this data: the contribution of epidemiology to policy.

Effective promotion, prevention, care and treatment in CAMH rely upon accurate and up-to-date monitoring of the mental health status of the population. This information is needed to guide the intervention point and nature of promotion or preventive action, as well as for tailoring service provision to the needs of the population. It is also an essential input to policies aiming to improve the mental health of the population, because where accurate and detailed prevalence data is lacking, there is no firm basis on which to develop effective policies and action plans. Effective policy needs to be based on the epidemiology and the social and economic consequences of psychiatry morbidity. Epidemiology



³http://www.gencat.cat/salut/imhpa/Du32/html/en/dir1662/dd11710/imhpa_questionnaire_01.pdf

⁴This questionnaire was prepared by F. Braddick, E. Jané-Llopis and R. Jenkins, who are grateful for the additional input and support of Howard Meltzer.

⁵WHO (2005). Mental health: facing the challenges, building solutions. Copenhagen, WHO, 2005.

⁶E.g., UK prevalence = 9.5%; NL & DE = 22% from Jané-Llopis, E. and Braddick, F. (Eds). (2008) Mental Health in Youth and Education. Consensus paper. Luxembourg: European Communities.

⁷Belfer, M. (2008) Child and adolescent mental disorders: the magnitude of the problem across the globe. *Journal of Child Psychology and Psychiatry* 49:3, 2008, pp 226–236.

⁸Jenkins R. (2003). Making psychiatric epidemiology useful: the contribution of epidemiology to government policy. *International Rev Psychiatry*, 15(1-2):188-200.

contributes both to the development of the overall framework for policy and to the specific objectives within that policy⁸.

Internationally comparable data is needed to have an accurate global overview, and in order to identify large-scale cultural determinants. It is also important to have a comprehensive picture of prevalence at the national and regional level, so that a particular problem area in children's mental health can be accurately defined in terms of the cultural context, to enable the more effective targeting and implementation of large-scale programmes.

Mental health needs are best measured at the population level, through national surveying and screening programmes. This is because admission statistics represent only on those individuals who actively seek care and therefore provide no data on patients with less severe conditions, or with a greater fear of stigmatisation, who may not self-refer even to low threshold health-care professionals⁹. In addition, the proportion of the population who are treated or attended in private practice may be difficult to include in national administrative data, depending on variable reporting systems used in European countries.

The CAMHEE data

The majority of CAMHEE partners reported some collection of data on mental disorders among children and young people, either through surveys (9 of the countries) or administrative data (12 of the countries).

Some of the countries have this information available only at the national level (4 countries), others only at the regional level (2 countries), and other countries collect it on both levels (5 of the countries).

It is important to note that out of the 4 countries reporting no data collection (Bulgaria, Greece, Hungary and Slovenia), 3 are new European member states. Even in these cases some data does exist or is in the process of being collected but as yet unavailable at the time of reporting (as is the case in Greece, where a national level epidemiological study is in process). However, the quality of data in these countries was seen as inadequate and unreliable by the respondents and is often patchy in terms of the mental health problems covered.

The nature of the information provided is quite heterogeneous. The administrative data provides information on the amount of people attended in specialist mental health services according to a set of categories which may vary across European countries. Information on children attending primary care units may or not be synthesised and available as separate from the adult population in different countries. Additionally, the surveys of the general population which aim to assess the prevalence of mental health status, are carried out with a high level of heterogeneity in terms of the age ranges covered, year of evaluation, mental health problems assessed, and the instruments of evaluation used (examples include the Rutter questionnaire, DAWBA, CBCL, SDQ, etc.)

The difficulty in systematically collecting information through

routine service use records often lies at the infrastructural level. As the CAMHEE partners in Bulgaria report, there is a lack of infrastructure to enable data collection in terms of administrative process data from the health system. Elements needed to facilitate this collection would include reasonably well functioning health facilities at primary care and specialist care levels, clear care protocols, the ability to provide accurate assessment and diagnostic information, and incentives or legislation in place to motivate professionals to provide systematic documentation.

In addition, a strong recommendation was voiced by the questionnaire respondents to improve the speed with which data was collated and released for use. In some countries, 15 years elapsed between the collection and publication of prevalence data, and others mention the lateness of official figures becoming available.

Examples of good practice in Europe

Several countries with partners in the CAMHEE project report systematic gathering of prevalence data, either at a regional level (Norway) or at both the regional and national level (Belgium, Finland, England and Catalonia – Spain). However, although some cross-over exists in the tools used, no two of these countries have an identical methodology (e.g., sample frame, sample, screening instruments, interviewers, diagnostic categories, time period) making international comparison of prevalence rates difficult.

The benefits of systematic data collection are amplified by the collection of complementary types of data, using screening instruments and diagnostic scales to estimate prevalence figures. Both approaches are necessary in order to design adequate promotion and prevention approaches, but also for the care and treatment resources, respectively. This is the case in England, where the SDQ (a questionnaire developed for screening purposes) and the DAWBA (a diagnostic assessment tool) provide extensive data on the prevalence of possible and present mental disorders in children and young people as part of the British Psychiatric Morbidity Survey Programme. The administrative data also provides information on the amount of children and adolescents that are being treated in the mental health departments.

All in all, it seems that data is incomplete and not readily comparable due to the different study methodologies used. Different studies at the national level have focussed on a variety of different mental disorders, assessing prevalence across a range of time periods and using a number of different diagnostic scales and data gathering instruments and methodologies.

Areas for improvement and suggestions for moving forward

Estimation of the epidemiological prevalence of childhood mental disorders, and also of those children at risk of developing a mental disorder, is a challenging task. Compared to the adult epidemiology, the epidemiology in infants, children and adolescents face additional assessment difficulties. Firstly, the categorical classification usually developed to assess the mental

disorders (i.e., DSM-IV or ICD) is not generally suitable to describe the psychopathology of the youngest cohorts of the population¹⁰. There is a need to go beyond more circumscribed studies of prevalence and incidence using DSM-IV or ICD-10. Symptom clusters have been proposed as estimates of cases at-risk, rather than as ascertained cases¹¹. Secondly, for the accurate assessment of some disorders multiple informants are required (e.g., child, parent, teachers, clinician), and the prevalence can vary considerably, even more than 10%, depending on the different perspectives of the informants. Third, the inclusion of functional impairment defined as a lack of adaptive functioning for the child developmental stage within each specific cultural context also accounts for differences in the prevalence rates found¹². These methodological characteristics of the studies seem to explain the great difference in prevalence estimates¹³.

difference between the rates of children receiving treatment in the health system and those who are attending but have not been diagnosed indicates the ability of the health staff to make correct diagnoses. By repeating community surveys it is possible to monitor the health of the populations and trends together with changes in potential risk factors.⁷

- The ideal approach would include the systematic collection of data at each level in the health system, from the community level upwards, in order to understand needs and to what extent they are dealt with by the health service.
- The first level would thus comprise the collection of comparable, systematic, cross sectional and longitudinal data on the prevalence of mental disorders (for care and treatment planning) and of the prevalence of children and adolescents at risk (as a basis for prevention and promotion programmes). The evaluation should include a dimensional approach, and take impairment into account with respect to collection methodology.
- The second level would comprise studies of the numbers of children and adolescents attending primary care health facilities who are found to have mental disorders through research methodology.
- The third level would be use of the administrative data on children and adolescents attending primary care, who have received diagnoses of mental disorders.
- The fourth level would be studies of the numbers of children and adolescents attending secondary care health facilities who are found by research methodology to have mental disorders,
- The fifth level would be the use of administrative data of children and adolescents attending secondary care who have received diagnoses of mental disorder .
- The difference between the rates of children receiving treatment and the prevalence estimates, while not representing accurately the proportion of children in need that are not receiving treatment, could at least point towards gross treatment or service deficits in areas of child and adolescent mental health. The

2.2. Vulnerable child populations

The term ‘vulnerable child population’ encompasses a broad spectrum of different individuals who are at greater risk of mental health problems (See Table 1. below for a non-exhaustive list of vulnerable populations). Those groups may have very different mental health needs, but often share experiences of stigma, discrimination and/or difficulties accessing mental health services and promotion or preventive action. In addition, the available services may not be adapted to their specific needs.

Some of these groups also constitute a low-prevalence group, and for this reason are further neglected. For example, in most of the surveys there are problems with general indices representing the circumstances of children in minority groups – ethnic minorities, Roma, refugee/asylum seeker, disabled children – which are too small in numbers to be represented in general samples of the population, and a tendency has also been noted for many of the indicators to relate only to the circumstances of older children¹⁴. However, these low-prevalence groups usually have a greater need of attention compared to other more numerous groups which may already receive more attention.

Table 1.

CHILDREN LIVING IN POVERTY
HOMELESS CHILDREN
EARLY SCHOOL LEAVERS
CHILDREN EXPERIENCING BULLYING
UNEMPLOYED YOUTH
CHILDREN IN CARE
ASYLUM SEEKER CHILDREN
TRAVELLER CHILDREN
JUVENILE OFFENDERS
CHILDREN ABANDONED DUE TO PARENTAL MIGRATION FOR EMPLOYMENT
MINORITY ETHNIC/MIGRANT GROUPS
ADOPTED CHILDREN
PSYCHICAL AND LEARNING DISABLED CHILDREN
CHILDREN WITH PARENTS WITH MENTAL DISORDERS OR DRUG ABUSE
CHILDREN USING ALCOHOL
ABUSED CHILDREN

¹⁰Belfer, ML (2008). Child and adolescent mental disorders: the magnitude across the globe. *J Child Psychology and Psychiatry* 49:3, pp 226-236.

¹¹Chen KW, Killelea-Jones LA, Vega WA. (2005). Prevalence and co-occurrence of psychiatric symptom clusters in the U.S. adolescent population using DISC predictive scales. *Clin Pract Epidemiol Ment Health*, 28;1:22.

¹²Roberts RE, Attkisson CC, Rosenblatt A. (1998). Prevalence of Psychopathology Among Children and Adolescents. *Am J Psychiatry* 155:715-725, June 1998.

¹³Polanczyk G, de Lima MS, Horta BL, Biederman J, Rohde LA. (2007). The worldwide prevalence of ADHD: a systematic review and meta-regression analysis. *Am J Psychiatry*, 164(6): 942-8.

¹⁴Jonathan Bradshaw. Paper of session 5: Social inclusion and child poverty. In: *Interdisciplinary Workshop Report - Changing Childhood in a Changing Europe*, 26-27 February 2009, Nicosia, Cyprus. European Science Foundation, Strasbourg, 2009.

Children living in poverty

The EU Statistics on Income and Living Conditions (SILC) allows a comparative analysis of child poverty based on household income¹⁵ and the proportion of children living in families without an income from gainful employment.

High rates of child poverty are observed in countries such as Lithuania, Poland, Romania and England, with values around 30%, despite the statement in the International Convention on the Rights of the Child asserting the right of children to adequate living conditions¹⁶. Moreover, with a few exceptions, the child poverty rate in most European countries is higher than the overall poverty rate for the general population (e.g., in Poland 29,5% of children and 16,2% of the general population live in poverty, respectively) and more pronounced for the younger cohorts of children (e.g., in Belgium the risk of poverty is of 19% for those under 16 years; and of 12% for those between 16 and 24 years old).

Homeless children

Developmental and mental health problems are more prevalent in homeless children than those who have homes¹⁷, and their high level of need justifies the development of services which specifically target homeless people and their children¹⁸.

Only 6 CAMHEE partners have reported some data on the prevalence of homeless children, with large differences in the rate reported between these countries. For example, while Norway has reported a prevalence of 0%, Romania reported 70.000 homeless children in the year 2004 (giving an approximate prevalence of 0.33%¹⁹).

Early school leavers

There is variation across countries, publications and studies in the definition of "early school leavers", resulting in a range of possible figures for this item. The Eurostat survey recorded the prevalence of early school leavers²⁰ across European countries. This indicator is both a proxy measure of the efficiency of the education system and a predictor of the future ability of the society to fight poverty and social exclusion²¹. The term 'early school

leavers' used in the CAMHEE questionnaire refers to young people leaving school before the legal school leaving age and/or with limited or no formal qualifications²². Young people leaving education without recognised qualifications are at a disadvantage in the labour market, have their personal and social development curtailed, and are at increased risk of poverty and social exclusion. By this more stringent definition, the group identified are less prevalent (i.e., in Poland there are 0,28% and 0,19% of school leavers in the range of 7-13 and 14-16 years old, respectively; while 5% of 18-24 early school leavers according to the Eurostat criteria)²³, but represent a population at greater risk of multiple determinants for mental health problems.

Children experiencing bullying

Most of the CAMHEE countries have reported some data on children experiencing bullying. The percentage can vary considerably depending on the age range, reference period and instrument used to measure bullying. Therefore, once again it is difficult to make comparisons across countries, but estimates vary from 8% (Finland) to 36% (Lithuania), with the mean at around 20.5%.

Youth unemployment

Unemployment early in the working life is associated with a higher percentage of somatic and psychological symptoms²⁴. Most of the CAMHEE countries collect national data on youth unemployment and use a similar age range to report it (from 15 to 24 years in most countries). The highest rates are noted in England (UK) and Catalunya (Spain), where at least one in four of young people up to 25 years old are unemployed.

Children in care

10 out of the 15 countries here report some data on children in care, meaning those living in residential places other than their biological families. The figures range from 0,3% (Poland) to 1,6% (Romania). A striking increase was reported in Finland from 1991 to 2005, where 1.4% of children have been displaced from their own home, and 1% placed outside the family in year 2005²⁵.

¹⁵The proportion of children living in households with income less than the 60 per cent of the national equivalent median before housing costs

¹⁶<http://www2.ohchr.org/english/law/crc.htm> Article 27, 1. States Parties recognize the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.

¹⁷Grant R, Shapiro A, Joseph S, Goldsmith S, Rigual-Lynch L, & Redlener I. (2007). The health of homeless children revisited. *Adv Pediatr*, 54:173-87

¹⁸Vostanis P. Child mental health problems. In: Vostanis, P and Cumella, S. (Eds)(1999). *Homeless Children: Problems and Needs*. (1999).

¹⁹Based on an estimated population size of 21.5 million people.

²⁰Defined as: persons aged 18-24 with secondary education as the highest level of education and not in further education or training in the four weeks preceding the survey.

²¹<http://epp.eurostat.ec.europa.eu/tgm/table.do?tab=table&init=1&plugin=1&language=en&pcode=tsisc060> ²²Cullen B. (2000); *Evaluating Integrated Responses to Educational Disadvantage*, Dublin, The Combat Poverty Agency. http://www.cpa.ie/publications/submissions/2001_Sub_NESF_EarlySchoolLeaving.pdf

²³Oswiata i Wychowanie w roku szkolnym 2006/2007 [Education in the school year 2006/2007] GUS, Warszawa 2007 http://www.stat.gov.pl/cps/rde/xbcr/gus/PUBL_oswiata_wychowanie_2006-2007.pdf

²⁴Hammarstrom, A. and Janlert, U. Early unemployment can contribute to adult health problems: results from a longitudinal study of school leavers. *J Epidemiol Community Health*. 2002 August; 56(8): 624-630.

²⁵Tilastokeskus (Statistics of Finland) and Stakes 2007.



Asylum seeker children

Asylum-seekers are persons who have applied for asylum or refugee status, but who are pending a final decision on their application. Most industrialised countries lack a refugee register and are thus not in a position to provide accurate information on the number of refugees residing in their country.²⁶ Some of the CAMHEE partners have reported having some data on child asylum seekers. In 2007 Finland, Lithuania, Norway and England (UK) reported absolute numbers of 98, 165, 222 and 2965, respectively. However, it is not clear in which process of the application they are. According to the UN Refugee Agency²⁷, a distinction should be made between the number of asylum-seekers who have submitted an individual request during a certain period ("asylum applications submitted") and the number of asylum-seekers whose individual asylum request has not yet been decided at a certain date ("backlog of undecided or pending cases").

Traveller children

Traditional traveller populations, also known as gypsies (of Roma, or other descent) are distinct from "new" traveller populations, and yet both share a number of risk factors which adversely affect these groups' mental health, in particular that of their children. Traveller children are from ethnic and/or cultural minority groups. They may speak a distinct language or dialect from the majority population, have very different cultural norms and often experience discrimination and exclusion from the wider population in a country. Access for travellers of all ages to health care is poor, and parental mental health problems may go untreated for a long time, increasing the risk to children. Other high risk behaviours compound the problem in new travellers^{28,29}. In addition, traditional traveller communities have been especially hard hit in times of economic crisis, being often

the first to lose jobs. For this and other reasons, travellers are amongst the most poverty stricken minority groups in Europe, and their children's mental health suffers accordingly. While observational experience informs us that traveller populations with children exist throughout Europe, only Lithuania has reported data on traveller children (1183 itinerant individuals between 0 and 19 years, in 2001).

Juvenile offenders

Young offenders have high levels of diverse needs that often go unmet, including mental health needs³⁰. Recent advances have been made in the development of screening tools for mental health problems in young offenders, but the risk of depression and suicide, as well as mental health problems associated with illicit drug use and poor educational attainment remains high in this group³¹. The proportion of young offenders reported varies between 0.5% (cautioned or prosecuted in Norway) up to 9% (cautioned in Slovenia), with 7 of the country respondents reporting figures collected for this vulnerable population³².

Children abandoned due to parental migration for employment

Lithuania, Poland and Romania have reported some data on children abandoned due to parental migration for employment. The amount seems to be relatively high in Poland (25,9-29,3% in 2006) and Romania (350000 in 2007), and this situation places children at greater risk of vulnerability, comparable with other childhood family disruptions, such as parental divorce or death.

Children with parents with mental disorders

Parental mental health problems are a major risk factor for children's adverse development and it has been estimated that about 20-25% of minors live with parents who have mental health and/or substance abuse problems. According to the CAMHEE work package 5 on children with parents with mental disorders, there are very few countries in Europe with systematic preventive and promotion activities, and some recommendations are proposed according to this fact³³. The recommendations include a mapping of existing practices related to parents and their families when a parent has mental health or substance abuse issues; community-based mental health centres in place; and multidisciplinary and inter-sectoral outreach teams extending their focus to prevention, promotion, and the well-being of all family members, among other actions.

Other vulnerable child population:

Data on other vulnerable populations have been reported by some countries, such as disabled children, abused children, adolescents in transition between child adolescent mental health service and alcohol abuse. Heavy drinking is relatively high in Finland, with 23% of 14-16 years old teenagers drinking heavily at least once a month (data

²⁶http://www.unhcr.org/statistics/STATISTICS/45c06c662.html#ESTIMATING_REFUGEE_POPULATIONS

²⁷<http://www.unhcr.org/statistics/45c063a82.html>

²⁸www.esbhhealth.nhs.uk/...health/travellers.asp

²⁹Hawes D. Gypsies, Travellers and the Health Service: A Study in Inequality. Policy Press: University of Bristol, 1997. ³⁰Bailey S, Tarbuck P. (2006) Recent advances in the development of screening tools for mental health in young offenders. *Curr Opin Psychiatry*. 2006 Jul;19(4): 373-7.

³¹Puri BK, Lambert MT, Cordess CC. (1996). Characteristics of young offenders detained under section 53(2) at a young offenders' institution. *Med Sci Law*. 1996 Jan;36(1):69-76.

³²Belgium, Finland, Lithuania, Norway, Poland, Slovenia and Catalunya/Spain.

³³Puras, D and Sajejicene, J. (2009). CAMHEE Project: General Overview of Preliminary Conclusions and Recommendations.

collecting in 2000-2004). In Belgium, alcohol use has been reported at 45% for boys and 34% for girls.

2.3. Positive child and adolescent mental health

Mental health has been variously conceptualised as a positive emotion (affect) such as feelings of happiness, a personality trait inclusive of the psychological resources of self-esteem and mastery, and as resilience, which is the capacity to cope with adversity³⁴. Positive mental health also refers to autonomy, as in individuals having the ability to identify, confront, and solve problems themselves³⁵. It can also be conceptualised as a subjective sense of well-being. Currently there are comparable well-being indicators available at the European level in the material, educational and subjective dimensions of well-being^{36,37,38}. However, other indicators associated to positive mental health, such as resilience or self-esteem, are not widely available.

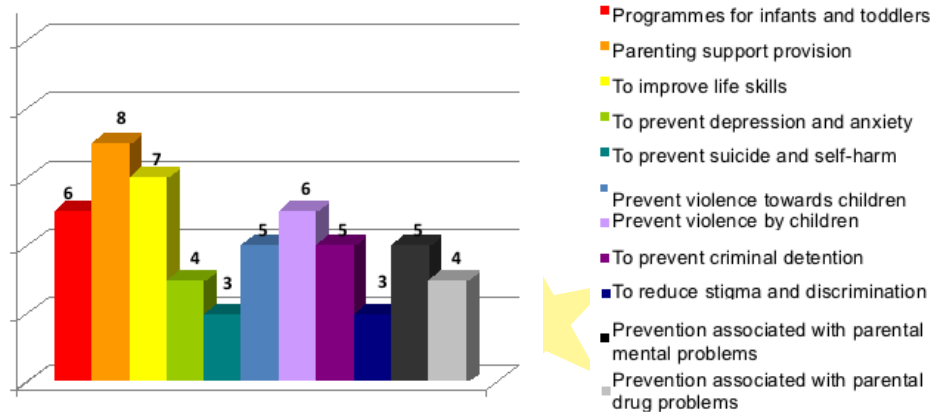
Table 2. Collection of data on positive child and adolescent mental health

Wellbeing/self-esteem	Quality of Life	Resilience	Other
5 countries	5 countries	3 countries	2 countries (measures on: Peer relationship and Family environment/ Social support)

3. Actions for promotion and prevention in mental health

3.1. Policies and programmes for CAMH

Good child mental health arises through an interaction



between several domains: individual factors, social and environmental factors. Conditions to support the development of infants into mentally healthy children, adolescents and adults are founded on societal and contextual factors in the form of cultural beliefs on one hand, and policy, legislation and available action to improve resilience or reduce adverse situations, on the other.

In this sense, mental health (and in particular child and adolescent mental health) is everybody's business; it is not only an issue for the health sector, but also for other sectors of public policy. Action for mental health is an issue of shared responsibility, and health and economic gains can be achieved by the support and action of many different sectors and actors in society. For example, policy and programmes in sectors as diverse as criminal justice, education, environment and urban planning, finance, housing, labour, and social welfare³⁹ all have a profound effect on child and adolescent mental health.

This section explores the CAMHEE partners' reports of public policy and judicial enactments, which may impact on children's and adolescents' mental health (CAMH) in either a positive or negative way, including public health measures, large-scale programmes (figure 1), taxation, legislation, equity and human rights. An introduction of the fundamental issues of each type of programme and an example is provided here. More examples of programmes can be found in the country profiles which follow.

Specific policies and large-scale programmes for CAMH

³⁴Promoting mental health: concepts, emerging evidence, practice : summary report / a report from the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation (VicHealth) and the University of Melbourne.

³⁵Jahoda M (1958). Current concepts of positive mental health. New York, Basic Books.

³⁶Richardson, D., Hoelscher, P. & Bradshaw, J. (2008). Child well-being in Central and Eastern European Countries (CEE) and the Commonwealth of Independent States (CIS). Child Indicators Research, 1/3, 211-250.

³⁷Currie, C. et al., (2008). Inequalities in young people's health: Health Behaviour in School-aged Children (HBSC) International Report from the 2005/2006 Survey. Health Policy for Children and Adolescents, No. 5, Copenhagen: World Health Organization, Regional Office for Europe. http://www.euro.who.int/eprise/main/WHO/InformationSources/Publications/Catalogue/20080617_1

³⁸UNICEF, Child poverty in perspective: An overview of child well-being in rich countries, Innocenti Report Card 7, 2007. UNICEF Innocenti Research Centre, Florence. (<http://www.unicef.org/media/files/ChildPovertyReport.pdf>)

³⁹Jané-Llopis, E. & Anderson, P. (2005). Mental Health Promotion and Mental Disorder Prevention. A policy for Europe. Nijmegen: Radboud University Nijmegen.

Parenting support provision

Positive proactive parenting can increase children's self-esteem, their social and academic competence, and protect against later disruptive behaviour and substance use disorders. This said, programmes to support and encourage good parenting skills are important to break the cycle of poor parenting where things have gone wrong. Adults often learn parenting styles from their own parents and usually show their children the same degree of attention and love, or lack of those, that they received as children. Parents with mental health problems can find it difficult to show their infants and children the care they require. This means that programmes should support parental mental health whilst also encouraging good parenting practice.

Within the large population of parents, those at points of transition, such as the perinatal period and parents of adolescents, are especially important groups to support, as are vulnerable parents, such as teenage parents and those with depression.

Seven of the CAMHEE countries reported provision of parenting support on a large scale.

Since 2006, the Greek Ministry of Education and Religious Affairs has run programmes for the briefing and sensitisation for parents, as well as programmes to educate front-line personnel in the community, using specially developed training material for the instructors and for apprenticeship.

Initiatives to improve life skills

Life skills are competences that we use in our daily life, e.g., ways to handle stress, make major life decisions, and form more satisfying interpersonal relationships

Programmes or policies aimed at improving life skills may be universal or targeted at higher risk groups, such as those who show pre-cursors to behavioural problems or children with specific physical or mental impairments.

For example, the project "Coolness training" is offered in Heidelberg, Germany, and is directed at young people who have become obstructive in their social environment, at risk of getting involved in violent offences and becoming socially marginalised. The training works by improving the children's capacity for action in conflict situations and their social competences, promoting de-escalating behaviour to prevent violence and encourage them to intervene to prevent violence.

Another example from England is SEAL (Social and Emotional Aspects of Learning), a voluntary programme designed to develop the social and emotional skills of all school pupils in the areas of self-awareness, managing feelings, empathy, motivation and social skills.

There is an overlap of life skills initiatives into other areas of prevention/promotion, such as prevention of depression and anxiety, prevention of violence and criminal detention.

Preventing violence and aggression by or towards children

The protection of children from violence is mentioned in the international charter of children's rights and is a proven means of universally promoting mental health and well-being among children and preventing mental

disorder in later life. In light of this, it is curious that there are more examples reported of large-scale programmes or policies which address violence by children than violence towards children. Aggression perpetrated by children is often directed at other children, meaning that programmes in these two areas are inextricably linked.

In Belgium, the programme HERGO presents a model of group conferencing in the field of school and education with proven positive effects. This consists in a guided conference between a perpetrator and its victim as a response to serious problem behaviour in the school environment, such as violence or aggression. It is obligatory for Belgian schools and also aims as much as possible to re-integrate students back into the same school, to avoid the social exclusion and further alienation of such young people.

Activities of the CAMHEE project have resulted in significant policy changes in some EU countries. In Lithuania, for example, the concerted efforts of stakeholders have led to an increased awareness of the problem of bullying, and have prompted a decision of the Government to fund and implement systematic anti-bullying programmes in schools throughout the country. This is a good example of how positive change can be stimulated if all the necessary components of policy development are in place: a citizens grass-root movement, involvement of children and youth, collection of research data, the search for international best practices and the political will to invest in evidence-based interventions.

Preventing criminal detention

Criminal detention is costly to society and there is evidence that early anti-social behaviour results in huge costs, in particular in the criminal justice sector, in early adulthood⁴⁰. For individuals of all ages, criminal detention and mental health problems form a vicious circle: mental and behavioural problems may increase the risk of detention via a number of routes (through co-morbid drug use, violence and aggression), and concurrently, detention or incarceration has a negative impact on mental health. For young people the negative effects of detention are multiplied with studies showing substantial psychiatric morbidity among juvenile detainees⁴¹. There is a clear need to break the course of this vicious circle early on in childhood both because of the strain posed to societies by growing juvenile detainee populations, and because youth with psychiatric disorders pose a challenge for the juvenile justice system and, after their release, for the larger mental health system.

Prevention of criminal detention among young people requires a coordinated effort from multiple sectors, including personnel in schools, the police force and NGOs. Such an initiative is now in place in Poland, where the National Programme for Prevention of Social Maladjustment and Crime among Children and Adolescents⁴² has been developed and implemented by an intersectoral governmental committee. The Programme describes the framework and gives directives for action. The main type of resulting programme has been a combination of

⁴⁰Scott S, Knapp M, Henderson J, Maughan B. Financial cost of social exclusion: follow up study of antisocial children into adulthood. *BMJ* 2001; 323: 191-194

⁴¹Nearly two thirds of males and nearly three quarters of females met diagnostic criteria for one or more psychiatric disorders". Teplin LA et al (2002). *Psychiatric Disorders in Youth in Juvenile Detention*. *Arch Gen Psychiatry*. 2002;59:1133-1143.

supporting families endangered by social pathology and supporting various forms of day-care for children.

Preventing disorders associated with parental mental health or drug problems

As described above, parental mental health problems can have a major impact on children's mental health with negative future outcomes in child- and adulthood. Alcohol and substance abuse can be considered both a cause and symptom of mental distress and parents with drug problems often have co-morbid depression or psychotic disorders. In addition, the deeply entrenched stigma surrounding mental disorders, addiction and drug use means that this group of parents require particular attention. Historically, legislation has often been punitive in these cases and parents in such predicaments are often fearful of losing custody of their children. Large scale programmes which are proactive and offer positive support and solutions are necessary across Europe.

One example is the Efficient Child and Family Programme organised by STAKES. This is a nationwide development and training programme for professionals who work with children and families at high risk, which aims to develop working processes for use by social and health care professionals, different co-operating partners and organisations.

Preventing depression and anxiety

Children and young people go through many periods of transition involving changes in physical development, cognitive abilities, emotional adjustment, and self-esteem. In addition, especially during early adolescence, there are changes in family relationships, and these, along with family life events and family dynamics, have been found to play a significant role in the development of adjustment problems and mood dysfunction during this period⁴³. In Norway, "Mental Health in School" is a school-based national intervention initiative to prevent the development of emotional and behavioural problems in adolescents. The programme supports both children and staff on issues relating to mental health, including coping strategies and peer supporting.

Preventing suicide and self-harm

Suicide is a major cause of premature deaths in Europe. 12 of 1000 EU citizens die prematurely due to suicide, with young men suffering from mental disorders being the highest risk group⁴⁴. However, it is young women who are more likely to deliberately self-harm, which is paradoxically one of the risk factors for depression and suicide. This practice is under-reported and often hidden by adolescents⁴⁵. Negative life events in childhood and adolescence can lead to severe long-lasting mental and social problems in adolescence and adulthood. For instance, childhood sexual and physical abuse is linked

with an approximately twofold risk of adult depression⁴⁶; the more severe abuse, the higher is the risk for major depression and suicide.

Recent work by the European Alliance Against Depression has found favourable results for programmes which target multiple levels using a variety of preventive strategies. Such multi-faceted programmes are underway in Poland and Catalunya. The Polish initiative includes simultaneous branches aimed at educating teachers and guardians, educating and supporting pupils and early identification of those needing help by health professionals.

Reduce stigma and discrimination

Stigma and discrimination exacerbate the negative personal and economic impacts of mental health problems across Europe. Negative attitudes towards people with mental health problems are not only found among the general public and media, but even among mental health professionals⁴⁷. These and other elements of stigma increase social distance and lead to social exclusion: they, for instance, reduce the likelihood of an individual becoming employed or accessing health care services.

The available evidence suggests that anti-stigma campaigns targeted at specific population groups, such as school children, may be more effective than those for the general population⁴⁸. Research carried out in England suggests that in the short term at least interventions in school settings can improve attitudes towards people with mental health problems⁴⁹.



⁴²<http://www.mswia.gov.pl/portal/pl/199/4203/>

⁴³Nilzon, K. R., Palmerus, K. (1997) The Influence of Familial Factors on Anxiety and Depression in Childhood and Early Adolescence. *Adolescence*, Vol. 32, 1997

⁴⁴Wahlbeck K. & Mäkinen M. (Eds). (2008). Prevention of depression and suicide. Consensus paper. Luxembourg: European Communities.

⁴⁵Madge N, Hewitt A, Hawton K (2008). Deliberate self-harm within an international community sample of young people: comparative findings from Child and Adolescent Self-harm in Europe (CASE) Study. *J Child Psychol Psychiatry* 49(6):667-77.

⁴⁶Fryers T (2007). Childhood determinants of adult psychiatric disorder. Research reports. Stakes, Helsinki

⁴⁸David McDaid (2008) Countering the stigmatisation and discrimination of people with mental health problems in Europe.

⁴⁹Pinfold, V., et al., Reducing psychiatric stigma and discrimination: evaluation of educational interventions in UK secondary schools. *Br J Psychiatry*, 2003. 182: p. 342-6.

One generic principle for good practice which applies to all types of large scale programme is that of cross-sectoral cooperation. The most effective approaches to mental health promotion and prevention of mental disorders include the involvement of a variety of actors who children and adolescents come into contact with children and adolescents in all settings, such as families, teachers, doctors, police and community figures. Many of the CAMHEE partners have mentioned national initiatives to improve or stimulate cross-sectoral cooperation. This can take the form of partnerships to provide a programme or policy initiatives such as the governmental initiative, Every Child Matters, from England.

Other general policies related to CAMH

Existing research highlights the crucial role that a variety of other general policies play in affecting child mental health and well-being. These effects occur indirectly through impact on poverty, deprivation, vulnerability, and the risk factors that can trigger a lifelong cycle of disadvantage, leading to an increased risk of mental problems and later disorders. Policies to encourage or facilitate early childhood education and care services also have positive consequences for children, especially pre-school children, as do policies directed at preventing teen pregnancy and parenting, supporting single parents and promote parental employment (especially maternal employment). Other general policy areas which are likely candidates to improve or promote CAMH, but where research is less advanced, are those influencing child welfare and protection, and those affecting children of immigrants and ethnic and racial minorities.⁵⁰

In the CAMHEE country stories, all countries report the existence of social policies which impact on CAMH (policies on poverty and social exclusion, social welfare or child protection), although not all countries have policies on all 3 of these. Likewise, educational and family policies with elements to promote or protect child and adolescent well-being are widespread. In the areas of industrialisation, urbanisation and housing, however, far fewer CAMHEE partners report governmental policies relating to CAMH, although these areas can be seen as having a moderating effect on risk and protective factors directly associated with mental health or disorders.

Social Policies:

Promoting maternal employment is an important strategy for preventing child poverty and disadvantage,

and promoting child mental health by minimising inequalities. However, it seems that as a strategy, this is only successful in positively impacting on child well-being in the context of a family-friendly workplace where flexibility was the norm. Therefore, improving CAMH by promoting maternal employment requires a cluster of policy interventions including higher wage levels, income transfers to supplement low wages, and child care services along with parental leave policies to facilitate and sustain maternal employment and labour force attachment. Finnish policy, for example, allows for a high degree of flexibility including shared parental leave between mothers and fathers.

Policies for schooling:

Early Childhood Education and Care among the first years of life (in particular between 2 and 6 years of age) are particularly important for cognitive, physical, social, and emotional development⁵¹. This is in a large part due to the impact of child care availability on parental employment possibilities. In addition, research now indicates that participation in good quality early education programmes has positive impacts on children with regard to cognitive, social, and emotional development, school readiness, and school performance⁵². Positive impacts are seen to be especially strong among children from the most disadvantaged and low-income groups, perhaps because of the role of pre-school in removing children from adverse home environments as well as allowing parental income to increase⁵³. Here the emphasis is on the quality of early childhood education and care, with policy factors such as training of care-givers, child to staff ratios and pre-school education centre resources or subsidised places to increase spending in this sector being key deciding factors in the positive outcomes for child well-being. The conclusions of the OECD twelve-country Thematic Review of Early Childhood Education stressed the importance of ensuring universal access and improving the quality of these services, and achieving these goals by a substantial increase in public investment and enhanced staff training.

Family and parenting policies:

The importance of parental leave policies in promoting healthy family and parent-child relationships has already been mentioned above. There are documented potential benefits to children's cognitive development from longer paid and job-protected parental leaves (6 -12 months) or other "family friendly" policies that facilitate time at home with infants⁵⁴.

Policies directly addressing the quality of parenting, and consequent family functioning, are also important to ensure good child development and well-being.

⁵⁰Sheila B. Kamerman, Michelle Neuman, Jane Waldfogel and Jeanne Brooks-Gunn (2003) OECD SOCIAL, EMPLOYMENT AND MIGRATION WORKING PAPERS NO. 6. Social Policies, Family Types and Child Outcomes in Selected OECD Countries. <http://www.oecd.org/dataoecd/26/46/2955844.pdf>

⁵¹OECD. (2001a) Starting Strong: Early Childhood Education and Care. Paris, France: OECD Publications. ⁵²Andersson, B.E. (1992). Effects of Day Care on Cognitive and Socioemotional Competence of Thirteen-Year-Old Swedish School Children, *Child Development*, 63, 20-36

⁵³Sylva, K., Melhuish, E., Sammons, P. & Sirj-Blatchford, I. (2000). "The Effective Provision of Pre-School Education [EPPE] Project: A Longitudinal Study Funded by the DfEE (1997-2003)." Paper prepared for The House of Commons Education Committee Enquiry into Early Years Education, June 2000

⁵⁴Ruhm, C. (2000) "Parental Employment, and Child's Cognitive Development". NBER Working Paper 7666. Cambridge, MA: National Bureau of Economic Research (NBER).

On the one hand this can take the form of prohibitive policy, such as the sometimes controversial legislation to protect children of all ages from abusive disciplinary practices (such as smacking or hitting) inside the home as well as in public arenas. On the other hand, positive and proactive policy to support good parenting and improve poor parenting in high risk situations is effective. Finally, policies to prevent and reduce rates of teenage pregnancy can be effective in promoting mental health of adolescents. Sex education and easy access to free and effective contraception in an accepting environment, and availability of abortion are the key interventions in this sense. However, policies which aim reduce inequalities in income, which exclude youths from the benefits, cultural norms and aspirations of the majority population, have also been found to be a deciding factor in reducing teenage pregnancy nationally⁵⁵.

Community and environment:

The neighbourhood or community environment in which children and adolescents grow up influences their well-being, social behaviour and mental health. Neighbourhood poverty is associated with less favourable child and youth outcomes, because more deprived neighbourhoods present fewer opportunities for social cohesion and involvement, present greater risks of exposure to antisocial behaviour and normative low aspirations of employment and are kept in poorer condition in terms of maintenance and safety (from accidents or crime). The more threatening the neighbourhood, the more common are symptoms of mental disorders and social exclusion. Lack of a suitable environment and social deprivation may also limit the possibility of recreation activity (mental, cultural and physical) with detrimental effects, through reduced opportunities for children to play outside the home, enjoy pleasurable physical activity as well as fewer opportunities for them to learn to cope with risks or build resilience.

General policies aiming to reduce community deprivation (both social and environmental) address issues such as proportion of green spaces in urban planning, involvement of local residents (including children) in decisions affecting the neighbourhood to increase social cohesion and mobilization, provision of cleaning services and enforcement of security standards in public places, and equity in access to leisure activities and transport services.

This is possibly the least developed and least well-understood of policy areas affecting child and adolescent mental health, whilst representing one of the most complex and important factors determining mental health and well-being.

Children's rights and Mental Health:

Mental Health is directly related to the enacting of the children's rights agenda including the mainstream of children's rights when drafting EC legislative and non-legislative actions that may affect them. In order to enact children's rights, children participation and involvement is crucial.⁵⁶ The existence of an ombudsman for children can be viewed as a country's commitment to children's participation in the political arena and a sign of national respect for children's rights.

Ombudsman for children – CAMHEE Results

Table 3. CAMHEE data about existence of ombudsman for children's rights

Is there and ombudsman for children's rights?	Yes	No
Proportion	11/15	4/15
Countries/Regions	Catalonia (Spain), England, Finland, Greece, Hungary, Latvia, Lithuania, Norway, Poland, Slovenia	Bulgaria, Estonia, Heidelberg (Germany), Romania

Ombudspersons for children in Europe

It is the responsibility of an ombudsman to look after the interests and legal affairs of individual citizens, or a particular group of citizens and defend its fundamental rights. The most common functions of the ombudsman are to receive and investigate complaints, to act as a spokesperson and to advocate changes to improve things for individuals or for a particular group. Norway was the first country to establish in 1981 a commissioner, or ombud, with statutory rights to protect children and their rights.

In 1997, the European Network of Ombudspersons for Children (ENOC), a not-for-profit association of independent children's rights institutions (ICRIs), was established. Its mandate is to facilitate the promotion and protection of the rights of children as formulated in the UN Convention on the Rights of the Child. The Convention on the Rights of the Child, adopted in 1989, symbolises a new worldwide determination to do better for children. The Committee on the Rights of the Child consists of 18 experts elected by States Parties to monitor progress towards its implementation, including their right to be heard⁵⁸. Some of their statements include⁵⁹:

"It is the view of the Committee that every State needs an independent human rights institution with responsibility for promoting and protecting children's rights. The Committee's principal concern is that the institution, whatever its form, should be able, independently and effectively, to monitor, promote and protect children's rights"

⁵⁵Unicef Innocenti Center, Florence, Italy. (2001b) Report Card, A League Table of Teenage Births in Rich Nations. Issue No. 3, July 2001b.

⁵⁶Jané-Llopis, E & Braddick, F. (Eds). (2008). Mental Health in Youth and Education. Consensus paper. Luxemburg: European Communities.

⁵⁷<http://www.ombudsnet.org/enoc/>; <http://crin.org/enoc/index.asp>

⁵⁸The right of the child to be heard. General Comment no. 12. Committee on the rights of the child. Fifty-first session, Geneva, 25 may-12 June 2009

⁵⁹Convention on the Rights of the Child. Committee on the Rights of the Child: Thirty-second session. 13-31 January, 2003.

"While adults and children alike need independent national human rights institutions to protect their human rights, additional justifications exist for ensuring that children's human rights are given special attention. These include the facts that children's developmental state makes them particularly vulnerable to human rights violations; their opinions are still rarely taken into account; most children have no vote and cannot play a meaningful role in the political process that determines Governments' response to human rights; children encounter significant problems in using the judicial system to protect their rights or to seek remedies for violations of their rights; and children's access to organizations that may protect their rights is generally limited."

Children's rights are also included in the main priorities of the European Commission for its strategic Objectives 2005-2009.

Youth involvement

Although the right of the children to be heard is a priority of the Committee on the rights of the child, it is currently under-recognized and scarcely supported. Adults often under-estimate children's capacities because of differences in their means and manner of expressing themselves. In fact, the vulnerability of children derives, in some part, not from their lack of capacity, but rather, from their lack of power and status with which to exercise their rights⁶⁰. The work in this area requires an extra of creativity, respectfulness, and sensitivity.

In general, the results from the CAMHEE project show that children and adolescents are not systematically included in the process of policy decision-making, programme planning, design and implementation or development of CAMH policies or evaluation. Their involvement is more common in the implementation or designing of programmes (8 and 9 of the CAMHEE partners have found, respectively, some positive example of this in their countries or regions) than in decision-making processes (6 CAMHEE partners mention an example of this), or development of policies (only 3/15 report some positive example).

Mental health is directly related to policy and implementation supporting children's rights, and in order to enact children's rights, children's participation and involvement is crucial. Some commendable examples of this are the Centre for youth policy in Belgium⁶¹; the Parliament of Schoolchildren of Lithuania that actively

involves children⁶²; in UK the National Children's Bureau and Young Minds have children on their boards, and the National CAMHS Support Service has a user participation lead⁶³. Other examples of sporadic proceeding to involve children have been given in the CAMHEE country profiles of Finland, Greece, Lithuania, Slovenia and Spain (Catalonia). Most usually, there is an indirect approach to enact their rights through the ombudsman of children, but it could be argued that a more systematic and direct approach is needed.

When constructing opportunities for participation, it is important to take into account the capacities of the children and adolescents with regards to their age, and means of expressing their opinions. Currently, there are already guidelines available for facilitating child participation, such as the Child-to-Child (CtC) approach, an approach to health promotion and community development that is led by children⁶⁴; some good practices⁶⁵ and minimum standards for consulting with children⁶⁶; and reports on consultation with children about key issues for them (i.e., their rights) for dissemination at the policy level⁶⁷. However, more evaluative research on the best methods to achieve effective consultation is needed.

While there are some commendable examples, although still not widespread, of children consulted on a practical level to contribute to programme designs and even be involved as implementers (through peer-led initiatives), there is a great need to include the voice of children and adolescents in the development of policies that affect their health and well-being. Means of enhancing youth involvement in policy decision making include the consultation of child populations, through surveys or focus groups, and the use of this information by children's ombudsmen or commissioners. A more direct approach could be the introduction and participation of young people's representatives in parliamentary question time sessions, and to include in the budgets of the projects some part for consultation with children. Finally, children's participation (in research, implementation, planning and decision making) needs to be handled sensitively, and with the participating children's well-being in mind, with due care being taken over issues of disclosure, confidentiality and disengagement (all of which themselves may have positive or negative impacts on children and adolescents' mental health).

⁶⁰Landsdown, G (2005) Can you hear me? The right of young children to participate in decisions affecting them. Number 36, working papers in Early Childhood Development.

⁶¹<http://www.steunpuntjeugd.be/english>

⁶²Country profile of Lithuania, CAMHEE

⁶³Country profile of England, CAMHEE.

⁶⁴Morgan, M, Gibbs, S, Maxwell, K & Britten, V (2002) Hearing children's voices: methodological issues in conducting focus groups with children aged 7-11 years. *Qualitative Research*, Vol. 2, No. 1, 5-20

⁶⁵CPWG, 2003. http://www.unesco.org/most/pla42_intro.htm

⁶⁶Inter-Agency Working Group on Children's Participation (IAWGCP), 2007. <http://www.iawgcp.com/download/ms.pdf>

⁶⁷Feinstein, C & Lind Haldorsson, O (2007). You could begin by listening to us – A consultation with children on the EC communication "Towards an EU Strategy on the Rights of the Child" Save the Children.



4. Organisations and resources for implementation

4.1. Institutions and organisations

There is much variation across Europe in the institutions and organisations involved in implementing policy and action for child and adolescent mental health. These organisations represent an important infrastructural factor, affecting the effectiveness of policy and ease of carrying out programmes in this area.

In many CAMHEE countries, CAMH services, usually limited to care and treatment, and mental health policies (affecting children and adolescents) are the domain of governmental or regional health departments.

In contrast, promotion and prevention programmes are more often the responsibility of non-governmental organisations such as not-for-profit organisations or university research departments. These programmes tend to be run on funds of short-term grants rather than integrated into the sustained services offered by a public health department or agency.

As a result, in many of the CAMHEE countries, policies and services are sustained without evaluative research on their effectiveness and, in parallel, promotion and prevention action for CAMH may be studied but not sustained as it is carried out in 2-3 year bursts of activity. In addition, several governmental departments may be involved in developing policy and action in different domains affecting child mental health and well-being.

For example, Departments of Health, of Education and of Social Affairs may all independently be involved in action which has an impact on child and adolescent mental health. In such cases, collaboration across sectors is key in augmenting positive outcomes.

Certain countries, such as Finland, have integrated institutions combining research and public health competencies in an effort to overcome such problems.

4.2. Services

Traditionally, and still in many of the CAMHEE partner countries, provision of mental health services for children and adolescents is restricted to treatment and care services for those already experiencing mental problems or suffering from mental disorders. Provision of such services in terms of quality, availability and access is extremely important and the availability of resources in these areas is indicative of a national concern with equity and quality of life.

It is important to note a shifting in resources in many new member states from institutional to community care services and from inpatient to outpatient treatment, although in some countries there is still overuse of institutionalisation of children⁶⁸. For children, who are so sensitive to surroundings, this shift, which increases their likelihood of staying in familiar surroundings or reduces the time spent away from home in treatment, is fundamental to raising the quality of care, improving their chances of recovery and preventing any mental

⁶⁸Browne K., et al. (2006). Overuse of institutional care for children in Europe. *BMJ*, 332: 485-487.

health problems from developing or worsening.

The health sector also represents a great opportunity for mental health promotion among children and adolescents. The health services environment presents a unique setting to foster child mental health and development as it allows a developmental perspective from family planning and pregnancy through to adolescence and early adulthood. The responsibilities of the health sector are not restricted to individual children and families, but extend to the societal provisions necessary for positive child development.

Situations of scarce resources often place treatment and promotion services in competition as they are still seen as separate units with different goals. In order for children's mental health services to achieve their goals of reducing mental problems and improving CAMH, a conceptual shift to acknowledge the profound interactions between effectiveness in treatment and preventive/promotion services and the interdependency of these areas is needed. Only then will health services operate efficiently, by preventing the development of disorders simultaneously to speeding recovery.

4.3. Funding

From 2004 to 2008, it seems that there has been a small increase in resource allocation to CAMH in general. However, funds dedicated to CAMH are generally not clearly identifiable in the national budgets (only one third of the countries reported identifiable budgets) and only visible in the budgets of some NGOs (with some examples of identifiable budgets in half of the countries). Moreover, in most of the countries (12 of 15), funds for CAMH are mixed with other funds, making it hard to discern the real amount available. It is also difficult to discover how funds are distributed across CAMH treatment services and preventive activities. This data is in agreement with other sources reporting that funding for child and adolescent mental health services comes from largely temporary and vulnerable sources rather than by more stable government allocations in both high and low income countries. Even in countries that have identifiable budget for child and adolescent mental health services there is no parity with the resources provided for adult mental health services⁶⁹.

The CAMHEE data was collected at around the time, but before the point of wider recognition of the global economic downturn hitting European countries. It deserved mention that economic crises have been shown to have discernable effects on the distribution of funding allocation in mental health arenas. Despite evidence that widespread economic depression has negative outcomes in particular for the mental health of young people, with the highest rate of unemployment being seen among younger workers^{70 71} and documented adverse impact on family functioning⁷², funding cuts often occur first in those services and activities which are preventive and aimed at the more distant future, namely child and adolescent prevention and promotion.

4.4. Training of professional workforce

The training in mental health of professionals working in the areas related to children and adolescents, shape the quality of their day to day contact with children, and can also convert them into direct agents of mental disorder prevention for children at risk. Currently, the professionals that have the most training in CAMH issues in their curricula of higher education are psychologists and psychiatrists at the postgraduate or master's levels. At the undergraduate level this training is not always available. Primary care doctors, paediatricians and primary care nurses, are recognised more and more as key agents in the early detection of mental health problems of children. However, there are still some countries where this training is not available for them neither at the undergraduate or postgraduate level. This availability is even scarcer for the staff of juvenile detention centres, teachers and social workers, who are rarely required to complete a postgraduate course, and especially for public health professionals.

It is important to remark that there are 2 possible strategies to achieve the desired end of a trained workforce: the training in child and adolescent mental health issues of the professionals involved, and also the strengthening of interdisciplinary work between professionals in daily contact with children and the main experts in mental health (i.e. psychiatrists and psychologists).

⁶⁹Belfer, M. (2008) Child and adolescent mental disorders: the magnitude of the problem across the globe. *Journal of Child Psychology and Psychiatry* 49:3, pp 226–236

⁷⁰Altogether, 4.9 million youngsters across the EU were unemployed in the first quarter of this year, up by 900,000 since the same period last year, with the highest rates in Spain (33.6%), Latvia (28.2%), Italy (24.9%), and the lowest in the Netherlands (6%), Denmark (8.9%) and Austria (9%).

⁷¹Europolitics, Young people hit hard by crisis, Eurostat data | 23 July 2009 Statistics in Focus, Population and social conditions, 53/2009 'Sharp increase in unemployment in Europe', available at ec.europa.eu/eurostat

⁷²Solantaus T, Leinonen J, Punamäki R-L. (2004) Children's mental health in times of economic recession: replication and extension of the family economic stress model in Finland. *Developmental Psychology* 40:412–429.

The content of the training in CAMH issues in undergraduate curricula of key professionals was outside the scope of this study. It is quite evident; however, that at present it focuses mainly on treatment and recognition of disorders, and less on prevention and promotion. At the postgraduate level, most countries reported at least one institution of higher education in children and adolescents' mental health promotion and/or mental disorder prevention. However, there are still some countries (3/15) without any institution providing this training.

Child mental health/child psychiatry is recognised as an independent field from general mental health /general psychiatry in most of the CAMHEE countries (and in Finland and Germany 3 distinct disciplines are available: child, adolescent and adult psychiatry), but there are still some countries without this division (8/15 without child mental health and 3/15 without child psychiatry).

5. Monitoring and evaluation of the actions for the promotion and prevention in mental health

"A mental health policy provides the overall direction for mental health by defining a vision, values, principles and objectives, and by establishing a broad model for action to achieve that vision. To be effective, the policy should have a plan, appropriate to local needs and conditions, that details the strategies and activities that need to be implemented for achieving the objectives of the policy. The policies and plans must be carefully assessed (according to expected outputs, targets and indicators) and changes made if they are not having their desired outcomes or effects."⁷³

According to the World Health Organization recommendations (2007), the monitoring and the evaluation of policies, are the key processes used for determining whether the goals set in the policy and plan are being realized and for allowing decision-makers to make long – and short-term service – and policy-related decisions and changes. Monitoring refers to the routine tracking of a plan to assess how well the plan is being implemented so that any identified problems can be rectified on an ongoing basis; whereas evaluation refers to a systematic means of appraisal to assess the value, worth or effectiveness of the policy or plan and is a "tool for decision-making" (WHO, 2007).

However, according to the CAMHEE reports, most of the countries do not evaluate or monitor the actions in mental health service and care policies, mental health promotion policies, or mental disorder prevention

for children and adolescents (8/14; 9/14 and 10/14, respectively).

Exceptions to this are England, Norway and Belgium. In England, CAMHS services are evaluated and supported through the National CAMHS Support Service and the National Service Framework requires that all services should routinely audit and evaluate their work and the results used to inform service development. Some programmes of mental health promotion, such as SEAL programme and SureStart programme, are also evaluated. In Norway, the department for mental health services research of the SINTEF Health Research organization⁷⁴ evaluate policies for children and adolescents.

6. Research and dissemination

Research helps us to gauge whether a treatment, a care system, a programme or a policy is effective. Research is more challenging in children than in the adult population, and is less common, but is crucial for a well-grounded evidence base for effective policy and practice. In addition, developing and implementing policies without evidence-based knowledge may be harmful and/or wasteful.

Different research methodologies each have their own strengths and weaknesses and a well-designed evaluation of a programme or policy in child and adolescent mental health would be likely to include qualitative as well as quantitative methodologies to address questions on public attitudes, satisfaction and process and implementation factors. Research on the cost-effectiveness of interventions at the policy and programme levels is also important in guiding resourcing decisions.⁷⁵

A few examples of good research in the children and adolescent mental health area being carried out in the CAMHEE countries are:

- "The Efficient Child and Family Programme for Families": for parents with disease or psychiatric problems (Finland)
- The OPCS/ONS surveys of psychiatric morbidity aim to provide up-to-date information about the prevalence of psychiatric problems in Great Britain, as well as the associated social disability of people with MH problems and use of services.
- The "Mannheim study of risk children (MARC)"⁷⁶, in Germany, follows a cohort of children at risk for later psychopathology born 1986-88 from birth to adolescence with assessments at the ages of 3 mo., 2, 4.5, 8, and 11 years. The research focuses on factors that determine the origin and course of mental disorders during childhood in order to facilitate the possibilities of prevention, early recognition, and early treatment.

⁷³Monitoring and evaluation of mental health policies and plans. Geneva, World Health Organization, 2007 (Mental Health Policies and Service Guidance Package).

⁷⁴<http://www.sintef.no/Home/Health-Research/Mental-Health-Services-Research/>

⁷⁵Jané-Llopis, E, Katschnig, H, McDaid, D, and Wahlbeck, K. Commissioning, interpreting and making use of evidence on mental health promotion and mental disorder prevention: an everyday primer. Lisbon: 2007

⁷⁶<http://www.zi-mannheim.de/941.html>

- The SAMDATA project in Norway has been to develop performance indicators that can monitor the development and functioning of services according to central governmental policy guidelines.
- Evaluation of the programme “Amazing Alternatives” in Poland, adapted to the country and Polish culture, collecting qualitative alongside quantitative data.

and community services for child and adolescent mental health; although in one country (Lithuania) a lack of residential services for disturbed adolescents and youth was also mentioned. The economic depression in which we now find ourselves does not improve the outlook for increasing budgets or achieving the optimum balance between treatment and prevention. For example, in Greece services have undergone drastic cuts (of nearly 50%) in funding between 2007 and 2008. This has resulted in a regression in services provided through the community and a revival in institutionalisation.

7. Challenges, opportunities and advances in the field

Across the CAMHEE country profiles data, several challenges or barriers are recurrent a large proportion of the 15 countries. Alongside several more country-specific challenging characteristics or situations, the respondents mention again and again a lack of resources, especially good quality human resources; the need for a cultural and political shift, and; the challenge presented by working and cooperating across boundaries – between sectors, disciplines, geographical levels, age groups and languages.

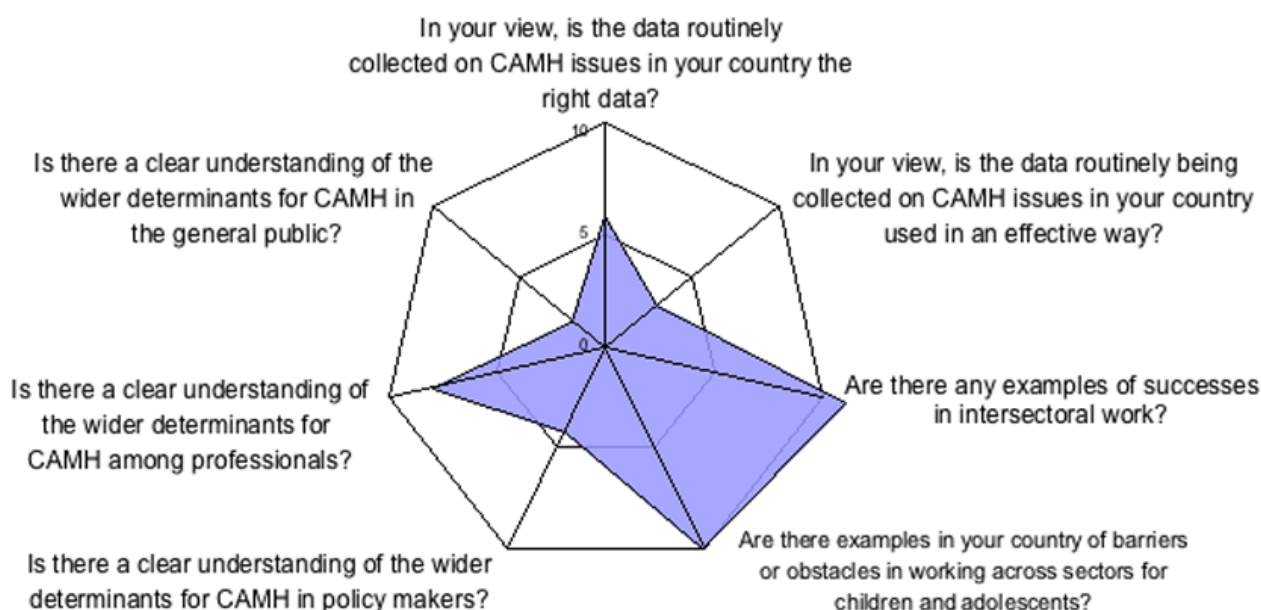
The most frequently cited barrier to action on child and adolescent mental health among the CAMHEE respondents is resources, both financial and human. In part this has to do with the lack of political priority given to child and adolescent mental health and well-being, resulting in budgets for CAMH which are often not separate or identified apart from the budget for mental or general health of the whole population. This puts child and adult mental health in competition for funds which are not earmarked. Scarcity of funds was especially noted with regards to mental health promotion and mental disorder prevention, outpatient

Human resources and the quality of training in CAMH is also an issue. The CAMHEE partners often report a scarcity of well-trained professionals in child and adolescent mental health. One partner (Catalonia, Spain) notes the difficulties that arise through the absence of a recognised specialisation in child psychiatry. This lack of specialisation is also reported in the questionnaires of Greek and Hungarian partners. However, it should be noted that the division between adult and child psychiatry can also cause problems, as noted in Heidelberg, Germany, where initiatives have been developed to overcome this divide for those entering adulthood and to provide smooth continuity in psychiatric services.

Many of the CAMHEE partners (for example, Bulgaria, England, Latvia, Poland and Spain) mention the present socio-political and cultural climate in their country as a barrier to child and adolescent mental health policy and practice in general, and to promotion and prevention in particular.

In practical terms, these are often one and the same as a central tenet of mental health promotion and mental disorder prevention across the lifespan is the exigency for early intervention, to prevent later mental health problems, and thus an attention to the younger population’s mental health.

Figure 2. Barriers and opportunities among the CAMHEE respondents



The conceptual shift from general population to child and adolescent mental health, from treatment and care to prevention and promotion and from reactive to proactive policy requires a great degree of political foresight and a commitment to longer-term outcomes.

In some cases, the CAMHEE respondents see this barrier more in terms of a lack of awareness – of the magnitude of the problem, wider determinants of child mental health, how to interpret research and the possibility of effective action. Three of the points in Figure 2 show the perceived knowledge of CAMH determinants among public health personnel, mental health professionals and the general public. Whilst specialist staff and NGOs in the field are more and more aware of these wider determinants of child and adolescent mental health, it is clear that awareness-raising aimed at the general public and governmental bodies could improve the situation. Furthermore, a cultural shift is needed to stimulate the evaluation of public policies with regards to their impacts on child and adolescent mental health. This will require both political will to prioritise CAMH as an outcome of indirectly related policy and willingness to develop and adopt new research methodology to evaluate effect on such a scale.

Stigma and fear of discrimination also represent powerful barriers to child and adolescent mental health, and the CAMHEE country stories attest both to the magnitude of the problem of stigma nationally and a number of attempts to overcome this. The stigma surrounding mental illness and the discrimination and exclusion which people, especially youth, suffering from mental disorders or problems experience acts as a deterrent to help-seeking for mental distress of their children, reducing the likelihood of early diagnosis, treatment and recovery. Similarly, stigma can reduce uptake and the effectiveness of targeted preventive action or even augment problems by labelling vulnerable children at risk as not normal or mentally ill.

Another recurrent theme encountered in this work is that of intersectoral cooperation and responsibility. Because children are in contact with a number of different environments on a regular basis (e.g., home, school, neighbourhood, public services), the sources of their well-being or poor mental status are multiple and influence through a number of different actors across sectors. Communication and collaboration between different sectors, such as the health, social or education sectors, is not always easy, not least because the heavy workload of professionals in these areas often leaves them little time to build effective partnerships. In addition to this, the responsibility for CAMH falls across a number of administrative levels, being subject to local,

municipal and national policy, which sometimes creates a paralysing confusion, not conducive to action. In Belgium, there is an additional complication of different linguistic and cultural communities within one country, making the implementation of effective policy a trilingual matter requiring much care and consideration. Finally, programmes and practice in CAMH are often implemented by non-governmental organisations (NGOs) as well as the member states' governments, making the responsibility for good child development and mental health further fragmented. The CAMHEE partners comment on the need for creative means of partnering and dissemination to cross these various boundaries.

New pan-European challenges have also arisen in recent decades. These include challenges linked to complex socio-demographic phenomena such as changes in family structure, the increasing number of single-parent and ethnic minority families, and the economic migration of workers to richer European countries, often leaving dependent families behind in the newer member states. New and ever more popular forms of media and technology, such as the television, mobile phones and the internet present new risks to European children in the form of expanding and potentially intrusive social domains, and contracting and limited physical domains, which can affect their safety and well-being. In addition, there is an increasing pressure on children and young people to excel academically and socially, presenting for many a stressful situation. On the other hand, the problematic situation of socioeconomic inequalities is set to be exacerbated with the current economic crisis, which can be seen as a threat to the mental health of children through the weakening of family capacity and the increasing probability of unemployment as a young adult.

Having said all this, there is also a great deal to be hopeful about. There is a growing awareness of the importance of child and adolescent mental health in Europe, as is evidenced by the inclusion of this topic as a priority in the EC Pact on Mental Health and Well-being⁷⁷ and the forthcoming Thematic Conference on Mental Health in Youth and Education. There are other examples of positive action at the European level, ranging from the formation of European networks to increase online safety for children⁷⁸ to cross-national initiatives to reduce discrimination and stigma in schools⁷⁹, and proposals of action for the well-being of childhood⁸⁰. And these European organisations connect a multitude of national bodies, also striving for better child and adolescent well-being. There is also a growing body of research on European determinants of mental health, including children and adolescents, and efforts to develop indicators of positive mental health which

⁷⁷http://ec.europa.eu/health/ph_determinants/life_style/mental/docs/pact_en.pdf

⁷⁸http://ec.europa.eu/information_society/activities/sip/index_en.htm

⁷⁹Thornicroft, G., et al., Reducing stigma and discrimination: Candidate interventions. *Int J Ment Health Syst*, 2008. 2(1): p. 3.

⁸⁰Interdisciplinary Workshop Report - Changing Childhood in a Changing Europe, 26-27 February 2009, Nicosia, Cyprus - European Science Foundation, Strasbourg, 2009.

⁸¹http://www.camhee.eu/about_project/

can, in time, be extended to children, improving the possibility of monitoring and evaluating CAMH action.

The CAMHEE country stories also contain numerous encouraging examples of initiatives and strategies to improve or protect children and adolescent's mental health at the national level, and of intersectoral collaboration to benefit CAMH. Other CAMHEE project work packages have furthered the development of effective practice in CAMH in the areas of parenting, preventing violence at schools and community mental health services through fruitful exchange across participating countries⁸¹.

8. Summary and conclusions

The country profiles in the following chapters contain information on a fantastic variety of and practices for child and adolescent mental health across this selection of European member states, which can only hint at the diversity of initiatives to be seen across Europe as a whole.

While this variety bodes well for the future of CAMH, analysis of the data from the 15 CAMHEE respondent countries points towards several probable disparities at the European level:

- **Epidemiological studies:** prevalence data collection needs to be designed to be representative, and to be useful for national policy decision-making as well to be suitable for comparison across member states.
- **Policy evaluation:** Whilst some evaluation of service and care policies are documented in the European countries included, the majority of countries report no evaluation of relevant policy and programmes aimed at preventing mental disorders or promoting mental health among children.
- **Positive indicators:** Only about 50% of countries reported prevalence rates on positive mental health in children. More specifically, 13/15 countries reported the existence of information about the prevalence of mental disorders, whereas just 8/15 reported collecting the prevalence of some indicator of positive mental health (e.g. wellbeing, self-esteem, quality of life, resilience).
- **Youth involvement:** Children are not often involved in the decision-making processes affecting practices in CAMH in European member states (6/15 report some example of this), especially those decisions behind policy development (only 3/15 report some positive example).
- **Training and Capacity:** There is a clear lack of CAMH issues in relevant higher education

degrees.

- **Mental health understanding:** there is a gap in knowledge about the determinants of CAMH among stakeholders and the general public.
- **Budgets for CAMH:** budgets dedicated to CAMH issues are rarely clearly identifiable, and generally they are mixed with other funds. They are also rarely sufficient to encourage prevention and promotion alongside treatment.

9. RECOMMENDATIONS

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

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

There is a need to evaluate educational policies in terms of mental health outcomes.

There is a tendency to evaluate education and care policy only in terms of children's academic achievement. Given the impact that this domain has on child and adolescent mental health (and, incidentally, as we are now discovering, the lack of impact on educational outcomes without mental health ones), it must start to be evaluated in such a light.

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

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

⁸¹http://www.camhee.eu/about_project/

There is a need to increase child and youth involvement

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

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

It is important that units on CAMH issues are included in the national curricula for relevant higher education degrees, such as medical undergraduate degrees, specialist training of primary care doctors, public health professionals, paediatricians, psychologists, teachers and juvenile detention centre staff. It is important that such training covers childhood mental disorders, risk and protective factors and also includes training in practical skills (such as communication and consulting) for approaching and dealing with issues of relevance to children's mental health and well-being.

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

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

There is a need to specify specific funding for CAMH issues, rather than funds mixed in with that allocated to adults.

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

There is a need to ensure sustained funding for child and adolescent mental health promotion and mental disorder prevention through times of economic crisis.

Foresight is needed to plan sustainable, long-term budgets which support the ongoing development of prevention and promotion and community based action.





BELGIUM

Prepared by Franz Baro and Linda De Lausnay

1. Introduction

1.1 Policy at a glance

Since the 1970's, Belgium has gradually transformed itself from a unitary into a federal state. It was turned democratically into a system of constitutional areas known as regions and communities. This twofold subdivision makes Belgium a unique federal state with a complex structure full of subtle balances. It has a federal government and three regions and three communities, each with their own autonomous government and parliament.

The three regions of Belgium are:

Flanders: : www.flanders.be

Wallonia: <http://www.wallonie.be/en/index.html>

Brussels Capital: <http://www.bruxelles.irisnet.be/en/citoyens/home.shtml>

The population of 10 million persons consists of three communities, the Flemish (5.8 million), French (4 million) and German (80.000) speaking communities. The regions and communities are partly, but not completely, overlapping. The region of Brussels Capital, for example, is a bilingual area where both the French and Flemish Communities have particular competences, whereas the part where the German-speaking Community lives falls under the Walloon region. Flanders, however, decided to merge the competences of the Flemish Community with those of the Flemish Region. As a result, Flanders has one Flemish Parliament, one Flemish Government and one public administration, competent for community and regional matters. This federal structure implies that competences are divided between the different policy levels. The communities are competent for 'person-related matters' such as education, culture and certain aspects of health care and prevention. The regions are competent for 'territorial-related matters' such as employment, economic policies and environment¹.

The complexity of this small country must be taken into account when considering the policy context of CAMH. Although there are a lot of similarities, the different policies, legislation, infrastructure and practices lead to

a growing differentiation across the 3 regions, also in the field of CAMH².

Urbanisation covers 26 % of the country's total area. An overview of the social, co-operative and public housing in the country shows that social housing is qualitatively suitable to ensure hygienic standards and sound living conditions, but still affordable and with a certain security of tenure for households on a low income. The key point in the cultural policies of the Communities is the clustering of cultural actors in the community: libraries, cultural centres and local initiatives. Together, as a subsidized cultural centre, they should set the course of cultural life in the community.³

Belgium welcomes the WHO declaration and action plan for mental health in Europe (Helsinki, 2005).⁴

1.2. Process to prepare the country story

This report was compiled by Franz Baro, professor emeritus of mental health at the Catholic University Leuven and director of the WHO Collaborating Centre on Health and Psychosocial and Psychobiological Factors (Brussels) and Linda De Lausnay, scientific collaborator of the WHO Collaborating Centre on Health and Psychosocial Factors (Brussels).

Substantial help was given by:

- Peter Adriaenssens, MD, Professor of Child Psychiatry, Catholic University Leuven
- Jorge Barudy, MD, Director, EXIL Brussels
- Dirk Deboutte, MD, PhD, Professor of Child Psychiatry, University of Antwerp and University of Ghent
- Guy Deboutte, researcher, Faculty of Law, Catholic University Leuven

¹For more details about Belgium, see:<http://www.diplomatie.be/en/belgium/belgiumdetail.asp?TEXTID=1586>

²<http://www.childpolicyintl.org/countries/belgium.html> <http://socialsecurity.fgov.be/firstpage-en.htm>

³<http://www.culturalpolicies.net/web/belgium.php?aid=842>

⁴http://www.euro.who.int/mentalhealth/publications/20061124_1

- Johan Deklerck, PhD, Professor of Youth Criminology, Catholic University Leuven
- Jo Lebeer, MD, PhD, Professor of Family Medicine, University of Antwerp
- Cees van Heeringen, MD, PhD, Professor of Psychiatry, University of Ghent
- Nicole Vettenburg, PhD, Professor of Educational Sciences, University of Ghent

Given the fact that website information in English language has become increasingly available in matters related to the Flemish Community, the report – without any value judgement - relies more on this kind of information.

The contributors are willing to share selected bibliographies as well as their unpublished reports used in the context of this country profile.

2. What we know about children and adolescents in our country and their mental health

2.1. Prevalence of mental disorders in children and adolescents

Self reported anxiety, sleep or depressive disorders
Based on its 2004 Health interview survey in Belgium, the Scientific Institute of Public Health gives the following figures on covering the past year:

Disorders	Ages 15-24				Age 15+
		men	women	total	total
Anxiety	Belgium	4.0 %	7.0 %	5.5 %	6.0 %
Sleep	Belgium	11.0 %	18.0 %	15.0 %	20.0 %
Depressive	Belgium	4.0 %	6.0 %	4.8 %	8.0 %
Depressive	Flemish region			4.0 %	7.0 %
	Walloon region			5.0 %	10.0 %
	Brussels region			6.0 %	10.0 %w

Other figures, such as the self reported psychological problems over the past year, also point to important regional and gender differences.

Special educational needs

In order to identify special educational needs in Flanders an a select series of samples of 8648 pupils (out of a total of 1109909 pupils, aged 2,5-18 years) from the various types of regular and special primary and secondary education in Flanders, has been assigned to one of 5 levels of educational needs and 4 clusters of impairments⁵.

The levels of educational needs include:

- Level I: able to follow the normal curriculum, possibly with some differentiation of quantity, modality or remedial measures
- Level II: able to follow the normal curricular objectives, with more differentiation or some compensatory or dispensation measures
- Level III en IV: able to follow a highly individualized curriculum with special assistance and/ or equipment where needed, according to an IEP (Individual Education Plan) tuned to the specific needs
- Level V: temporarily out of school because of

illness or circumstantial impossibility to be in a school.

Pupils' impairments are classified in four categories or "clusters":

- Cluster 1: children without a diagnosis
- Cluster 2: difficulties mainly presenting in school context (such as specific learning disabilities and/or mild intellectual impairment)
- Cluster 3: difficulties in school and daily life context (with intellectual, physical or sensorial impairment)
- Cluster 4: behavioural functional disturbances and/or autistic spectrum disorder.

This recent study yielded interesting epidemiological results.

In primary school age (6-12 years of age), 15.9 % of children require some form of educational adaptation (level II or higher). Moreover, there are 4.8 % of children in cluster 2,3 and 4 functioning on level I. This means there are about 20.7 % of children of primary school age with some kind of special needs.

Of all primary school age children, 12.5 % have mild intellectual impairment and/ or learning disability (cluster 2) and 3.3 % have a diagnosed behavioural or autistic spectrum disorder (cluster 4).

⁵Lebeer (2009).

Of all secondary school age children (12-18 years), 11.0 % require higher levels of adaptation (II-V). Moreover, there are 4.9 % of children in cluster 2, 3 and 4 functioning on level I. This means there are about 15.9 % of children of secondary school age with some kind of special needs. Of all secondary school age children, 8.9 % have mild intellectual impairment and/ or learning disability (cluster 2) and 3.4 % have a diagnosed behavioural or autistic spectrum disorder (cluster 4).

Self-destructive behaviour

The 'Unit for Suicide Research' of the University of Gent has examined in 2001, as part of the CASE Study, 4500 pupils (age 14 -17) in Flanders, using the questionnaire 'Lifestyle and Coping' on self-destructive behaviour (Van Rijsselberghe, L., Portzky, G. & Van Heeringen C., 2002). On the question of self-destructive behaviour (e.g. too much pills, cutting with a knife) 8.1% mentioned they were involved (20.3% less than a month ago, 45.7% more than a month ago until one year ago). Of this group of 8,1%, 14.7% were hospitalized.

The results of the study clearly show the gender bound aspect of thinking on suicide, as this thinking is reported

- less than a month ago by 4.7 % of the boys and 10.3 % of the girls (total 7.5 %)
- more than a month ago until one year ago by 8.1 % of the boys and 18.1 % of the girls (total 13.1 %)
- over the last year by 12.8 % of the boys and 28.4 % of the girls (total 20.6 %).⁶

Also, suicidal ideation is less present at the age of 14 years and more present at the age of 15-17.

In Belgium, there are currently 7 suicides every day. In ten years, the suicide number has doubled among men and is now 25.4 per 100.000. Suicide attempts are estimated to be 10 to 15 times the number of suicides, thus giving about 30.000 suicide attempts per year.

In Flanders (according to the Flemish Agency for Care and Health and based on the death certificates) suicide at young age is estimated in 2006 at

- 0.6 per 100.000 at age 10-14
- 7.1 per 100.000 at age 15-19 (8.9 for boys and 5.2 for girls)
- 11.9 per 100.000 at age 20-24.⁷

Between the ages of 15 and 24, suicide is the second most frequent cause of death, after accidents: for male adolescents, it is 26 % of all causes of death, for females it is 15 %.

2.2 Vulnerable child population

Child abuse

Unlike in many countries, in Belgium it is not mandatory

to report child abuse to the judicial authorities, except in cases where protection is not possible. In the first place, child abuse is considered to be a health and welfare problem for the child and family. Only if initial responses fail, does legal intervention become necessary. This vision is translated by the call to the public to report any suspicion of child abuse.

Every parent that reports a problem from his own family or agrees to cooperate with the Confidential Centre when abuse is suspected will get help, and will not be reported to the judicial authorities. If a report proves to be malicious (e.g. in divorce matters), both parents are informed about this decision.

Different media convey the message that at least 10% of children are confronted with child abuse. The problem is a fact in Belgian society; one should not be ashamed to seek help for this problem, but one is responsible if no help is sought. In this framework, parents are invited to acknowledge that child abuse took place in the family. In Flanders, child abuse in as much as it is registered at the Confidential Centres in 2005-2006, amounts to a total of 6.646 cases with the following categories:

Category:	%
Physical abuse	25.2
Physical neglect	16.2
Sexual abuse	31.7
Emotional abuse	15.7
Emotional neglect	10.4
Other	0.5
Total (N = 6.646)	100.0

Sexual abuse is intra familial in 55%, extra familial in 27% and uncertain in 18% of cases. The problem was related to recovery of previous abuse in 2.1% of cases. In 4.4% of reports, no child abuse was found.⁸

In the same time period, 6321 youngsters were reported to the Department of Justice for the whole country (Flanders and Wallonia). In the Flemish Confidential Centres, 40% of reports originated from the child's extended family, and 20% were reported by schools. A further 20% of the reports originated in the healthcare sector.

The fear that the 'Confidential Centres model' would encourage fake reporting seems to be groundless; manipulation and abuse of the report is found only in 4% of the files.

Children of refugees and asylum seekers

In 2009, Belgium hosts about 17.000 refugees and 14.000 asylum seekers in need of protection and awaiting a decision on the merits of their claims.

Since the Belgian government only counts adults and

⁶<http://users.ugent.be/~cvheerin/english/Presentation.html>

⁷<http://www.zorg-en-gezondheid.be/EN/contact.aspx>

does not count accompanied children separately, the U.S. Committee for Refugees uses the government's average multiplier of 1.3 to estimate the number of individuals.

Those granted access to the asylum procedure move to local communities where they receive housing and permission to work and they may apply for family reunification.

Human rights groups in Belgium expressed concern that unaccompanied minors seeking asylum were falling into exploitative situations such as prostitution and forced labour. A study by the group Child Focus suggests that 25 percent may be involved in these activities.⁹

Juvenile Delinquency

Juvenile delinquency is described in statistics on registered crime and in self-report studies.

General statistics on registered crime for minors between 12-18 years old at the level of the public prosecutor in 2005, for the whole country of Belgium show:

	Boys %	Girls %	Total %
Crimes against goods	79.5	20.5	100.00
Crimes against persons	79.9	20.1	100.00
Traffic crimes	72.5	27.5	100.00
Drug crimes	83.1	16.9	100.00
Crimes against public safety	80.9	19.1	100.00
Total (N = 6.646)	79.1	20.9	100.00

Crimes against goods comprise 42.7 % of the total, crimes against persons 17.8 %, traffic crimes 14.4 %, drug crimes 11.3 % and crimes against public safety 10.2 %.

The period of adolescence, between 12-17 years, shows an age bound peak of temporary delinquency, which fades out after the age of 17-18 years for most youngsters. As expected, girls are far less involved in delinquency and especially in violence than boys.

In the framework of the OECD project 'Improving School Leadership - Country Background Report', teachers report that they are mostly the victims of verbal violence and to a much smaller extent of material violence. Hardly any physical violence is reported. Of the investigated facts involving physical violence committed against the respondents personally, robbery ranked first (2.1 %), followed by battery of assault (1.2 %) and armed threats (0.6 %).¹⁰

Next to figures of registered crime, Flanders has also figures of several self-report studies.

The most recent one is the "Youth Monitor"-study (JOP, or Jeugdonderzoeksplatform), a survey of 2006 of

youngsters aged 14-25 years. This large study shows that in 2006, 1 on 20 had been involved in a physical fight with injuries, but, in general, serious violence remains a marginal phenomenon.¹¹

Truancy

Defined as unmotivated absence at school of more than 30 days within one school year, truancy is rising in the secondary schools of Flanders. For example, in the city of Ostend it has risen from 0.6 % in school year 2003-2004 to 2.6 % in 2007-2008. Generally, truancy fluctuates between 0.5 % and 1.0 %, up to 1.5 % in the large cities such as Antwerp and Ghent¹².

2.3. Positive child and adolescent mental health

Based on its 2004 Health interview survey in Belgium, the Scientific Institute of Public Health gives the following figures on self reported subjective health and well being covering the past year for ages 15-24:

		%
Belgium, past year	Good general health: total	
	No somatic problems: total	96.1
	male	97.0
	female	95.0
	No psychological problems	81.1
Flanders, past 2 weeks	Intake of psychotropic drugs	3.3
	hypnotics	1.8
	tranquilizers	1.0
	antidepressant drugs	1.4

3. Actions for promotion and prevention in mental health

3.1. Policies and programmes for CAMH

Specific policies and large-scale programmes for CAMH

General care

The field of public health is partly the competence of the Federal Government and partly of the Communities, with some regional exceptions. As a consequence, the legislation and policies can be different; as a result practice on the ground will also be different, but the same elements may be found in all. 13

In general, the Communities have the main responsibility for childcare. In Flanders two thirds of parents with children between 3 months and 2.5 years use childcare on a regular basis.

A Flemish governmental agency, called Kind & Gezin (Child & Family), operates under the direct authority of

¹⁰http://www.oecd.org/document/53/0,3343,en_2649_39263231_38529205_1_1_1_37455,00.html

¹¹www.jeugdonderzoeksplatform.be

¹²Source: Stadsmonitor, Flemish Agency for Internal Affairs, 2008. <http://www.ond.vlaanderen.be/English>

¹³<http://www.ulb.ac.be/soco/pepsi/BE.pdf> <http://www.wvc.vlaanderen.be/welzijnengezondheid/presentatie/en/index.htm>

the Flemish Minister of Welfare, Health and Family, and works in close co-operation with the Flemish Ministry of Education. Its main task is to implement government policy for young children and for families with young children, in particular in the fields of preventive care, childcare services, family support, diversity and children's rights.¹⁴

The counterpart of 'Kind & Gezin' for the German speaking Community is 'Dienst für Kind und Familie' and for the French speaking community 'L'Office de la Naissance et de l'Enfance' (ONE).¹⁵

The Flemish Decree concerning mental health of 18 May 1999 concerns almost exclusively the Centres of Mental Health Care and gives reference to the Convention on the Rights of the Child.¹⁶

The French speaking Community has a decree of 16 March 1998, concerning the support of abused children. It has also the decree of 1 July 2004 concerning the protection of minors against the negative effects of television.

The Brussels Capital Region has an edict of 17 July 1997 concerning the recognition and subsidizing of the mental health care services in the region.

Prevention of depression and suicide in Flanders

In 1999 the Flemish government implemented a Suicide Prevention Project of the Centres of Mental Health. In this project suicide prevention is interpreted as a social responsibility involving all government sectors and as a task for all social services. Therefore, the Centres for Mental Health (Centra Geestelijke Gezondheidszorg, CGG) are directed towards intermediary target groups such as doctors, hospitals, youth care facilities, police, families and media.¹⁷

In 2002 a Health Conference 'Prevention of depression and suicide, 10 preventive strategies' (Gezondheidsconferentie "Preventie van depressie en zelfmoord, 10 preventiestrategieën") was organized by the Flemish Government. In 2006 a Flemish Action plan: Prevention of Depression and Suicide 2006-2010 (Vlaams Actieplan: Preventie van Depressie en Zelfdoding) was launched.¹⁸

The plan includes 5 strategies for all ages:

- promotion of mental health
- promotion of an easy accessible tele-homecare
- development of the expertise of professionals and the formation of networks for a better care continuity
- counteraction of provocation of suicide
- attention for specific target groups (such as support for the survivors).

Components of the action plan¹⁹ are, for example:

- an electronic help-line for general practitioners
- recommendations for the media
- psychosocial evaluation and relief in the general hospitals of persons who attempted suicide (province of Limburg)
- relapse prevention for suicide attempts in collaboration with general practitioners
- support for relatives of people who committed suicide
- intensified follow-up by the Centres for Mental Health Care.

The Belgian French Community has taken similar initiatives.²⁰

Youth violence

Due to inter alia its political structure, a single, coherent action plan to deal with youth violence does not exist in Belgium.

Initiatives at the federal level

Young people (under eighteen) in contact with the police and justice system due to committing violent acts, can only be referred to a public community institution for youth protection, which are under the competency of the three regional ministers of Welfare (the Flemish, the French-speaking and the German-speaking). The federal departments of Justice and Interior Affairs are responsible for the jurisdiction and the protection of society. The ministries of Welfare, a regional competency, are responsible for educational and supportive measures taken against minors having committed an as crime described act.

The basic assumption of the Youth Protection Law (1965, amended in 2006) remains that minors cannot be punished (based on the principle of the criminal non-responsibility of minors); consequently, they cannot commit a crime, merely an act described as criminal.

Subsequent to the new youth law, two new cooperation protocols were drafted between the federal government and the regional governments. The first was concerned with the creation of restorative initiatives, the second dealt with parental training courses. The integration of restorative principles (such as mediation) creates the possibility for young people to make an appeal for their own responsibility. It also enables the integration of the views, perceptions and experiences of the minors themselves. The focus on parental training courses emphasises the need for attention to the educational context of young people.²¹

¹⁴http://www.kindengezin.be/English_pages/default.jsp

¹⁵<http://www.one.be>

¹⁶<http://wvg.vlaanderen.be/juriwel/geoalgemeen/index.htm#cgz> ¹⁷<http://209.85.229.132/custom?q=cache:uztPCh-Uc8J:www.zelfmoordpreventievlaanderen.be/upload/And%2520Suic%2520prev%2520and%2520new%2520policy%2520in%2520Flanders%2520Glasgow08.ppt+suicide+prevention&hl=nl&ct=clnk&cd=6&client=google-coop-np>

¹⁸<http://www.zelfmoordpreventievlaanderen.be/index.php>

¹⁹<http://www.zorg-en-gezondheid.be/HomeEN.aspx?id=1182>

²⁰<http://www.aidealajeunesse.cfwb.be>

²¹<http://www.egovmonitor.com/node/23306>

Initiatives at the level of Flanders

In order to deal with the problem of school violence the Department of Education has established a Support Centre 'Undesirable Behaviour at School' (Steunpunt Ongewenst Gedrag op School)²². 'Limits' is the non-profit organisation behind this Support Centre.

In 2003 a 'Policy plan to prevent and combat violence, bullying and sexual harassment at school'²³ was sent to the schools. The centre deals with problem situations at the level of school staff and tries to mediate in case of bullying, conflicts and sexual harassment in which minors are involved.

In Belgium, compulsory education exists until the age of eighteen. Since a couple of years, an active truancy policy (spijbelbeleid) is pursued in Flanders in order to reduce antisocial behaviour in a more effective and enforceable way. Kids or youngsters that are more than thirty halve days absent from school risk losing their scholarship. This scholarship is meant for vulnerable families to help bearing the costs of going to school.

To implement restorative prevention initiatives in the educational system in order to reduce problem behaviour in schools (e.g. violence, truancy) several initiatives have been taken, such as Time Out and HERGO.²⁴

'Time Out' initiatives offer pupils who are having a bad relationship with their school, the opportunity to spend their educational time for a relatively short or longer period outside the school itself. These "Time Outs" have proven to have a positive impact on the family relations, the bond with school is being strengthened and pupils develop better and more social skills.

Another initiative is HERGO (Herstelgericht Groepsoverleg), a model of group conferencing with equal positive effects. This kind of guided conference between a perpetrator and its victim helps to cope with serious problem behaviour in the school environment. It also aims as much as possible at re-integrating the student in the same school (in Belgium obligatory for the schools).

The Flemish Department of Education also supports a number of initiatives or projects that deal with the phenomena of bullying and violence at school.

Early 2009, it has published an online handbook for all Flemish schools, titled 'Bullying and violence at school. Tools for a more powerful school policy' (Pesten en Geweld op School. Handreiking voor een daadkrachtig(er) schoolbeleid).²⁵

The Flemish Network 'Choose your Position against Bullying' (Kies Kleur tegen Pesten) takes care of networking and sensitizing.

Initiatives of the French speaking Community

Specific projects have been developed in the field of youth violence.²⁶

Other general policies related to CAMH**Child protection**

The relatively small Belgian population (10 million) may contribute to a high level of public agreement regarding serious threats of children's safety and integrity. This is manifested, for instance, in the general approval of the Confidential Centres' model, which now exists for twenty years.

On the other hand, there is an unmistakable protection from the European social model of which Belgium is part. This is a vision of society that combines sustainable economic growth with ever-improving living and working conditions. This involves full employment, safe and healthy jobs, equal opportunity, social protection for all, social inclusion, and involving citizens in the decisions that affect them.

Belgian social security legislation minimizes the risks linked to certain socio-economic factors. Social security payments are provided either to those who have or had a professional activity (pensions, unemployment benefit, sickness and disability benefits, industrial accident, occupational diseases), and are extended to all the members of the family (family allowance, sickness insurance). The vaccination level is 98%, there is free medical care, primary school reaches 98% of children, poverty affects around 8%, unemployment is around 5%, only 2% of adults used drugs in the last 12 months. These and several other social measures contribute to child protection.

When comparing models for child protection - prevention and intervention with child abuse in particular - it is very important to consider these contextual circumstances. The existence of different models to approach child abuse functions as a protection for children. The consequent discussions contribute to a continuous critical analysis of the quality of the clinical and judicial approach.

In 1991, the communities fundamentally reformed child protection. A key element of this rearrangement is the "subsidiary" principle, meaning that priority is always given to the intervention that most adequately meets the families' needs, that is most accessible to them, and that least compromises their liberty.

The communities set up non-profit organisations with government grants to offer a variety of services in the best interests of children and parents. These services include nurseries, babysitters, education shops (where every parent can explain his/her educational problem concerning children (up to age 18 years) to an educational specialist), educational support, counselling, day care centres, family centres, evaluation centres, and treatment centres. Most of these services are free. In 2005 Flanders has developed a programme 'Integral Youth Help' (Integrale Jeugdhulp) that coordinates the action in several important sectors of care, welfare, education,

²²<http://www.iswlimits.be/nl/onderwijs.asp>

²³<http://onderwijs.vlaanderen.be/antisociaalgedrag/beleidsplan/>

²⁴<http://www.schooldirect.be/contact>

²⁵<http://onderwijs.vlaanderen.be/antisociaalgedrag/default.htm>

²⁶<http://www.aidealajeunesse.cfwb.be/>

pupil guidance, disability and rehabilitation.²⁷

Children's Rights

The Belgian Federal State, Regions and Communities subscribe to the Convention for the Protection of Human Rights and Fundamental Freedoms and the Convention on the Rights of the Child, and guarantee the application of the convention in their legislation.²⁸

The Belgian Constitution (to be consulted in French, Dutch and German) specifies (Art. 22bis) that every child has the right to protection of his moral, physical, mental and sexual integrity.

In Belgium children and youngsters are considered as minors until they have reached the age of 18.

The legal position of the minor adjudges rights to minors, but maintains in principle a juridical (legal) ineligibility. This substantive (legal) ineligibility of the minor is general and concerns all rights and duties, unless the law or legal practice diverges from this principle. This (legal) ineligibility is moreover completely comprehensive; this means that a minor cannot carry out any juridical transactions, and thus is always dependent on an adult to represent his/her interests. This general principle is the starting point for the law on youth protection of 1965 and adapted in 2006. It specifies the duty of the youth judge to hear every minor who has reached the age of 12 in the case of civil disputes in relation to parental authority, the administration of goods of the minor, the execution of the visiting rights, and the indication of a co-guardian.

The right to be heard of the minor is given by article 931 of the Belgian Civil Procedural Code, in addition to the article 12 of the International Declaration of the Rights of the Child, which states that every minor can give his opinion in every judicial or administrative procedure in which he is involved. It is up to the juvenile judge's decision, to hear the minor, younger than age 12. A minor, who has the power of discernment, can be heard by a judge, on his own initiative or on demand of the judge. In the first hypothesis, the judge cannot refuse the hearing except when the minor lacks the necessary power of discernment. In the second hypothesis (hearing on demand of the judge), the minor can refuse.

In relation of the Children's Rights Declaration the Flemish Community Government decided to establish a Children's Rights Commission and the appointment of a Flemish Children's Rights Commissioner²⁹. Their role is to observe the implementation and application of the Declaration, and they are directly associated with the Flemish Parliament, act as ombudsmen/women

and produce a yearly report with information and recommendations.

The French speaking Community has also appointed its own children's rights commissioner. This 'Délégué Général aux Droits de l'Enfant' carries out the same tasks as his Flemish colleague³⁰.

Global Plan Youth Care Flanders

Regarding youth care, a Global Plan (Gloaal Plan Jeugd zorg³¹) was developed in 2006 by the Flemish Ministry of Welfare, Public Health and Family. The plan aims to be integral as it is concerned with both prevention and treatment. It consists of six fundamental policy choices and 37 objectives being elucidated, elaborated and budgeted. Based on nine working principles, the ministry wants to direct the current and the future possibilities within the field of youth care in the Flemish Community.

The six policy choices are:

- developing current and future help programmes
- increasing the programmes' flexibility
- differentiation and extension of the programmes regarding support to parents in bringing up their children and the programmes that provide assistance in problematic educational situations
- extension of assistance and support to minors who committed a crime, in correspondence with the reformations in Youth Law
- gaining insight in processes of intake, referral, and release, in order to more adequately manage these processes
- scientific research in order to turn Youth Care towards a more evidence-based action

Educational policy

In Belgium, the Communities are largely responsible for taking decisions on services for individuals, such as education. The Flemish Community is therefore responsible for education in the Dutch-speaking part of the country whilst the French Community is the competent authority for the French-speaking part of Belgium³². Education is compulsory for all children between the ages of 6 and 18. The school system covers pre-primary, primary, secondary and higher education as well as a number of international schools³³.

Constitutional freedom allows the organisation of educational networks and umbrella organisations. Traditionally, three main networks (all subsidised) are distinguished: community education, education run by public institutions, and 'free' private (often Catholic)

²⁷Flemish Community: www.kinderrechten.be; French speaking Community: <http://www2.cfwb.be/dgde/>

²⁸<http://www.diplomatie.be/en/policy/policynotedetail.asp?TEXTID=2069> ²⁹Decree of 15 July 1997. <http://www.kinderrechtencommissariaat.be>

³⁰Decree of 20 June 2002, completed in the decree of 19 December 2002 <http://www2.cfwb.be/dgde/>

³¹http://www.wvc.vlaanderen.be/jongerenwelzijn/professioneel/onlinebib/ob_gpj.htm

³²Flemish Community: <http://www.oecd.org/dataoecd/43/32/1942279.pdf>; Belgian French Community:

http://www.oecd.org/LongAbstract/0,3425,en_2649_39263231_37423291_1_1_1_1,00.html; German speaking Community: <http://www.cor.europa.eu/Pesweb/pdf/contribution-lambertz-EN.pdf>

³³Flemish Community: <http://www.ond.vlaanderen.be/English/>

French speaking Community: <http://www.enseignement.be>; German speaking Community: <http://www.dglive.be>

schools. All these networks have far-reaching autonomy. They are free to choose their pedagogic methods, curricula and schedules, as long as they achieve the end terms. They have pedagogic counsellors who are in charge of the external guidance of schools and staff.³⁴ Education policy in Belgium has opted for an overall approach to specific school problems and opportunities. Measures are implemented to give schools sufficient room to take initiatives fitting in their pedagogical project and aiming to prevent and/or tackle problems (including bullying, drug abuse, emotional problems, etc.). In this context a number of life skills projects have been developed, with a relatively extensive supply of materials, at the school level, the class level and the individual level, as well as together with the parents. Behavioural and emotional problems occur more frequently in children with learning problems than in a cross-section of the general population, both at home and at school. While behaviour problems are reportedly a key obstructive factor impeding inclusive education, children with both behavioural and learning disabilities carry a high risk of social exclusion and school dropout when they are in mainstream environments.³⁵ In fact, in Wallonia as well as in Flanders, educational themes related to the improvement of life skills have received due attention, for example: <http://www.ond.vlaanderen.be/ict/english/> Important in this respect are the Flemish interventions for youngsters in a problematic educational situation.³⁶ Such interventions are often based on UNESDOC Educational practices series.³⁷

Youth at Risk

For 'Youth at Risk' the Flemish Community approved a new decree on 7 March 2008 changing the existing legislation of 8 May 1990 on special youth care; this new decree has not yet entered into force.

In Flanders the label of 'youth in a problematic educational situation' is often used in this context.

A problematic educational situation is a condition in which the physical integrity, and/or the affective, moral, intellectual or social developmental chances of minors are under pressure by traumatic events, relational conflicts or bad living conditions. This broad definition gives room to include every problematic situation, independent of a concrete cause, such as chronic truancy, parental abuse, child abuse and neglect or runaways.

In a first step assistance is voluntarily. Children older than 12 and parents should accept the offered help; if it is demonstrated that immediate help on a voluntary basis is not possible, the juvenile judge can impose a

measure. In both cases the help can take very different forms.

In all scenarios family oriented care is central. Parents or co-guardians keep the first responsibility for the education and the development of the child and guarantee, within their possibilities and financial means, the living circumstances needed for the development of the child.³⁸

The approach of 'Youth at Risk' in the French Speaking Community is regulated by the decree of 4 March 1991. This decree is applicable to all young people in a problematic situation, to those experiencing difficulties with their parental duties and to every child that is at risk for their health, education or security as a result of his/her behaviour or the behaviour of his parents or other children.³⁹

In Brussels Capital Region, the decrees of the both the Flemish and the French speaking Community can not be applied as such, because this Region does not belong to one of these Communities: it includes both Dutch and French speaking inhabitants. As long as youth care happens on a free basis, the inhabitants of Brussels can attend youth services of both Communities. This specific situation is regulated by the Joint Community Commission of 29 April 2004.

Parental support

Included within the Belgian social security system are the systems that provide replacement incomes in the event of unemployment, retirement or the inability to work, support for financing costs such as child support or health care and annual paid holidays. In fact, there are three systems: one each for salaried workers, civil servants and self-employed persons. For salaried workers, special regulations apply to certain professions.⁴⁰

In Belgium, policy measures for childcare and parental support provision both contribute to the policy purpose of a better reconciliation of work and family life. Furthermore, measures such as childcare and parental leave are named as instruments that contribute to the equal opportunities policies for men and women. In general, the Communities have the main responsibility for childcare, but the system of parental leave, on the contrary, is a responsibility of the federal Belgian Government. Parental leave is incorporated in the career break system.⁴¹

The Flemish Government reinforces the parental leave measure by providing incentive premiums. The parents receive a fiscal benefit if the provider is registered and/or certificated with the (already mentioned) public organisation 'Kind en Gezin' monitoring childcare. For

³⁴http://europa.eu/youth/studying/index_be_fr.html

³⁵<http://www3.interscience.wiley.com/journal/118491781/abstract>

³⁶<http://www.wvc.vlaanderen.be/jongerenwelzijn/Nieuws/globalplan.pdf>

³⁷<http://www.ibe.unesco.org> - n° 8 (Preventing behaviour problems; what works); n° 11 (Academic and social-emotional learning); n° 16 (Creating a safe and welcoming school)

³⁸<http://wvg.vlaanderen.be/jongerenwelzijn>

³⁹<http://www.aidealajeunesse.cfwb.be>

⁴⁰<http://www.diplomatie.be/en/policy/policynotedetail.asp?TEXTID=49097>

⁴¹French Community: http://www.oecd.org/searchResult/0,3400,en_2649_201185_1_1_1_1_1,00.html; Flemish Community: <http://www.oecd.org/dataoecd/43/32/1942279.pdf>

children between 2.5 years to 6 years half of the parents use these measures on a regular basis; for children between 6 and 12 years old almost one third of the parents use these measures.⁴²

Alcohol and Other Drug Problems

Alcohol abuse, defined as the use of six doses of alcohol at least once per week is reported in 10% of the Belgian adult population over the past six months with the highest rate in the age 45-54.

The Association for Alcohol and Other Drug Problems (Vereniging voor Alcohol- en andere Drugproblemen, VAD) offers a website aiming to inform children of parents with drinking problems. Questions many children of alcoholics have concerning the drinking behaviour of their parents are answered in a nutshell. The site is very concise but to the point. It is written in clear and simple language. VAD is an umbrella organisation for most of the institutions and organisations active in Flanders in the field of alcohol and other drug problems and gambling. The Flemish government provides funding. VAD is active in the domains of prevention, treatment, study, research, policy support, training, networking and information supply. It runs a telephone helpline (De Druglijn) and publishes reports and educational materials. The VAD library⁴³ has a rich collection of books, reports, educational materials and journals. 'A Cool World' is part of the VAD campaign. It targets adolescents from 12 to 16 years of age. The message is: you can be cool without alcohol. The style is humorous. The site is built around four identifiable cartoon characters. Interactive features include a quiz, E-cards and the opportunity to publish stories on experiences with alcohol. The site contains a FAQ section.⁴⁴

Help for children confronted with parental alcohol abuse is offered by KOPP/KOAP⁴⁵ and ALATEEN⁴⁶. Moreover, the family doctor, JAC (Youth Advice Centre), SIMILES, and the Mental Health Centres are available.

Fight against Poverty, Insecurity and Social Exclusion

In 1998, a "Partnership Agreement between the Federal State, the Communities, and the Regions on the Continuation of the Policy on Poverty" was signed⁴⁷. This agreement provides for, among other things, the formation of the Service for the Fight against Poverty, Insecurity, and Social Exclusion. This Service was established in July 1999.

3.2. Availability of programmes for CAMH promotion and mental disorder prevention

'Fit in your head - well in your skin'

In 2006 the campaign 'Fit in your head - well in your skin' (<http://www.fitinjehoofd.be>), in other words 'Have a fresh mind and feel well in your body' (Fit in je hoofd – Goed in je vel) was launched by the Flemish Government and implemented by the Flemish Agency of Care and Health. Information about ten steps that can help people to improve their mental wellbeing is presented, together with practical guidelines, personal stories, application forms for free campaign materials, and links concerning professional help.

Centres for Pupil Guidance

Every school has to cooperate with a Centre for Pupil Guidance (Centra voor Leerlingenbegeleiding or CLB's <http://www.ond.vlaanderen.be/CLB>). These centres possess the required knowhow to advice schools, students, and their parents, to assist them and to refer them to professional care programmes if necessary.

Klasse

'Klasse, journal for school education' (Klasse, onderwijstijdschrift www.klasse.be) is an educational journal for different target groups such as teachers, students (primary and secondary schools) and parents. Klasse reaches these groups through different channels (magazines, digital newsletters, e-TV, website). The monthly journal Klasse regularly comes with an extra appendix, called 'the first line', in which information about certain themes such as bullying, violence, self-mutilation, eating disorders, cyber bullying, depression, mental health, is brought together in a very functional manner.

Youngsters for Youngsters

The system of 'JoJo's' (Jongeren voor Jongeren <http://www.ond.vlaanderen.be/JoJo>) recruits underprivileged and allochthonous young people working on better contacts between teachers, pupils and families. Besides reducing the youth unemployment among some specific vulnerable groups, these JoJo's also aim at contributing to a more positive school climate.

Equal Chances Policy

At the national level, there exists a 'National action plan social inclusion'⁴⁸. The Federal Government sees a broad-based fight against all forms of (mainly race) discrimination as a necessity. Its new bills particularly target the field of employment and labour. The Institute for the equality of women and men was founded by law

⁴²http://www.kindengezin.be/English_pages/default.jsp

⁴³<http://www.vad.be/>

⁴⁴http://www.vad.be/aanbod/Doorverwijzen/kinderen/DVG_kinderen_vlaams.html

⁴⁵www.koppvlaanderen.be

⁴⁶<http://al-anonvl.be>

⁴⁷<http://www.armoedebestrijding.be/welcome.htm> <http://www.luttepauvrete.be/index.htm> <http://www.armutbekampfung.be/index.htm>

⁴⁸<http://fatherhood.social.dk/Partners/Belgium.html>

in 2002.

There is also an official Federal Government action on disability policy (involving the Communities and the Regions) expressed in guidelines adopted by the Government. The emphasis in this policy - in descending scale - is on individual support, rehabilitation, anti-discrimination law, accessibility measures, and prevention. At the Communities and regional levels there also exist policies with regard to the fight against poverty and social exclusion.⁴⁹

The King Baudouin Foundation (<http://www.kbs-frb.be/index.aspx?LangType=1033>) offers partnership and support for such projects, e.g. 'The schooling of Romany children in Belgium'.

Since 2002, the Flemish Department of Education focuses on the 'Equal Chances Policy' (GOK, Gelijke Onderwijskansenbeleid⁵⁰). Its main goal is to improve the learning return of pupils with reduced social chances, so that they also can take profit of the emancipatory power of education. Based on characteristics of the school population, schools receive more funding for ameliorating the school functioning. This must allow the more underprivileged pupils to enjoy in a more adequate way the chances schools have to offer. Within this policy, a lot of attention is directed towards the pupils' wellbeing and the prevention of problematic behaviour at school. This broad concept also covers aggression, violence and annoying behaviour.

'How different is different?' / 'A la rencontre de l'autre'

As regards programmes at schools, there are two programmes bringing together adolescents and people with mental illness: 'How different is different?' in the Flemish Community and 'A la rencontre de l'autre' in the French Community.

'How different is different?' (Hoe anders is anders?) is a programme (in the form of a contest) bringing together adolescents and people with mental illness in the Flemish Community. The Flemish Mental Health Association (VVG www.vvgg.be) initiated this module of mental health promotion in 1991, involving five schools and only 20 pupils; currently, more than 100 schools and 1000 pupils participate in the project. At first the Ministry of Health of the Flemish Community supported this project; subsequently, it was taken over by the Ministry of Education with co-financing by the bank sector.

'School on turn'

The city of Antwerp supports a programme of youth

violence prevention, called 'School on turn'51 (School aan de Beurt), involving all Antwerp schools and especially those, which are located in disadvantaged neighbourhoods. It coordinates the preventive interactions between the schools, students and parents, health and welfare workers, police, neighbours, authorities.

GO!⁵² (the Flemish Community Education, one of the three main education networks in Flanders, with 773 establishments in Brussels and Flanders, spread over 28 school groups with more than 32 000 staff and 300 000 pupils) has a daily online newspaper that covers a series of CAMH related information, initiatives and anchorpersons training.

Training for parents

The umbrella organisations of parents' committees are the primary providers of information, advice and training for parents with children of school age.⁵³

- 'Klasse voor Ouders' is a periodical on education, published by the Flemish Ministry of Education. Every parent can obtain it freely through their children's school. It explores different themes concerning education and parenting.
- 'Parenting information centres' are part of the Global Plan Youth Welfare in Flanders. They centres give free advice to parents with questions and problems concerning their parenting skills. They also offer information brochures.
- Training school for parents (Gezinsbond vzw)⁵⁴ offer short training courses for small groups of approximately 12 participants, guided by professional counsellors.
- Centres for integrated home care⁵⁵, intervening when crisis situations arise within the family, are accessible to all families and offer support and guidance during 9 months (at most), in or outside the home.
- Centres for child care and family support⁵⁶, organised by Child and Family and targeting all parents who have problems with bringing up young children, up to 12 years old, and who don't have enough time at their disposal to raise their children, e.g. after a divorce. They offer different types of care: guidance in the home and temporary short day and/or overnight care for one or more days.

SIMILES⁵⁷

Children of parents with a mental illness are at 50% increased risk of a mental health problem later in life. The Belgian Association SIMILES for Families confronted with

⁴⁹http://books.google.be/books?id=scv4l2qjENIC&pg=PA44&lpg=PA44&dq=diability+policy+Flemish+Community&source=bl&ots=KqjufOMil_&sig=VaDphDtDKPezxVI35GMifVBgW9A&hl=nl&ei=G4iRSanoPKTEjAe8muS_Cg&sa=X&oi=book_result&resnum=2&ct=result

⁵⁰<http://www.steunpuntgok.be>

⁵¹<http://www.indymedia.be/en/node/24891>

⁵²www.g-o.be/gezondheid

⁵³There are three such organisations, each responsible for a particular segment of the educational system: www.vcvob.be; www.evovzw.be; www.koogo.be ⁵⁴http://www.gezinsbond.be/index.php?option=com_content&task=blogcategory&id=37&Itemid=61

⁵⁵http://www.kindengezin.be/KG/Themas/Hulpknop/thuisituatie_onveilig.jsp

⁵⁶www.ckg.be

⁵⁷SIMILES francophone: <http://www.similes.org/fr>, SIMILES Flanders: <http://nl.similes.be>

mental health problems has published a series of books and brochures in order to prevent disorders in children associated with parental mental health problems. Examples (selected in French language) are:

- Un papa qui a des ailes "Ouplaboum". (a book for children age 6-9 living with a mentally ill parent)
- Un regard insondable. (a book for adolescents living together with a mentally unstable mother)
- Papa n'est jamais fatigué. (a book for children age 3-6 living together with a hyperactive father)
- Frères et soeurs face aux troubles psychotiques. (book for young persons confronted with the early symptoms and dangers of mental disorder in brothers or sisters)
- Next to SIMILES, KOPP/KOAP⁵⁸ (Kinderen van Ouders met Psychiatrische Problematiek/Kinderen van Ouders met Afhankelijkheidsproblematiek) provides a specific project for children of parents with mental problems.

4. Organisations and resources for implementation

4.1. Institutions and organisations

Flemish Agency for Care and Health⁵⁹ (Vlaams Agentschap Zorg & Gezondheid) develops and implements the health policy of the Flemish community. It is part of the Flemish Ministry for Welfare, Public Health and Family. Its website give an overview of the Flemish competences in health, the Flemish health policy and the main health indicators for the Flemish population.

Child & Family⁶⁰ (Kind & Gezin) is a Flemish governmental agency with responsibility for young children and families in Flanders. Its main task is to implement government policy for young children and for families with young children, in particular in the fields of preventive care, child care services, family support, diversity and children's rights. It operates under the direct authority of the Flemish Minister of Welfare, Health and Family, and works in close co-operation with the Flemish Ministry of Education.

In principle all childcare activities need to be reported to Kind en Gezin except for care by grandparents and other relatives.

Its services include:

- Preventive family support and services
- Pre- and postnatal follow-up

- Childcare: a complete overview of types of childcare available from babies to school children
- Supervision of quality
- Help in specific situations (child abuse, family crisis, adoption)

The counterpart in French speaking Belgium is the Office de la Naissance et de l'Enfance (O.N.E.)⁶¹

Agency of Youth Welfare⁶² (Agentschap Jongerenwelzijn) is an internal independent agency within the policy domain of Welfare, Public Health and Family. It guards the chances for prosperity of youth in difficult situations by offering different forms of competent help. It takes responsibility for the broader context by helping to prevent problematic living situations and by correcting breaches in the context and in the social equilibrium. The Agency's target group is youth for whom social integration and participation is at risk, young people having received a protection measure because they committed an as a crime described acts as well as parents and significant others in the life of the young people.

It consists out of three departments: the department "Facilities policy" (Voorzieningenbeleid), the department "Prevention and Referrers Policy" (Preventie- en Verwijzersbeleid) and the department "Community Institutions" (Gemeenschapsinstellingen).

Special Childcare⁶³.

Most concerns regarding youngsters and families in need are handled by this organisation, which is led by a committee of representatives of the community who are informed by social workers/counsellors and especially deals with reports of neglect and high-risk families with serious psychosocial difficulties.

In consultation with parents, Special Childcare evaluates the parents' demand for help. The subsidiary principle is followed here as the family's own demand has the highest acceptance rate.

Flemish Welfare Association⁶⁴

The Flemish Welfare Association (Vlaams Welzijnsverbond) unites some 700 services of the Flemish free initiative in the welfare sector. It combines institutions, services and departments from the care for the disabled, special youth care, family support, childcare and voluntary work. Its main task consist in providing the member organisations with information and advice, policy development, promotion of interests and representation, for example on the implementation of Children's Rights in Flemish Provisions for Special Youth Welfare (Minorius Project).

⁵⁸<http://www.koppvlaanderen.be>

⁵⁹<http://www.zorg-en-gezondheid.be/topPage.aspx?id=3046>

⁶⁰http://www.kindengezin.be/English_pages/default.jsp

⁶¹http://www.vbbe.be/default.asp?V_DOC_ID=1814

⁶²<http://wvg.vlaanderen.be/jongerenwelzijn>

⁶³<http://www.pleegzorgvlaanderen.be/organisatie/foster-care>

⁶⁴<http://www.vlaamswelzijnsverbond.be/?action=onderdeel&onderdeel=1&titel=Acquaintance>

Service Centre for Youth Policy⁶⁵

This centre (Steunpunt Jeugd) aims to co-operate with the Flemish government on youth policy: from deciding the agenda and policy development to implementation and evaluation of such policies. The centre started in 2002 with an assignment in the youth work sector.

Many actions of policy influence the lives of children and young adults. Every day all kinds of cabinets and administrations discuss and take measures that, directly or indirectly, concern young people. Steunpunt Jeugd guides policymakers in the direction of children and young people. An integrated youth policy can only be achieved when policy principles and measures are geared to one another with the best interest of children and young people in the forefront.

Confidential Centres for Child Abuse and Neglect

Intra-familial violence is the main task of a multidisciplinary organisation, called Confidential Centres in Flanders or Children SOS Teams in the French-speaking region. The centres provide assessment and intervention without any obligation to report to the judicial authorities, except when the child's safety cannot be guaranteed. The confidential doctor is entrusted with confidential information about abuse or neglect. Such information can be given without risk of prosecution, for violation of professional confidentiality or for avoiding reporting to them. The Centres are specialised in the following tasks:

1. provision of expert support to professionals confronted with child abuse in their work environment, and assistance to families and others involved;
2. assessment, coordination, intervention and, if necessary, psychotherapy for families and other persons involved in a case;
3. raising awareness of health care providers, teachers and the general public regarding child abuse and neglect, in order to optimise detection.

The legislation also requires the Centres to be multidisciplinary (the cooperation of a medical doctor, a psychologist and a social worker form the minimum requirement) and to be accessible day and night. Each province has its own Centre, providing free services.

The Confidential Centres in Flanders and their counterpart in the French-speaking part of the country, the SOS Child Teams, have similarly developed this model.

Children's Rights Coalitions⁶⁶

In Belgium Children's Rights Coalitions form networks of non-governmental organisations for the defence of children's rights. The areas in which these organisations work, the public they target and the levels at which they operate vary, but they all have the child's interest

at the heart of their programs. The coalitions dialogue with public authorities, national and international organisations and with the children and youths themselves. Children's rights are fundamental in many areas, such as adoption and fostering.

In 2005 Belgium has approved a law allowing same-sex couples to adopt children domestically or internationally. Gay couples won the right to marry in Belgium in 2003. The new law grants them the same adoption rights as heterosexual couples.

In the framework of its "International Campaign against Child Trafficking"⁶⁷, Terre des Hommes⁶⁸ raises the problematic of inter-country adoption as a potential form of trafficking, the responsibilities of which are not exclusively of the country of origin. It is up to the receiving countries to adopt legislation in conformity with the rights and best interest of the child and to assure adoption procedures in accordance with the international conventions.

Many more organisations actively help in the field of CAMH, such as:

- **the Flemish Foundation for Trafficknowledge (VSV)** <http://verkeerskunde.be/EN/>
- **Sensoa (the Flemish expert organisation on sexual health)** <http://www.sensoa.be/en/index.php>
- **Red Cross** http://www.rodekruis.be/NL/_TopNavigatie/EnglishSummary/
- **LOGO** (Lokaal Gezondheidsoverleg), involving the cooperation of the local Centre for Mental Health, the Flemish Institute of Health Promotion (Vlaams Instituut voor Gezondheids promotie, VIG), and representatives of the local first line of welfare and health care).

4.2. Services

Child protection services

In 1991, the communities fundamentally reformed child protection. A key element of this rearrangement is the "subsidiary" principle, meaning that priority is always given to the intervention that most adequately meets the families' needs, that is most accessible to them, and that least compromises their liberty.

Child protection services consist of two organisations focussed on voluntary aid: the Special Childcare and the Confidential Centres for Child Abuse & Neglect. They work independently.

The communities set up non-profit organisations with government grants to offer a variety of services in the best interests of children and parents. These services include nurseries, babysitters, education shops

⁶⁵<http://www.steunpuntjeugd.be/english>

⁶⁶Francophone Children's Rights Coalition (Coordination des ONG pour les Droits de l'Enfant, CODE) <http://www.lacode.be> Flemish Children's Rights Coalition (Kinderrechtencoalitie Vlaanderen) <http://www.kinderrechtencoalitie.be/content.aspx?l=000.002>

⁶⁷<http://www.childtrafficking.com>

⁶⁸www.terredeshommes.org

(where every parent can explain his/her educational problem concerning children (up to age 18 years) to an educational specialist), educational support, counselling, day care centres, family centres, evaluation centres, and treatment centres. Most of these services are free.

Centres of General Welfare Work – Youth Advice Centres

The regions of Flanders and Brussels count 27 centres of General Welfare Work (Centra Algemeen Welzijnswerk). They offer low threshold help for the promotion of wellbeing, where every citizen can with all kinds of questions or problems regarding their personal wellbeing. Specifically for young people, each centre has a Youth Advice Centre (JAC or Jongerenadviescentrum). Some centres have specific attention for immigrants and refugees. Victims of a crime (youngsters as well as adults) can go to the centre for Victim Aid (Dienst Slachtofferhulp) in every judicial district. A centre for Judicial Welfare Work (Justitiele Welzijnswerk) is active in each prison. On a local level a 24 hours crisis aid is sometimes available.

Special Childcare Services

Many concerns regarding youngsters and families in psychosocial need are handled by these services. The offer consists of many free services such as home counselling, day and night nurseries, mental health consultation, etc. These services use risk taxation instruments and treatment protocols to evaluate and adjust their assessments. When parents refuse voluntary care and when the child protection service considers the situation as harmful to the child, the course of events depends upon the specific region in Belgium. In the French-speaking community, the file can be forwarded to a juvenile prosecutor. In Flanders, additional efforts are required to make voluntary assistance successful by submitting the file to a mediation commission. This commission, active in every judicial district since 1991, focuses on parents and children as well as other caretakers familiar with the situation. The mediation commission is flexible in working with families; for example, evening meetings are very common. When an agreement is reached, work is coordinated by the Special Childcare on a voluntary basis. If no agreement is reached with the parents and if the commission confirms the dangerous situation of the minor, the commission transfers the file to a juvenile judge.

A simple concern can be sufficient for reporting. The help procedure is started as soon as possible, followed by an assessment. The initial help can then be adjusted progressively after the assessment. This order of sequences is a specific characteristic of these Centres. The team's tasks include a number of initial phases in the therapeutic process: assessment, confrontation, conclusion, motivation for therapy, and the transfer to an external child welfare or mental health service. If there are no referral options, the centre may offer

psychotherapy.

Youth at Risk (YAR) Vlaanderen⁶⁹

YAR is a community-based project of the Flemish Community, linked to the Global Plan Youth Care. It offers special assistance for youngsters in a problematic educational situation. Fundamental to the project are the strong motivational involvement of the youngsters and the input of a large number of trained volunteers.

Prevention of depression and suicide in Flanders

As part of the action plan, the Flemish government supports phone and internet help lines directed towards people, including youth, who are directly or indirectly confronted with suicide: Tele-accommodation (Tele-onthaal), Suicide prevention line (De Zelfmoordlijn) and the Children- and Youth phone (De Kinder- en Jongerentelefoon (KJT)). This last help line deals with all possible problems confronting children and youth (such as bullying, parental divorce, eating disorders, self-mutilation) and offers children and youth the possibility to communicate through e-mail, mail or chatrooms.

The 'Werkgroep Verder' (Working Group 'What Next') co-ordinates, organises and supports initiatives for relatives of people who committed suicide in Flanders. Its purpose is to improve the relief for relatives and to make the theme 'mourning after suicide' debatable in society.

An example of local support on a provincial level given to the action plan is the "Province of Limburg: Project Youth Suicide Prevention" (Provincie Limburg: Project Suïcidepreventie bij jongeren), consisting of a cooperation between prevention of General Youth Care (GYC), the project Suicide prevention of the Centres of Mental Health (CGG's), the Centres for Assistance to Students of all the educational networks and the Provincial Service of Wellbeing and Health. It offers training to schools and other intermediary bodies.

LE TAMARIS (Centre d'Accueil Spécialisé, CAS) is a residential centre in Brussels specialized in adolescents with severe behavioural disorders, aiming to family and/or social reintegration of the adolescent. It welcomes at most 15 adolescents (11-18 years), boys and girls, all referred by a children's judge or a legal aid. The team includes an important educational staff. Due to the important influence of the environment in a youngster's life, collaboration with significant parties is critical to rehabilitation.

The programme framework is therefore very systemic in nature.

EXIL⁷⁰ is a specialised mental health centre in Brussels, taking care of severely traumatized and often tortured political refugees from all over the world. It is supported by the French speaking as well as the Flemish Community. Its team is composed by doctors, psychologists, therapists and volunteers who form a multicultural and

⁶⁹<http://www.yarvlaanderen.be/index.html>

⁷⁰www.exil.be

interdisciplinary system, embedded in a community and cultural practice and based on the natural resources present within the individual, family and community. Priority and specific programmes are offered to the most vulnerable groups, especially the second and third generation children.

Services for unaccompanied minors

Unaccompanied minors are considered an important risk group. On 24 December 2002 a law was passed in the Belgian Parliament, which creates a system of guardianship, allowing for the appointment of a guardian to every unaccompanied foreign minor on Belgian territory.

Reception centres specialising in the reception of victims of trafficking of human beings already exist for several years in Belgium. Since 2000 three specialised centres for the reception of minor victims of trafficking and unaccompanied minors were opened in both regions of the country. The regional governments finance those centres that offer temporary reception while efforts are made to find a long-term solution for the young people.

The regional governments dedicated more resources to street social work as an important instrument in the detection of and care for young foreign prostitutes. The objective is to take steps so that the victims of prostitution – whose unstructured, underground lifestyle are an obstacle to any initiative – come into contact with social assistance. For example, such assistance is given in Antwerp by the non-profit association

Payoke⁷¹ (to groups of prostitutes starting up, groups of very young pimps, children of prostitutes, and young street children in red light districts).

Similar associations exist in the two Communities.⁷²

Child Focus⁷³, the European Centre for Missing and Sexually Exploited Children, is a foundation of public utility. It actively supports investigations in disappearance, abduction or sexual exploitation of children and, secondly, tries to prevent and fight against these phenomena.

'Young but not hetero'⁷⁴ (Wel Jong niet Hetero) offers support and activities for young lesbian, gay, bisexual or transgender (LGBT) persons. With the help of the Flemish Administration it develops programmes to combat prejudice and to facilitate social integration.

4.3. Funding

With regard to the budget for prevention and

promotion, it is difficult to get the overall picture due to the fragmentation of the competences and resources. At the national level, funds are available for mental health, but mixed in with other funding, and hard or impossible to link explicitly with mental health. At the community, regional and local level, the budget allocation for prevention and promotion of CAMH is not available.

Belgium has a compulsory health insurance system. In order to contain the costs of health care service reimbursement and avoid unnecessary health care consumption by their members. The health insurance providers give helpful information and organize campaigns about specific issues such as prevention of depression or drug abuse in young persons.

Sometimes, as a means to guarantee the implementation of specific policies, an internal independent fund is established. The Fund of Youth Welfare⁷⁵ (Fonds Jongerenwelzijn) offers an example of this policy. This fund guarantees the necessary financial means to make sure that every minor can make use of the necessary help and support.

Co financing is a frequently used method of funding. An example is given by 'How different is different?' (Hoe anders is anders?), a programme bringing together adolescents and people with mental illness. It is organised by the Flemish Mental Health Association (VGG), and funded by the Flemish Ministry with co-financing by the bank sector.

In the field of private funding 'Go for Happiness' (Ga voor Geluk vzw⁷⁶) is considered an example of good practice. This ngo, founded in 2005 as a survivors' initiative, intends to contribute to the prevention of depression and suicide, primarily in young persons. It embraces a strategy aimed at establishing a lasting impact on the administration of health and welfare through academically mentored pilot projects.

The 'King Baudouin Foundation'⁷⁷ develops its activities around current themes that it considers important and for which it wants to play the role of pioneer. CAMH is one of these themes. The Foundation establishes partnerships and conducts missions at the request of various authorities. It asks researchers, project leaders and committees to produce reports on the results of projects that have been carried out. Its site offers information about events, publications and calls for projects that are eligible for financial support.

4.4. Training of professional workforce

Professional education

The Community Ministry of Education and Training controls the development and recognition of a large

⁷¹<http://www.payoke.be/pages/eng/engindex.html>

⁷²French: www.lacode.be, German: <http://www.kinderrechtencoalitie.be/content.aspx?l=000.002>

⁷³<http://www.childfocus.be/en/index.php?language=en>

⁷⁴<http://weljongniethetero.be//index.asp?manch=17&nosub=1>

⁷⁵<http://www.wvc.vlaanderen.be/welzijnengezondheid/presentatie/en/index.htm>

⁷⁶www.goforhappiness.be <http://>

⁷⁷www.kbs-frb.be/index.aspx?LangType=1033

number of education and training programmes, including the formation of doctors, nurses, social workers and other health care professionals.⁷⁸

Specialised training

The Federal Minister of Health controls specialised training for doctors and nurses as well as a large number of postgraduate training sessions. There are many other initiatives taken by the community or regional authorities, by universities and high schools, by professional associations and by private initiative.

An example is given by the electronic help-line for general practitioners with regard to depression and prevention of suicide. Its aim is to promote expertise of GPs by means of a web-based 'info cell' and an interactive curriculum on suicide prevention.⁷⁹

Teacher training

The recent reform of the teacher training aims at enhancing the practical experience for teachers in training. Through an internship and regular contacts with their personal mentor, teachers learn how to manage a group of pupils and how to deal with pupils' (internalised and externalised) problem behaviour. Schools are funded to make sure every starting teacher is assigned to a mentor, who makes him/her familiar with the school culture and functions as a contact point in case of problems.

The high schools and universities organising teacher-training courses are free to select the themes within the curriculum limits. Additional workshops, hosted by experts, cover specific topics, such as coping with aggression, prevention of bullying and school interventions for cyber bullying. (Tools include, for instance, the movie 'Ben X', a Flemish movie about a 17-year old autistic boy who is bullied in school; an extensive educational package for teachers deals with themes such as autism, being different, cyber bullying and suicide.)

In Flanders the post-graduate courses are organised partly by the educational network of the Flemish Community:

- www.vsko.be (Flemish Secretariat for Catholic Education)
- www.g-o.be (public education organised by the Flemish Community)
- www.pov.be (Flemish Provincial Education)
- <http://users.belgacom.net/starterskit/fopem.html> (federation of independent pluralistic and emancipatory 'method schools': FOPEM)
- www.ovsg.be (Educational Secretariat of the Association of Flemish Cities and Municipalities)

- www.steunpuntgok.be (Equal Chances Agency)

and partly by education centres such as:

- www.cego.be (Centre for Experiential Education – University of Leuven)
- www.ua.ac.be/cno (Centre for Post-graduate Education – University of Antwerp)
- www.pdcl.be (Catholic Institution of Higher Education Leuven)
- <http://www.khlim.be/eCache/DEF/957.html> (Catholic Institution of Higher Education Limburg)
- http://old.khm.be/ENGLISH/2510/default.aspx?_vs=0_N (Catholic Institution of Higher Education, Mechelen)
- www.vormingscentrumguislain.be (Centre for Education Guislain, Ghent)
- www.jeugdenvrede.be (Voluntary Association Youth & Peace)
- www.kieskleurtegenpesten.be (anti-bullying network)
- <https://sites.google.com/a/oobc-nieuwevaart.be/public/publicaties> (Department of Orthopedagogy, University of Ghent)

In order to improve the quality of education in Flanders, most institutions of higher education have opted in favour of structural and functional cooperation, of which the largest example is the K.U.Leuven Association (70,000 students in campuses in 23 locations across Flanders).⁸⁰

Projects dealing with teacher training are equally present in the French speaking part of Belgium.

Examples include:

- Centre of Educational Resources for Social Action (Centre de Ressource Educative pour l'Action Sociale, Mons), offering information, workshops and seminars with direct relevance to social workers and teachers confronted with violence at school. <http://creas.umh.ac.be>
- Voluntary Association No Violence at School (Non-violence à l'école) organising pedagogic information files for schools, psychological support for victims, and meetings where children, adolescents, parents and teachers discuss violence related problems. www.nonviolence.be

Recommendations are given to the media with regard to coverage of mental health problems, especially about suicide and extreme violence. The aim is to inform the media about how to cover these issues by stressing the preventive possibilities and without enhancing the chance of imitation.

⁷⁸Flemish Community: <http://www.ond.vlaanderen.be/English/>, French speaking Community: <http://www.enseignement.be/index.php?page=25647>

⁷⁹https://portal.health.fgov.be/portal/page?_pageid=56,512473&_dad=portal&_schema=PORTAL

⁸⁰<http://associatie.kuleuven.be/eng>

In 2007 guidelines for safe ICT-use were made by the Flemish Department of Education and Training and distributed to all schools. The aim of the guidelines is to promote a safe, responsible and efficient use of ICT. Attention is also given to the prevention of cyber bullying.

5. Monitoring and evaluation of the actions for the promotion and prevention in mental health

5.1 National Statistical Institution (NIS)

This institution offers a large choice of statistical information.⁸¹

In the field of health it has links with, among others:

- The Scientific Institute of Public Health (Brussels) <http://www.iph.fgov.be/>
- Institut national d'assurance maladie-invalidité (INAMI) <http://www.inami.fgov.be/homefr.htm>
- Rijksinstituut voor ziekte- en invaliditeitsverzekering (RIZIV) <http://www.riziv.fgov.be/homenl.htm>
- Flemish Community <http://www4.vlaanderen.be/dar/svr/Cijfers/Pages/Excel.aspx>
- Communauté française de Belgique http://www.cfwb.be/index.php?id=portail_recherche

5.2 Service Centre for Youth Policy⁸²

(Steunpunt Jeugd) wants to be a centre of expertise that not only develops an information and documentation centre with interesting publications, but also strives to draw an exploration chart of the dynamic life of the areas researched. It wants to distribute and make accessible in a most comprehensible manner, all the knowledge, skills, valuable contacts, experiences and experiments that feed youth work and youth work policy.

5.3 Flemish Agency for Care and Health⁸³

(Vlaams Agentschap Zorg en Gezondheid) works in the framework of the Flemish Parliament Act on preventive health policy (2003). This Act contains a fixed procedure for the development of new health targets, through the organisation of health conferences.

The implementation of the preventive health policy has to be evidence-based. Data on the health status of the population as well as on health care are collected on a regular basis, and these analyses are published yearly as Flemish health indicators. Based on evaluations of

morbidity and mortality, health targets for the population are set. Reporting on the health indicators related to these health targets to the Flemish Government and Parliament is obligatory every 5 years.

5.4 Limits

In order to deal with the problem of school violence the Flemish Department of Education has established a Support Centre 'Undesirable Behaviour at School' (Steunpunt Ongewenst Gedrag op School). 'Limits' is the non-profit organisation behind this Centre, taking care of surveys, assessment and support.

5.5 Equal Chances Policy⁸⁴

The Flemish Ministry of Education has an Equal Chances Policy (Gelijke Kansen Onderwijsbeleid, GOK).

Its main goal is to improve the learning return of pupils with reduced social chances, so that they also can take profit of the emancipatory power of education. Schools get extra funding from the support centre Equal Chances in School Education. The evaluation of specific school action programmes is carried out by the schools themselves as well as through external evaluators.

5.6 Antwerp Youth Mental Health Project

In general the policy of government and providers (institutions) is defined by the characteristics of the services and not by the demands of children and parents. For instance, more than 70% of children and adolescents in child welfare suffer of psychopathology. On the other hand, there is an increase of children and adolescents falling between the system of child welfare and the system of mental health because they and their families have multiple (severe) problems in different domains.

In this project of collaboration between the different systems of childcare the aim is to establish a individualised team of professionals together with the child and the parents (the wraparound team). The of care and treatment is focused on the demands of the child and the parents, using the services and strengths of the different systems of care. In order to learn how to organise, monitor and assess such collaboration, a centre in the Province of Antwerp of integrated care and treatment for multi problem families has been established. In collaboration between a child welfare institution and a centre for child and adolescent psychiatry, it develops an integrated programme for screening, diagnosis and treatment of parents and children. It provides advice to parents, the judges, and other practitioners.

As a pilot it works on an evidence-based programme of integrated family treatment, according to the principles and methods of Triple P (Positive Parenting

⁸¹http://www.statbel.fgov.be/home_en.asp

⁸²<http://www.steunpuntjeugd.be/english>

⁸³<http://www.zorg-en-gezondheid.be/EN/contact.aspx>

⁸⁴www.steunpuntgok.be

Program, developed by Matt Sanders, Queensland University). Another project, called 'BYPASS'⁸⁵, explores the collaboration between child and adolescent psychiatry, the system of mental health and the system of child welfare. A protocol for consultation of a child and adolescent psychiatrist is developed focusing on the demands of practitioners and institutions in the system of child welfare. The aim of this consultation is to reinforce their competences.

5.7 Hearings and Councils

The parliaments of the Communities organise hearings about themes such as bullying at school, youth suicide prevention and youth delinquency. The High Health Council (Hoge Gezondheidsraad) is the independent scientific advisory body of the Federal Department of Health) and operates as a connection between science and policy in the field of health. Other health councils function at community and regional levels.

6. Research and dissemination

Scientific Institute of Public Health (IPH)⁸⁶

Its objectives are:

1. Identification of health problems
2. Description of the health status and health needs of the population
3. Estimation of prevalence and distribution of health indicators
4. Analysis of social (in)equality in health and access to services
5. Study of health consumption and its determinants
6. Study of possible trends in the health status of the population

The Belgian universities are involved in multiple CAMH related research projects.

- Vrije Universiteit Brussel: <http://www.vub.ac.be>
- Universiteit Antwerpen: <http://www.ua.ac.be>
- Katholieke Universiteit Leuven: <http://www.kuleuven.be>
- Transnationale Universiteit Limburg: <http://www.tUL.edu>
- Universiteit Gent: <http://www.ugent.be>
- Université catholique de Louvain: <http://www.uclouvain.be/index.html>

- Université Libre de Bruxelles: <http://www.ulb.ac.be>
- Université de Liège: <http://www.ulg.ac.be>
- Université de Namur: <http://www.fundp.ac.be>

Examples of CAMH policy oriented research projects in Flanders:

- Research- and Training project 'Youth with eating disorders'⁸⁷
- Cyber bullying among young people in Flanders.
- Evaluation of Time-out and Hergo of the school years 2006-2007 and 2007-2008.⁸⁸
- Yearly report on suicides and suicidal attempts in Flanders⁸⁹
- Identifying special educational needs in Flanders: validity of a new framework of graded adaptation,⁹⁰
- Meta-analysis of the results of the European Study on Epidemiology of Mental Disorders⁹¹
- A hundred best practices in youth suicide prevention' (2008).⁹²
- Child, Youth and Family Policy Regimes⁹³
- Antwerp Youth Mental Health Project⁹⁴
- Yearbooks "Child in Flanders" ⁹⁵
- Conceptual and practical application of the Belgian model of child protection in case of child abuse.⁹⁶

VRIND⁹⁷

The Flemish Government has a centre, called 'VRIND' that covers statistical data, strategic management issues, surveys and scientific reports relevant to the Flemish Community.

7. Challenges, opportunities and advances in the field

7.1. Key recent advances

Confidential Centres

Among the key recent advances in CAMH care in Belgium stands the practical application of the Belgian model of child protection in case of child abuse. It has a very positive effect on the public opinion and education as well as on the rights of the individual.

⁸⁵<http://www.usos.be/main.aspx?c=.CAPRI&n=37595&ct=037595&e=85849>

⁸⁶<http://www.iph.fgov.be/epidemie/epien/index4.htm>

⁸⁷www.eetstoornis.be

⁸⁸<http://www.ond.vlaanderen.be/OBPWO/projecten/2001/samenvatting0101hergo.htm> <http://www.ond.vlaanderen.be/leerplicht/actoren/time-out/default.htm>

⁸⁹<http://bjp.rcpsych.org/cgi/content/full/183/3/260>

⁹⁰<http://www.ua.ac.be/main.aspx?c=jo.lebeer&n=14> <http://www.ua.ac.be/main.aspx?c=jo.lebeer&n=14>

⁹¹www.iph.fgov.be/epidemie/epien/index4.htm

⁹²<http://www.gavoorgeluk.be/en/projecten.php>

⁹³<http://www.kuleuven.ac.be/kuleuven>

⁹⁴<http://www.ua.ac.be/main.aspx?c=.CAPRI>

⁹⁵http://www.kindengezin.be/English_pages/default.jsp

⁹⁶www.kindermishandeling.leuven.be

⁹⁷http://aps.vlaanderen.be/AutonomyPost.jsp?DBase=*&QueryText=jeugd&x=14&y=8

In 1991, Belgium fundamentally reformed child protection. This reform is based on the finding that the duty to report child abuse to the Justice Department led to avoidance of child abuse recognition and belated notifications by professionals. The judicial inquiry encouraged parents to deny and avoid problems rather than face them and accept assistance. In fact, parents did not learn to change their parenting behaviour.

The Confidential Centres worked in a discordant context between the judicial authorities and the communities. This situation ended in 1987, when the law regulated the roles of Confidential Centres. In these centres there is no obligation to report child abuse to the Justice Department, but Confidential Centres employees must take responsibility for children's safety based on the principle of shared vulnerability. It is a legal obligation to help a person in need, implying that the employees are responsible by criminal law for not reporting to Justice when they know a child's life is threatened and they do not protect this in a sufficient manner.

A key element of the reform is the "subsidiary" principle, meaning that priority is always given to the intervention that most adequately meets the families' needs, that is most accessible to them, and that least compromises their liberty. The national importance of the subsidiary principle explains the limited role of the justice system in the protection of minors in cases of child abuse. This change in policy represents the intention to evolve from a punitive strategy to a supportive one, encouraging individuals to take responsibility at their level, and to encourage everyone to take initiative when there is any early signal that a child's health or development might be in danger.

This resulted in the following policy developments:

- The priority for any care must be the rights of the child. The fulfilment of this task should be the prime concern in future development of health care sector and judicial procedures.
- Violence towards children is clearly divided into intra-familial and extra-familial categories.
- Intra-familial violence is best reported to a multidisciplinary team, called Confidential Centres in Flanders or SOS Child Teams in the French-speaking region. The centres provide assessment and intervention without any obligation to report to the judicial authorities, except when the child's safety cannot be guaranteed.
- In the case of child victims of extra-familial offenders, the judicial authorities are brought in, and their investigation takes priority. The judge's decision has to be reviewed at least yearly and has to be confirmed or finalized on the basis of follow-up information of his social services. During the conclusion, a child and family can be referred to voluntary Special Childcare.

The definition of child abuse used in child protection should first of all contribute to a growing alertness for any warning signal from children. The aim is to teach adults to think about child abuse as a possible contributor to many symptoms in children and to report any suspicion of child abuse. Every parent that reports a problem from his own family or agrees to cooperate with the Confidential Centre when abuse is suspected will get help, and will not be reported to the judicial authorities. If a report proves to be malicious (e.g. in divorce matters), both parents are informed about this decision. Different media convey the message that at least 10% of children are confronted with child abuse, that this problem is a fact in our society. Obviously, "Who reported me?" is the first reaction of most parents, because they experience this as a betrayal. It is up to the team of the Confidential Centre to change this reaction into: "Whoever calls our Centre does not want to harm you, because this person knows we are not a judicial service. Help is recommended and together with you, we want to evaluate the concern, together with you, as well as what the next steps should be." The effectiveness of the approach by the Confidential Centres is indicated by the increased self-reports over the past 20 years, from 7% of total reports in 1987 to 46% in 2006. The number of unjustified reports remained stable around 4.4%. The improved relationship between the Confidential Centres and the Justice Department can be deduced from the number of shared cases. The number of youngsters reported by the Centres to the Justice Department increased from 5% (1990) to 25% currently. Throughout the years, the model was supported by broad public opinion. The relationship with the Justice Department evolved from distrust to mutual respect. Both parties realized that the phenomenon of family violence is so prevalent that no organisation can handle it alone. The number of reports of physical and sexual abuse to the Justice Department did not change over the last ten years. Over the past 20 years, none of the Confidential Centre has been found guilty of malpractice, suggesting a high level of professional competence.⁹⁸

Inclusive education

During the last decades a worldwide movement towards inclusive education is taking place, with the objective to integrate children with special needs into regular education settings. This movement is motivated by a growing concern of parents and organisations of children with disability to be recognized as full citizens with equal rights and to be included in society, and not be excluded from the very beginning in separate schooling. The right to inclusive education has been crystallized in the recent UN Convention on the Rights of People with Disability (2006). Belgium, with its dense network of special schools, categorised in 8 subtypes of special needs, is one of the most separating countries in Europe when it comes to educating children with specific educational needs and/or impairments. Despite measures and financial

⁹⁸P. Adriaenssens, Catholic University Leuven, 2009

incentives to “broaden” the school and keep children as much as possible in the mainstream, referral to special schools has more than doubled during the past 7 years, creating reputedly long waiting lists.

The present Minister of Education of the Flemish Community has presented a plan for a graded system of school adaptation to the widely varying educational needs of children, whereby all children will have the right to choose for mainstream or special schools, and children will receive the same level of assistance whether in mainstream or special school). According to the social model of disability of the WHO (ICF), the degree of disability is not directly determined by the degree of bodily or functional anomaly. Therefore, the new proposal of educational adaptation suggests to first determining the level of curricular adaptation and assistance needed, taking into account the specific needs of the child, but regardless of the disturbance.

In order to identify the special educational needs, for the first time in Flanders the distribution of children with special needs is intensively examined. Especially the group of children with behavioural and/ or autistic spectrum disturbances has to be made “visible”. Up till now no specific special school type has been available for them (unless the most severely disturbed).⁹⁹

7.2. Youth involvement

The Service Centre for Youth Policy (Steunpunt Jeugd), acknowledged in the Flemish Youth Policy decree, specifically argues for empowerment of children and young people. It wants to enable and encourage the youth to act and provide them with a sense of ownership, albeit an idea of authority. For this to be accomplished successfully the youth will need the necessary skills, tools and positioning that allow them to fully understand and function in not only their immediate environments, but also in today’s world (employment, environment, mobility, migration, etc.). Empowerment reaches much further than participation. It is vital as children and young people are the last group to emancipate. They rarely hold the position in our society that is rightfully theirs. Steunpunt Jeugd wants to work on their empowerment and involvement through promoting an integrated youth policy. When different sectors work together, the youth are offered new possibilities to better shape their lives.

There are multiple examples of efforts to increase youth involvement in Belgium, such as:

- Project Linkedness (‘Verbondenheid’, KULeuven) works on school violence and bullying. Through small, lasting interventions in the school culture the project it tries to restore the basic school climate, whereby the link between children and their environment is repaired and reinforced.

Thus, new opportunities for youth involvement are created.¹⁰⁰

- The voluntary association ‘No Violence at School’ organises meetings where children, adolescents, parents and teachers discuss violence related problems at school.¹⁰¹
- Several organisations offer information, training and advice for parents, also on the theme of youth involvement. They aim at a synergistic interaction between parental involvement and youth involvement. The Parenting Information Centre (part of the Global Plan of the Flemish Ministry of Social Welfare) that gives free advice to parents with questions and insecurities concerning their parenting skills offers such an opportunity.
- A programme of youth violence prevention, called ‘School on turn’ (School aan de Beurt), involves all Antwerp schools and especially those, which are located in disadvantaged neighbourhoods. It is supported by the City of Antwerp and clearly encourages youth involvement.¹⁰²
- The Confidential Centres represent a new way of thinking about children. In the past, emphasis was put on protecting children “for their own sake.” Nowadays, the input of children is highly appreciated in such a way that they increasingly become active partners in protecting their own rights. Children have evolved from protected objects into lawful subjects.

Awareness-raising campaigns

Values and attitudes emphasized in most awareness-raising campaigns of the Flemish Government are: democracy, participation, cooperation between the target groups in schools.

The same values and attitudes prevail in the awareness-raising campaigns of the French or German speaking communities.

7.3. Difficulties and proposals for further development

Child abuse and neglect

The Confidential Centres system shows not only strengths but also weaknesses. They certainly fulfil a societal need by being a place of justice for children. However, in the current model, the family is interviewed several times by staff of the Confidential Centre before it may be concluded that some families do not want to cooperate, or, that an offender is dangerous to society. A report to the Justice Department may complicate the independence of the judicial inquiry. Often a child does not want to repeat to a police officer what she or he has already told at a Confidential Centre, stating “they

⁹⁹J. Lebeer, University of Antwerp, 2009

¹⁰⁰<http://www.vista-europe.org/>

¹⁰¹www.nonviolence.be

¹⁰²<http://www.indymedia.be/en/node/24891>

should ask the Centre.” Then the forensic interview gets stuck. The model of the Confidential Centre works well among families that accept voluntary help, but it can cause problems in others.

Also, the surveillance of child abuse and neglect still is a weakness in Belgium, because of the lack a uniform registration system. Special Childcare, Confidential Centres and the Justice Department use separate registries. More effort is needed, also at the international level, in order to develop a uniform approach to surveillance.

Inclusive education

In Belgium there are concerns regarding the growing number of children with behavioural/ emotional/ social functional impairments. The School Psychological Services will be required to obtain a psychiatric diagnostic report based on a DSM IV classification. The health system in child psychiatric clinics or centres is not adequately prepared to care for this group of children, having reputedly long waiting lists.

There is also a relatively large group of children with mild intellectual impairment and/or learning disabilities. Many of these do not fit the strict criteria of IQ-based intellectual impairment, and many of them come from poor socio-economic backgrounds. School staff is not yet adequately prepared either to welcome these children within the mainstream, because up till now it has been customary to refer them to special classes.

A massive investment in (re)training teachers will be needed to make schools more competent in dealing with children with special needs in an inclusive way. Considering functioning in the light of barriers in activities as well as to participation, rather than in the current widely used psychometric way, will also put a challenge on (re) training the Youth Psychological Services.

A coherent health promotion and prevention policy

Perhaps the most important challenge is to realise a coherent policy on mental health promotion and mental disorder prevention throughout the country. Since mental health promotion and mental disorder prevention are community matters, there is no real coherent policy at the national level with regard to these issues. Also, the commitment to prevention and promotion is still weak in Belgium. The fact that the budget for promotion and prevention stays very limited still adds to the fragmentation of the policy.

At the national level, most of the promotion and prevention is about drugs, not about mental health (which is not surprising, given the high co morbidity). Generally, more emphasis is given to prevention than to promotion. At the regional level, some regions have a more coherent policy than others. What often hinders concerted action is the fact that the different stakeholders are not informed about each other's initiatives.

Given the fragmentation of the competences and the limitations of the budget, policy innovation becomes a difficult task. More specifically, the exchange of good practices between the federal level and the communities and regions, and the mutual learning from successes and failures is an important task to prevent overlap and to reduce unnecessary expenses. An additional challenge is the setting

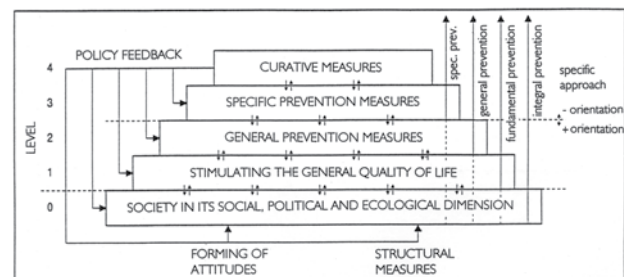
up of a more structured and solid evaluation research. Hopefully, international collaboration will give a stimulus for this.

The general economic situation in Belgium in the years to come includes several important risk factors for young persons. The government should ease temporary employment contracts, lower barriers to student work and seek ways to improve education outcomes to enable more young people to find a first job. Better education outcomes would also help to improve labour-market integration of ethnic minorities, and more effective anti-discrimination measures are required. Successful programmes to improve the language competence of migrant children should be offered more widely.

8. Conclusion

In Belgium there are many initiatives in the field of CAMH with a large degree of variation and differentiation, but the basic idea is the one of an ‘integral and positive’ approach, which is taking into account the complexity of the situation and its interacting components.

A model that is often put forward by Belgian experts is the ‘prevention pyramid’ (see diagram below).



The ‘prevention pyramid’ is a model that charts very diverse prevention measures and approaches to problem reduction and quality improvement. Prevention projects always emphasize certain problems. The diagram exemplifies five levels, including for example:

- level 4: conflict mediation
- level 3: camera surveillance
- level 2: improvement of school infrastructure
- level 1: improved public communication
- level 0: children's rights

The prevention pyramid orders, broadens and orients prevention measures.

The central criteria are their contribution to problem reduction and to improvement of the quality of life.

An integral approach tackles all levels with the accent on positive measures and brings clarity in the complex intertwining of experiences and responsibilities. In this way the ‘pyramid’ certainly contributes to a higher level of public agreement regarding the importance of promotion and prevention.

It is concluded that the synergetic interactions at different levels of governance have to be enhanced, in order to strengthen the capacity of the society to address the major challenges of CAMH prevention and promotion in Belgium.

BULGARIA

Prepared by Maya Mladenova, Toma Tomov, Svetlozar Vassilev, and Antoaneta Mateeva

1. Introduction

1.1. Policy at a glance

Bulgaria is a country in the South East of Europe, which is one of the newest EU member states, having joined in 2007. The population size according to data from the last census in 2001 is estimated at 7,679,290, including those who live outside the country's boundaries (approximately 700,000 people). The number of births in 2006 has been estimated at 74,495, while the number of deaths amounts to 113,438 people. Results of this constellation can be grasped by figures which show that due to these reasons the population has decreased by 39,460 people in 2006. Regardless of the dire demographic situation no action has been taken to address this.

During the transition process to join the EU the country endorsed a number of health and social policies required as a condition for the country's admission to the EU. Most of these policies concerned human rights protection (including the protection of children's rights).

Since the start of the social transformation in 1989, mental health services in Bulgaria have focused on providing psychiatric examinations and drug therapy to all patients with mental health problems. The individual approach to patients was not developed. Neither case management nor psychosocial rehabilitation was offered by the mental health services. Prevention or early interventions for mental health problems were not a part of the existing services, which were designed rather to respond to severe crises and not to cope with the issues of life with mental illness.

The social transformations started in 1989 brought about the development of several new and innovative mental health services and an attempt was made to introduce case management as one of the services offered to people with severe mental illness. However, child and adolescent mental health services seem to have been left out of mainstream reforms.

The practice of developing a mental health policy to openly state priorities and guide choices for resource allocation is also quite new to the country.

The first mental health policy document was developed

in 2001 and since then has been periodically updated every 4 years. The 2001 policy document focused its priorities on the most urgent needs of the mental health service system – the needs of patients with severe mental illness. However, child and adolescent mental health has never been stated as a priority of Bulgarian mental health policy, and no particular actions for its study, evaluation and development have been officially planned.

Child and adolescent services developed after 1989 were mainly under the Ministry of Social Welfare and related to the child protection act. However, no explicit relationship between child protection and child and adolescent mental health has ever been drawn and thus the role of child welfare services in providing better opportunities for the emotional and mental development for children at risk has remained to a large degree neglected.

The Bulgarian Psychiatric Association (BPA) also appears uninterested in the field of child and adolescent mental health. For the 10-year period from 1992 to 2002 there has only been one single publication concerning child mental health issues in the BPA Bulletin.

1.2. Process to prepare the country story

This report is written by Dr Maya Mladenova, psychiatrist, staff member of the Bulgarian Institute for Human Relations. The conclusions and data included in the report are the result of detailed literature search as well as interviews and focus group sessions with professionals and governmental officials working in the field of child mental health care and protection (for detailed information see the country profile questionnaire.)

The present material is grounded on:

- Review of policy documents;
- Review of document issued by the Bulgarian Psychiatric Association;
- Interviews with experts in the field of mental health;
- Focus group study of the child and adolescent mental health policies and practices.

2. What we know about children and adolescents in Bulgaria and their mental health

2.1. Prevalence of mental disorders in children and adolescents

The state of mental health and the problems which children and adolescent in Bulgaria are facing remains largely unclear. Most of the available data on the issue belongs to the so-called “soft data” category, making clear estimations of illness incidence or prevalence, service use, etc. problematic.

With scattered mental health services, no clear care protocols and a lack of motivation to provide proper documentation, the current mental health system is unable to produce valid process data concerning the prevalence and incidence of child and adolescent mental health problems. No epidemiological studies of child and adolescent mental health problems have ever been carried out in Bulgaria, and hence no estimations can be made of the number of children who may be in need of specific mental health services, nor of the nature of their disorders or mental health problems.

2.2. Vulnerable child population

Statistical data about children at risk is either unavailable or its validity is unclear. For example, there is no clear figure for the number of homeless children, the children experiencing bullying, or the children abandoned as a result of parental migration or unemployment in Bulgaria.

A recent document on encouraging social inclusion¹ of children stated that 8% of the children in Bulgaria live in poverty, but this document provides neither references of its sources nor the research methods through which these numbers have been obtained.

Similarly, a recent study of the reasons for school drop out conducted by UNICEF and published on the internet² announced that in 2004/2005 data obtained from the Ministry of the Education reveals 20,800 (2.8%) Bulgarian pupils have dropped out of the school system. However, the validity of this data is also under question; As the study quoted points out, the data obtained by the Ministry of Education differs greatly from data obtained by the National Institute for Statistics.

The validity of both sources, however, is questionable because schools are subsidised according to number of their pupils, so their management is interested to present bigger figures than the real ones to the Ministry of Education.³

2.3. Positive child and adolescent mental health

Information and prevalence data on positive child and adolescent mental health has not been identified.

3. Actions for promotion and prevention in mental health

The Child Protection Act and the Social Assistance Act both attempt to cope with one of the most difficult problems in Bulgaria – the large number of abandoned children who are placed in institutional care, with devastating effect on their intellectual and emotional development and to their chances of adapting to independent life in later years.

The main focus of the Child Protection Act, which was endorsed in 2000, is prevention of child abuse and neglect as well as prevention of child abandonment and institutionalisation.

There have been several main difficulties in organising services for children and their families in relation to the Child Protection Act. Children who suffer abuse or neglect have diverse needs, which cannot be met by a single institution. Hence, working with these cases requires collaboration with more than one organisation, which at present is difficult to bring about. Additionally, resources are still scarce for the case management of these children, regardless of the clear need to introduce this service.

The organisation and management of the services which provide care for children and their families (such as child protection departments) are geared towards emergency action and do not provide the setting needed for regular individual case work.

One important finding, in the course of studying available policies, was that the ongoing deinstitutionalization movement is not openly connected to the issue of mental health. Therefore, it is not usual that child mental health specialists are recruited to work on the issue of deinstitutionalization. There are no procedures or standards in place or planned to amend this situation.

One obstacle is the lack of policy for human resources development. The service organisation of protection units does not provide for the emotional welfare needs of personnel and the rate of burnout syndrome is high meaning that many leave the service. For example, the majority of professionals who started working in the child protection departments in 2000 have now left the

¹ Георги Богданов, Боян Захариев, 2007, България, Борба с детската бедност и насърчване на социалното приобщаване на децата. Преглед на националните политики., http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/experts_reports/bulgaria_1_2007_bg.pdf

² UNICEF, ПРИЧИНИ ЗА ОТПАДАНЕ НА ДЕЦАТА ОТ УЧИЛИЩЕ, Анализ на резултатите от проведено социологическо изследване, <http://www.vitoshka-research.com/fileSrc.php?id=2122>

³ For example, most of gypsy children dropped out from school, but school administrations keep their names in the list of pupils.

system, wasting a large amount of resources allocated for their training.

Another difficulty is that the process of service development takes place as a result of political pressure due to EU sources rather than following a natural and demand-led course. Hence, many of the services developed are not tailored to the local needs and are not sustainable external funding.

The Social Assistance Law⁴ is an attempt to introduce the practice of offering specific community social services, which are expected to provide an alternative to the institutionalisation of children. It is hoped that these services would work at the individual, family and community levels.

Mental health services are decentralised and are provided via state-delegated activities, entrusted to different organisations, including NGOs. The municipalities have also taken over part of the service provision. The practical implementation of these services takes place through several provider organisations: the Child Protection Departments, the Social Services Complex for Children and Families, the Municipal Support Centres, short term projects focus on specific tasks and needs, and provide private counselling services.

One major obstacle is the lack of proper training for professionals in charge of implementing relevant laws and policies.

To date there is no ombudsman for children and adolescents in Bulgaria.

3.1. Policies and programs for CAMH

A Master Plan developed under a PHARE twinning project in 2006 states that, in order to address the urgent need for child and adolescent mental health services, the following 5 steps should take place:

1. Increase the number of child psychiatry units;
2. Accredite child psychiatry as a separate specialty;
3. Increase collaboration between the Ministry of Health, Ministry of Labour and Social Welfare and the Ministry of Education and Science in relation to child mental health care problems;
4. Develop specialised psychiatric services for children and adolescents which take into account the developmental frame in which these services operate..
5. Acknowledge the adolescents' special needs."⁵

However these recommendations are seldom taken

into consideration at the level of local mental health policies, where such policies exist. For example, the Municipal Strategy, endorsed by the Sofia municipality for 2008-2015⁶, does not mention child and adolescent mental health care. Likewise, despite the fact that a large amount of the population of the country reside in Sofia and the city has the most abundant human as well as financial resources, and therefore the greatest potential to achieve meaningful development in the years to come, its priorities at the local level as stated in the Municipal strategy do not include children's mental health.

Social welfare (e.g. benefits and payments for disabled) Social welfare policies are most clearly stated in the Social Benefits Act and in the Act for Integration of People with Disabilities. Both documents deal with issues related to social benefits and social services, including those cases where children are involved.

The Social Benefits Act defines the criteria for offering social services, including those for children and adolescents, it also indicates the bodies which are expected to monitor and check the quality and standards of social services for children in Bulgaria. The National Agency for Child Protection has been identified for this specific task.

The Act for Integration of People with Disabilities arranges the development of consultative-diagnostic centres, offering their services free of charge for children with disabilities or children whose parents suffer from some kind of disability. It also upholds equal access to education for children with disabilities. Integrated education is endorsed as a core value in the document.

Poverty and social exclusion

Documents dealing with the Bulgarian state policy concerning poverty and social exclusion fail to explicitly highlight the role which poverty and socialisation may play in the development of young children. There are two basic documents which address the issue and offer specific measures to combat poverty and contribute to social integration, most of them related to offering financial benefits for specific vulnerable groups.

The National Strategy for the Children 2008-2018⁷ states that one of its most urgent priorities is to decrease poverty and social exclusion in groups at risk. Among the target groups, children at risk have been mentioned as a priority. It aims at providing equal access to school and education for all children, thereby improving children's health.

The document defines the concept of children at risk and offers measures to be taken for their protection and social integration.

⁴Published in 1998; Държавен вестник, бр 56 от 19.05.1998; <http://www.mlsp.government.bg/bg/law/law/ZSP.doc>

⁵PHARE Twinning Project, 2006, Основен план за развитие на психично-здравните услуги в България, http://www.hospilinks2007.com/docs/MentalHealth_MasterPlan_BG.pdf

⁶Общинска стратегия 2008 - 2015 за развитие и предоставяне на психично-социални услуги в общността за хора, страдащи от тежка психична болест. 2008. <http://www.blgmun.com/documents/Psiho2008-2015.pdf>

⁷Национална стратегия за детето 2008-2018. <http://www.bgstuff.net/content/view/4274/539/>

The National Strategy for Reduction of Poverty and Social Exclusion, 2003 also defines the concept of poverty, and offers measures to counteract it along several lines. The policy offers opportunities for additional income and provides social benefits in line with the Family Support for Children Act. Social benefits are also offered in terms of specific goods, e.g. financial support provided to families at risk of poverty. Social services, such as a personal assistant, social assistant, place at a day-care centre, centre for social integration and rehabilitation, etc. are also provided as measures to counteract poverty and social exclusion of children at risk.

Child protection policy

The Child Protection Act and the Social Assistance Act represent attempts to cope with one of the most difficult problems in Bulgaria – the large number of abandoned children who are placed in institutional care. This practice has devastating effect on their intellectual and emotional development and to their chances of adapting to independent life in their mature years. The main focus of the Child Protection Act, which was endorsed in 2000, is prevention of child abuse and neglect, as well as prevention of child abandonment and institutionalisation.

There have been several main difficulties in organising the services laid out by the Child Protection Act for children and their families. Children who suffer abuse or neglect have diverse needs, which cannot be met by a single institution. Hence, working with their cases requires the collaboration of more than one organisation, which at present is difficult to bring about. Additionally, there are still scarce resources to offer case management to these children, despite the clear need to introduce this service.

Education and school programmes

Education and school policies include regulations concerning the integration of children with special educational needs in regular schools. Act 5 and 6 for integration of children with sensory, motor and mental disabilities endorse the rights of children to an integrated education and professional training. It states the right of these children to a supportive environment in general schools and universities.

The Act also lays out plans for the development of resource centres whose task is to offer additional support for the integrated education of children with disabilities.

Further attention is focused on the social benefits provided for children with disabilities.

However, psychosocial rehabilitation, and its specific suitability in working with children and adolescents, is a field which has not been developed in the country. There is still no training programme, to professional standards, in psychosocial rehabilitation, to enhance the professional workforce in Bulgaria.

Adoption and fostering policies

Adoption is considered to be the most reasonable and desirable solution for children abandoned by their biological families. The regulations in the case of adoption are stipulated by two legal documents: the Family Code and the Child Protection Act. The Family Code lays out the procedure and legal consequences in cases of adoption.

The Child Protection Act views adoption and foster care as measures to protect children's rights and provide the proper environment for their development.

The Social Assistance Department is responsible for studying applications of potential parents and assessing their eligibility to adopt a child. The department is also expected to advise adoptive parents on issues emerging as a result of the adoption, and to monitor the adaptation of the child in their adoptive family for a period of two years. The Department carries out these measures, via the Child protection services.

However, a closer look at the organisation of these departments reveals structural obstacles which impede the process. The high case load, the management of time and space in the services and the professionals' training in the majority of service posts, render the task of individual engagement with clients impossible.

The Ordinance on the conditions and procedure for application, selection and approval of foster families and for placement of children with them, issued in 2003, lays out the practical steps for foster care.

Divorce and custody policies

The same two legal documents – the Child Protection Act and the Family Code – which lay down the procedures in cases of divorce in relation to the custody of children. The Family Code stipulates that right of custody cannot be granted to the partner who is responsible for the divorce proceedings if this is not in the children's best interests. It also gives older children (over 14) the right to a hearing to express their opinion concerning their custody. The child protection units are responsible for assessing and care for children best interests in such cases.

The Child Protection Act also gives the legal and administrative procedures for denying custody in relation to child protection measures.

Anti-discrimination

Bulgaria is a country with two large ethnic minorities – Roma and Turkish. A proportion of the populations of Turkish and Roma descent also belong to the Muslim religion, and comprise a significant religious minority.

The Anti-discrimination Law in Bulgaria was endorsed in 2003 and is a relatively new practice in the country. It defines discrimination as well as specifying what constitutes issues of direct and indirect discrimination

Other policy areas

No explicit policies have been developed concerning children's day-care and pre-school children relating to mental health. Likewise, industrialization, urbanization, and housing policies do not mention issues related to child and adolescent mental health.

Mental Health Policies

Following the social transformation in 1989, Bulgaria developed a large amount of legal acts and regulations to bring the country in line with the democratic values of Europe. The inclusion of issues such as child protection, antidiscrimination, poverty reduction, social inclusion and others in current Bulgarian general policies is a result of developments over the last 20 years.

However, following through on decisions made by endorsement of legal acts remains problematic. Many of the policies in the field of social and mental health care can only be implemented through the development of specific structures, care programmes and protocols. These need the investment not only in terms of financial but also human resources. The innovative services require increased capacity in terms of care professionals (clinical social workers, psychologists, specialists in psychosocial rehabilitation, child psychiatrists and educators), but they also need greater capacity in terms of specific evidence based managerial practices, research and the capacity to learn from the immediate experience gained during the working process. Such managerial practices can ensure service leaders to assert an appropriate managerial style.

Human resources development in the field of caring professions requires a long formative process, which

none of the policies endorsed to date has taken into consideration.

Therefore, it is often the case that the services and the care programmes needed in order to implement the legal acts in practice are either unavailable or their means functioning and organisation limit the implementation of the core values embodied in the legal procedures. One vivid example is the Child Protection Act which is intended to be implemented to a large degree by the Child protection services. Although effort has been made to develop these structures within a short amount of time over the whole territory of the country, the effectiveness of these services is limited, to a large degree, by the present organisation of services, the scarce human resources and the lack of proper educational and research activities.

Care Programmes

Although a large number of new structures have been set up in relation to the new mental health and social policy documents concerning children and adolescents, few of them have been conceptualised in terms of care programmes. Where such care programmes exist (usually under the auspices of different NGOs) the programmes have usually not been operationalised and it is therefore difficult to evaluate the quality and cost effectiveness of the programmes offered.

3.2. Availability of programs for CAMH promotion and prevention in mental health

An overview of the availability of prevention and promotion programmes in CAMH can be seen in the table below.

	0%	1-25%	26-50%	51-75%	76-100%
Home-based for infants	x				
Home-based for children	x				
Parenting programs (general population)		x			
Parenting programs (specified at risk population)		x			
School mental health promotion (e.g. teaching well-being life skills)		x			
School targeted preventive programs (e.g. anti-bullying)			x		
Drug and alcohol abuse prevention	x				
Promotion/prevention at hospital/clinic	x				
In Churches, clubs, recreation centres	x				
Promotion/prevention via Internet					x
Protective services					x
Community settings	x				
Telephone counselling		x			

A recent report on child and adolescent mental health prevention⁸ developed under a PHARE Twinning Project, states that a decrease in the number of child mental health professionals has been a general tendency for the country over recent years. The same report mentions a list of five obstacles which hinder the development of child and adolescent mental health services: lack of resources, lack of services, abandonment of the catchment area principle, stigma and lack of transportation.

The only systemic network which is developed to offer services for children and their families is the child protection system, which has developed structures throughout the whole country and is available for children living in most towns in Bulgaria. Its good interface with the school system renders it one of the most easily accessible services for children in the country. However, the problem with the child protection system is the poor organisation of the working process which does not allow for individual case work with children, the need for greater capacity within the personnel employed there and the fact that no clear link is made between child protection and child mental health.

4. Organisation and resources for implementation

4.1. Institutions and organisations

None of the available services which offer mental health or social services for children are able to focus on promotion and prevention. This is for two reasons: Their caseload is higher than their capacity (as is the case for child psychiatric services); or they are not considered to be responsible for or related to children's emotional development and mental wellbeing (as is the case for

child protection departments, social welfare department or centres for public support).

Prevention and promotion programmes are often developed by NGOs and later fade away as the funding for the piloting of the programmes discontinues.

4.2. Services

Child mental health care in Bulgaria is scarce, unsystematic and provided haphazardly by different kinds of statutory services, NGOs and private practices. There are difficulties concerning both availability and the accessibility of services, most of which are located in the large towns, if available at all.

The only child psychiatric ward, which has 12 beds, is located in the University Alexandrovska Hospital in the capital, Sofia. The ward provides short term interventions, the main purpose of the hospital stay being evaluation and crisis relief. Outpatient care is usually provided by the regional dispensaries with the role of the university clinics, and of the extremely small number of child psychiatrists, being usually consultative. Adolescents are usually treated by the adult mental health services.⁹

Community mental health services for children are available in two more of the largest towns in Bulgaria – Varna and Rousse. All three provide psychiatric examinations, treatment and some form of individual or family psychotherapy. Since psychotherapy is not standardised as a profession in the country, psychotherapeutic training is run by a number of different international trainers and no regulations exist concerning this training, it is unclear to what extent the psychotherapeutic treatment offered in these clinics meets international criteria.

	0%	1-25%	26-50%	51-75%	76-100%
Child psychiatrist appointments		x			
Psychologist appointments			x		
Social service appointments/ child protection		x			
Family therapy/ counselling		x			
Infant-specific services		x			
Adolescent-specific services/outpatient centres	x				
Group therapy		x			
School counselling		x			
Pharmacological treatment					x
Psychological rehabilitation centres for adolescents	x				
In-patient beds on child psychiatric ward	x				
In-patient beds on general psychiatric ward		x			

⁸PHARE Twinning Project, 2006, Основен план за развитие на психично-здравните услуги в България, http://www.hospilinks2007.com/docs/MentalHealth_MasterPlan_BG.pdf

4.3. Funding

While social services in Bulgaria are covered mostly by the state and municipality budgets, mental health services have three sustainable resources to use: the state budget, municipal budgets (in cases where such a municipal policy exists) and the Health Insurance Company.

Besides this, innovative practices targeted at developing new social and mental health services for children and adolescents may also apply for resources in relation to different EU budget lines and projects for the period of service development and piloting. The assumption is that once the programmes have been set up and piloted, local resources could easily be mobilised to achieve sustainable outcomes.

For example, activities related to child protection come from diverse sources – the state budget, municipal funding, national and international programmes, and the social assistance fund, among others.

Municipal budgets provide funding for the Complex for Social Services for Children and Families (CSSCF), including the Mother and Infant Departments affiliated to them. Mother and infant departments are responsible to provide basic support (home, food, guidance) to mothers who are not able to care for their babies alone. Duration of the residency is decided after detailed social and psychological assessment and often varies between 6 and 12 months.

Mental health services are primarily covered by the National Health Insurance Company (NHIC). In relation to the Child Healthcare Programme, the National Health Insurance Company covers the periodic assessment of mental functioning by GPs at 1-2 years of age and again between 2 and 7 years of age. The NHIC has also endorsed a list of specialised medical services performed by child psychiatrists (shown below), which are funded by the Company.

Child psychiatry – specialised medical services

1. Psychic status;
2. Interviews for family functioning;
3. Psychiatric expert evaluation;
4. Suicidal risk assessment;
5. Risk assessment for the patient and his/her immediate environment;
6. Assessment of statutory treatment;
7. Interviewing relatives;
8. Medication effect follow up session;
9. Psychosocial rehabilitation session;
10. Session for cases of sexual dysfunction;
11. Crisis intervention;
12. Therapeutic session with children and adolescents;
13. Other specialised psychiatric intervention;
14. Counselling of parents and/or relatives;
15. Session with parent and child at the beginning of treatment;

16. Assessment of child development and mental functioning;
17. Child abuse assessment;
18. Family session in case of disability for referral to psychosocial rehabilitation services;
19. IQ test;
20. Testing for cognitive and other mental functions;
21. Assessment of psychological expertise;
22. Psychiatric expertise;
23. Assertive outreach and monitoring of drug addicts.

However, the payment system of the Health Insurance Company does not take into consideration the specific nature of technology used in child psychiatry and the time-consuming nature of the tasks. For example, mental health assessments of children and families often require more than one session, but payment is provided only for one.

4.4. Training of professional workforce

Training for child and adolescent mental health is hardly integrated at all in most relevant professionals' curricula. Developmental aspects of mental health and developmental psychopathology are either lacking or poorly integrated in training programs.

For example, medical doctors' training in CAMH takes place within the framework of the programme in psychiatry, and consists of a couple of hours devoted to psychopathology in children. Primary care nurses have only 30 academic hours of Child psychology included in their curriculum.

The curriculum for specialisation in psychiatry includes a course in child psychiatry and 4 months practical experience in a child and adolescent mental health service.

Psychologists have 10 academic hours included in the general psychopathology course.

In addition the Sofia State University offers a Masters programme in Child and adolescent and school psychology (diagnostics and consulting), which prepares professionals for the school system, the child mental health care system, etc.

Training in Social work with children and families is available at the Department of Education at the Sofia State University.

Child psychiatry was developed as a separate specialty in 1996 and a module on child psychiatry was first integrated into the curriculum for psychiatry in 1998. At the same time, a 2-years course was started for acquiring a specialised qualification in child and adolescent psychiatry.

During the training in medicine at the Medical University

in Sofia, students receive two days of teaching devoted to child psychiatry in the course of their three-weeks cycle in psychiatry. These days are spent at the premises of the Child and Adolescent Psychiatry Clinic at the University Alexandrovska Hospital.

5. Monitoring and evaluation of the actions for the promotion and prevention in mental health

At present there are no studies or monitoring reports looking at the implementation of the current policies, their efficiency, cost-effectiveness or the difficulties encountered. The practice of policy evaluation requires a very different service culture and managerial approach, related to structured care protocols and evidence-based management, none of which has been introduced in Bulgarian mental health care or social services.

6. Research and dissemination

With the small number of professionals employed in the field of child and adolescent mental health and the lack of financial resources, research work in the field is to a large extent inhibited. A recent multi-national project, collecting epidemiological data on child mental health, which started in 2008, includes Bulgarian partners and will provide an idea of the prevalence of certain conditions in school aged children.¹⁰

This study will provide rigorous information for the first time in Bulgaria, allowing policy makers to estimate the number and kind of child mental health services the country needs to develop in the years to come. The project will outline the priorities concerning investment in child mental health.

It is expected that the survey will also contribute to the revision of the existing mental health policies for children and adolescents, most of which are grounded on soft data rather than on rigorous study of needs.

Research work in the field of child mental health care and social service provision requires large investments and research capacity in terms of human resources trained to apply scientific methodologies. Rigorous research work in the field of human services also requires that work is organised according to clear care protocols and algorithms. This is not the case with most of the care programmes introduced in Bulgaria and this fact hinders the development of proper studies.

Qualitative research, such as the work initiated under the CAMHEE project, could still be useful in order to identify research hypotheses concerning the state

and development of the field of mental health care for children. The feasibility of qualitative studies is only limited by the training of researchers.

In relation to the development of proper research capacity in the field of social and mental health services there is still no clear policy and prioritisation.

This group were unable to identify a specific organisation, which is responsible in Bulgaria for the dissemination of information on issues concerning child and adolescent mental health care.

7. Challenges, opportunities and advances in the field

7.1. Key recent advances

However imperfect the child protection system in the country is proven to be, the most significant advances in the field of child and adolescent mental health are due to this system. Following the endorsement of the Child protection Act in 2000, children at risk can be offered social care and community services in relation to the prevention of abandonment, neglect or abuse. The Child Protection Department has arisen as the structural foundation of the law.

The difficulty with this system, however, is that the child protection services set up in relation to this Act have problems with the level of qualification found among the staff. It is not equal across different geographical regions, and in most places it is not sufficient.

As a second important development, experts have pointed out the diverse and rich opportunities for professional development and training now available in the country. The difficulty here is related to poor quality assurance, which results in numerous training courses on offer without a clear end result in terms of knowledge obtained and skills developed.

A third development, which is slowly making its way through the culture of Bulgarian mental health and child protection services, is that the approach to mental health has been to some extent de-medicalised and has become more holistic. There is more attention to the importance of the early childhood, as well as to issues related to integration of children with special needs, disabilities or coming from different ethnic and cultural backgrounds.

Besides this, conditions have been developed for offering community health and social services. A process of decentralisation of health and social services and their funding has started, resulting in movement away from the State monopoly over mental health and social services provision.

¹⁰The project "School children mental health in Europe" studies the prevalence of internalized (e.g. general anxiety disorders, phobia, depression) and externalized disorders (ADHD, Oppositional Defiant Disorders and Conduct disorders).

7.2. Youth involvement

Youth involvement is not used in practice in mental health policy or service development.

7.3. Difficulties and proposals for further development

One of the difficulties which affect services for children and adolescents is the lack of a case management system. It is resulting in no clear responsibility for the case as a whole or clarity on the relative contributions of different services and professionals to the case. Introducing the case management model would contribute to a more team-based approach and to a greater involvement of professionals as well as more effective resource utilisation.

A further challenge is the variability of funding sources; while some providers (such as the social services) work with state or municipal funding, other providers are NGOs, private services or services funded by the health insurance companies. This situation results in poorly coordinated system which does not ensure financial support for services focused on complex needs of the children.

A specific obstacle in collaborating with the police, who represent an important access point to children and adolescents at risk of mental health problems, lies in legal limitations on sharing information.

Professionals involved in the child protection services quickly develop burnout, or experience a drop in motivation, due to the stressful nature of the work and lack of measures in place to protect staff, resulting in a retention problem among the personnel of this department. One important step to be taken is to reduce the fluidity and thus preserve expertise within the child protection services.

Intersectoral collaboration is also hindered by the lack of clear profile and care programmes in the services. Child protection professionals are expected to keep track of an enormous amount of risk-defining parameters for a limited time and to decide if special action is needed. The amount of work and its urgency prevents the professionals from developing relationships of collaboration with those working on the same case in other professional settings. Collaboration turns out to be time-consuming and this time has not been factored in to any of the job descriptions or protocols which child protection specialists are guided by in their everyday work.

Developing an adequate capacity for service management is of major importance to improve the structure and design of services and improve intersectoral collaboration.

8. Summary and conclusions

Although policies in the field are abundant, mental health and social services for children and adolescents are scarce, unevenly distributed across the country, and poorly accessible. Where they exist, they fail to provide proper engagement or individual case work with children, and much of the work carried out by social services remains largely administrative.

Future efforts should be concentrated at 3 different levels, to ensure effective advances.

At the policy level, it is clear that policy development needs to occur in paralleled with careful planning of the implementation of political decisions. This means that, in parallel with the policy development, the design and planning of services and care programmes should take place, operationalising the values of the political documents. Planning the development of human resources to implement endorsed policies is crucial to this end.

At the local service level, further structural organisation of the available services is needed, to introduce individual case work and case management for child and adolescent mental health and social service provision. This requires a careful revision of service intake procedures, case-loads and the profile of services, followed by the careful choosing of care programmes to be offered.

Epidemiological research, as well as needs assessment studies, are needed in order to support the both policy makers and the service management in their effort towards better service development and planning.

At the level of individual service provision, individual therapeutic relationships with the children and adolescents in need of mental health or social services is a requisite. Training and supervision need to be offered to caring professionals, providing support for on-the-job-training and the development of the specific skills needed for flourishing therapeutic relationships with young children and adolescents.

ESTONIA

Prepared by Inna Lindre, Katrin Pruulmann and Margit Koolmeister

1. Introduction

Policy at a glance

In Estonia child and adolescent mental health policies are regulated by the following laws: Republic of Estonia Child Protection Act¹, General Part of the Civil Code Act², Mental Health Act³, the Improved and Upgraded Law of Ratification of the European Social Charter⁴, and the Social Welfare Act⁵. An important document in the last decade was “Health Programme for Children and Adolescents” compiled in 1995-2000, by the PRAXIS Centre for Policy Studies. It also included “Mental health project until 2005”.

The main aim of this was the prevention of children’s mental health problems and mental disorders, early detection of these and increasing access to qualified psychiatric/psychological help.

Many proposals were made within this project, but few have been put into practice and data on them is scarce. There have been no other projects of this scale.

The current “Developmental Plan of Ministry of Social Affairs 2009-2012”, has no specific part dedicated to mental health. In other parts (common health, school food, and support to families) references are made to mental health. There is a common objective to decrease the death rate of children and adolescents. There are no specific documents on activity plans available. Financial resources have been reduced due to the economic crisis. From January 2009 there is no specialist in mental health in the Ministry of Social Affairs.

Existing statistics on help by child psychiatrists and other specialists do not reflect distribution and frequency of psychiatric disorders, but the number of children who have managed to get help despite unequal access in different regions.

1.2. Process to prepare the report

This report was completed by clinical practitioners from Foundation Tartu University Hospitals, Psychiatric Hospital: **Inna Lindre**, Child Psychiatrist; **Margit Koolmeister**, Clinical Child Psychologist; and, **Katrin**

Pruulmann, Clinical Child Psychologist/Psychotherapist, with information from the following sources, institutions and persons⁶:

- Anne Kleinberg, Child Psychiatrist, Head of Psychiatry Department, Children’s Hospital of Tallinn, Head of Child Psychiatry section
- Anu Susi, Child Psychiatrist, Tartu University Hospital
- Jüri Liivamägi, Child Psychiatrist, Tartu University Hospital
- Sirje Bunder, Ministry of Social Affairs
- Aare Vilu, Ministry of Education and Research
- Kristi Kõiv, Lecturer, Educational Sciences, PhD, Tartu University
- Katriin Hunt, Chief of Projects, The Counselling and Crisis Help Centre of Tartu
- Sirje Saar, Chief of Projects, Tartu Support Centre for Abused Children
- Jelena Jedomskihh, Counsellor/Psychotherapist, The Counselling and Crisis Help Centre of Tartu

Other sources:

Policy documents from several ministries, published research, statistics of Estonia, publications of the National Institute of Health Development, NGO representatives. Special thanks to Mrs. Iis Saame from the Ministry of Social Affairs who helped us to obtain concrete information about finances.

2. What we know about children and adolescents in our country and their mental health

2.1. Prevalence of mental disorders in children and adolescents

¹(consolidated text April 2004) RT reference RT 1992, 28, 370

²(consolidated text Dec 2003) RT reference RT I 2002, 35, 216

³(consolidated text July 2002) RT reference RT I 1997, 16, 260

⁴RTII, 04.07.2000, 15, 93

⁵(consolidated Text Jun 2007) RT I 1995, 21, 323

⁶A working-group meeting was held on 5.11.2008

The main source of data on prevalence rates of childhood mental disorders is medical practice and this current information is mostly not systematized or researched. The last epidemiological study was done in 1997 at the district level (Tartu town and district in South Estonia) using Achenbach's Child Behaviour Checklist. According to this research, carried out by J. Liivamägi of Tartu University, 31% of children aged 2-3 years, 32% of children aged 7 years and 26% of children aged 11-18 years had borderline or clinical psychiatric disorders. Evaluation of pupils in classes V, IX and XII of Tartu town and county schools (n=829 pupils) found prevalence of serious psychiatric disorders to be 16% of V class, 23% of IX class and 37% of XII class.

According to our own and our colleagues' everyday experience the most common reasons for referral of children and adolescents to a specialist service are learning disabilities, behavioural problems, mood disorders and developmental problems.

2.2. Vulnerable child population

The most vulnerable child populations are children whose parents are unemployed or overwhelmed with working at several jobs (including families where parents far from home), those whose parents are alcohol or drug abusers and children who experience "school-burnout" because of high demands in school and at home.

In the previously mentioned research the main etiological factors of children's psychiatric disorders were excessive load in school (52% of cases), parental alcohol problems (30%), lack of psychological security in the family (23%), economic problems within the family (20%) and disturbed relationships with peers (19%).

According to the Statistics of Estonia the rate of unemployment among 15 – 24 year-olds was 10% in 2007 and 12% in 2008. Under Estonian law there it is compulsory for children to attend school until 17 years (included). In 2003 there were 1790 pupils who dropped out of school before this age. In 2007 the National Audit Office of Estonia found that 3847 children were not enrolled in school. Most of them really lived abroad with their parents. In 2006 10.7% of children aged 0-15 years lived below the absolute poverty line, 6.6% lived in direct poverty and 6.4% of children aged 0-15 years were at risk of poverty.

*C/Q - The data is available but there are concerns over its quality.

Table. 2.2. Prevalence of specific vulnerable child population in Estonia.

Vulnerable child populations	% of child population (or not available code)	Age-range	Reference period (week, month, year, lifetime)	Instrument and version used to measure	Description of the data given
Children living in poverty	17,3% in this age group	0-15	year		2006
Early school leavers	1790		year		2003
Children experiencing bullying	C/Q*				
Youth unemployment	10% in this age group	15-24	year		2007
Children in care (living in any residential places other than families)	1493	0-18	year		2007
Juvenile offenders (cautioned or prosecuted)	304 (cautioned) 31 (in prison)	13-17 15-17	year year		2007 2007
Children abandoned due to parental migration for employment	Data not collected				
Other Vulnerable populations: children, who's parents are working far from home, in other countries	Data not collected				

In 2006, 1621 children aged 0-18 years lived in care (any residence other than with the family).

Rates for juvenile offenders in 2007 were: 304 of all 13-17 year olds were cautioned and 31 of all 15-17 year olds were in prison.

According to data from Foundation Innove, 15% of pupils have special needs; of these 12% are in mainstream schools and 2.9% are placed in special schools⁷.

2.3. Positive child and adolescent mental health

There is some new research on this topic, but the outcomes are not yet available.

In Estonia, children have the opportunity to participate in different youth activities. There are 19 national youth associations in Estonia. The Estonian Union of Youth Associations incorporates 48 youth and youth work associations. The umbrella organisation for school student councils is the Estonian School Student Councils' Union and student bodies are connected by the Federation of Estonian Student Unions. Local governments or

non-profit associations organise the activities of youth centres. Youth centres are divided into open youth centres, information and counselling centres, youth work centres, etc. Youth councils have been established in nine city governments. Pursuant to the study programme, hobby schools offer hobby education to young people in different fields: sports, music, art, dance, drama, nature, handicraft, technology, etc. Youth work in general education schools and vocational schools is based on extracurricular activities and is organised by leisure manager-teachers of the schools and school student councils. Youth exchanges, events, campaigns and other activities for youth associations, youth camps, youth centres and hobby schools are organised within the frameworks of different programmes and projects. The Ministry of Education and Research also has a Youth Work Strategy for 2006-2013. In spite of this, according to An Index of Child Well-being in the European Union (2006)⁸ children in the Baltics reported the lowest life satisfaction with values around 75 per cent. Few children in Estonia state that they like school. Estonia and Lithuania were at the bottom of the league table of child well-being in a 2001/02 Health Behaviour in School Age Children (HBSC) report⁹

3. Action for promotion and prevention in mental health

The developmental plan of the Ministry of Social Affairs 2009-2020, includes guaranteeing healthy and secure development for children and adolescents, its aim being to reduce mortality and psychological and behavioural disorders.

An implementation strategy for the developmental plan of public health for 2009-2012 also exists.

3.1. Policies and programmes for CAMH

Specific policies and large-scale programmes for CAMH

"Conception of Child Protection (from 2005)" Strategy to Guarantee the Rights of the Child

The strategy is used as a guideline for general actions to support the health, development and welfare of children and it also envisages actions for children in need of special attention (children living in poverty or at risk of poverty; children with disabilities, special needs; children from ethnic minorities and/or other marginal groups; children without parental care). Risk behaviour is common among socially excluded children, which also leads to deterioration of health indicators. Educational, economic and social factors have a major impact on population health and health behaviour. Reducing inequality, which

is caused by these factors and manifests itself in the health of children and adolescents, contributes to the improvement of general population health. Therefore, the strategy to guarantee the Rights of the Child helps to achieve the objectives of the National Health Plan in the field of child and adolescent health. The strategy also supports performance of the obligations laid down in the UN Convention of the Rights of the Child.

"Strategy of developmental plan of public health for 2009-2020", The National Health Development Plan establishes strategic goals for the ongoing improvement of the health of the population. The government has set extending average life expectancy and raising the quality of life in Estonia as priorities, and these form the basis of the development plan. Ensuring healthy and secure development for children and adolescents provides them with the opportunity to grow healthy and become active members of society.

Priorities are:

- Development of physical and mental health and social development of children and adolescents;
- Prevention of injuries and violence among children and adolescents;
- Prevention of chronic diseases and the associated risk factors among children and adolescents.

Examples of large scale programmes:

National health promoting networks - Healthy Settings

In Estonia, healthy settings have been developed within different Government strategies, policies and programmes. Currently there are four healthy settings initiatives that are integrated in various national strategies, policies and programmes:

- Healthy kindergartens, Estonian Network of Health Promoting Kindergartens/Nursery Schools
- Healthy Schools, Estonian Network of Health Promoting Schools
- Healthy Hospitals, Estonian Network of Health Promoting Hospitals
- Healthy Workplaces, Estonian Network of Health Promoting Workplaces

All of the abovementioned networks are coordinated by the National Institute for Health Development.

The Crisis Programme for Children and Youth

This project-based programme was started in 1995. From 1994, after the M/S "Estonia" disaster, specialists meeting the bereaved children and teenagers, became aware of the tremendous importance of providing professional help and support to children effected by traumatic events. They started rehabilitation work with total funding from Swedish Save the Children in 1995-1998. Since 1999 they have found contributors from Estonian Health Insurance, local governments and

⁷www.mentalhealthpromotion.net/resources/juhendmaterjal_vaimse_tervise_edendamiseks1.pdf

⁸Bradshaw, J., Hoelscher, P. and Richardson, D. (2006) An index of child well-being in the European Union, Social Indicators Research. <http://springerlink.metapress.com/content/f3642p2x00hn5h01/?p=c2bb8379bdd64df8bcc101ac93ecce0f&pi=1>

⁹Young People's Health in Context. Currie C et al (eds) (2004) Young People's Health in Context: international report from the HBSC 2001/02 survey, (Health Policy for Children and Adolescents, No.4). WHO Regional Office for Europe, Copenhagen

¹⁰http://www.sm.ee/fileadmin/meedia/Dokumendid/APO/Arengukavad/Rahvastiku_tervise_arengukava_rakendusplaan_2009-2012.xls

funds, international institutions and private enterprises. They have created a strong professional team. More than 500 traumatized children and teenagers have been supported by grief support work in the form of rehabilitation camps. Members of this programme have also offered immediate crisis intervention and assisted the survivors of several teenage suicide cases and suicide attempt cases.

They also offer guidance and information to bereaved children's families and to anyone concerned about a child after a traumatic event. The members of the programme are lecture in universities and hold seminars in educational institutions (schools, kindergartens) on crisis response.

Drugs and Drug Prevention in Estonia.

In Estonia the abuse of narcotic drugs and the range of related problems are a relatively new phenomena having developed into an issue demanding urgent attention over the last years of the twentieth century. In the 1990s, particularly in the second half of the decade, Estonia witnessed an increase in the use of narcotic and psychotropic substances, posing a threat to both the health of the user and the security of the living environment.

Medical and police statistics demonstrate that drug use has increased considerably over the past years, particularly among children and young people. Use of heroin, amphetamines and other narcotic drugs does not only have an adverse effect on the health and social position of a person, but also results in increased crime and transmission of hepatitis B and C and HIV in society.

Other general policies related to CAMH

Child care and protection

The Republic of Estonia Child Protection Act¹¹ defines children's internationally acknowledged rights, freedoms and responsibilities, their protection in the Republic of Estonia and is a base for all other acts concerning children.

Issues connected with family are included in the Family Law Act¹²

Some general CAMH related topics are included in the Improved and Upgraded Law of Ratification of the European Social Charter. Social support and social care services are regulated by the Law of Social Welfare.

Regulations and obligations of social care and services for people with special mental health needs are included in The law of social support services and payment for disabled.

Education and school programmes:

CAMH topics connected with the education system are included in the Republic of Estonia Education Act the national curriculum of basic and high school, and, The

Law of Preschool Institutions,.

They include Application of health protection demands for school timetables and curricula, and health protection demands for day care services.

Poverty, social inclusion and welfare

Youth Work Strategy 2006–2013

Strategic actions envisaged to support the development of young people exhibiting high-risk behaviour also create preconditions for the development of health behaviour among youth and prevention of health problems caused by risky behaviour. Actions to improve the quality of youth information and counselling services and achieve better service integration also support the development of awareness and coping of the youth. Counselling services enable young people to make conscious decisions about their lives. This creates conditions for the development of responsible health behaviour and, consequently, supports the achievement of the objectives established in the National Health Plan.

Development Plan for Reduction of Juvenile Delinquency 2007–2009

The overall goal of the development plan is to reduce juvenile delinquency, including recurring offences, and to improve prevention among minors. The actions under the Development Plan for Reduction of Juvenile Delinquency include social and educational prevention measures, improvement of the work of Juvenile Committees and development of re-socialisation programmes for juvenile offenders.

3.2. Availability of programmes for CAMH promotion and mental disorder prevention

Information on the availability of programmes was scarce. Availability is usually better in towns and district centres. It also depends on resources (human and financial) e.g. Eastern-Estonia vs. Tallinn or Tartu.

4. Organisation and resources for implementation

4.1. Institutions and organisations

Department of Public Health in the Ministry of Social Affairs, whose duties are development of national social welfare policy; development, coordination and administration of national social welfare programmes and projects; collection and analysis of information relating to social welfare and dissemination of information to the general public; administration of the national social register and maintenance of national social statistics;

¹¹(consolidated text April 2004) RT reference RT 1992, 28, 370

¹²(consolidated text April 2005) RT I 1994, 75, 1326.

requesting supplementary financial resources for local governments for social welfare; organisation of adoption from and to foreign states and maintenance of a corresponding register.

Duties of County Governor in administration of social welfare: development of county social welfare policy; development, coordination and administration of social welfare programmes and projects in the county; administration of state social welfare institutions located in the county; collection and analysis of information relating to social welfare in the county and dissemination of information to the rural municipality governments and city governments and the general public; organisation of substitute home services and financing of state-funded childcare services; organisation of adoption and maintenance of a corresponding register.

Duties of local governments in administration of social welfare: drafting of a local social welfare development plan as a part of the rural municipality or city development plan; administration of the provision of social services; emergency social assistance and other assistance and

the grant and payment of social benefits; preparation of statistical reports relating to social welfare and submission of the reports to county governors. Some projects in this area (Healthy behaviour) are financed by the Estonia Health Insurance Fund.

4.2. Services

Mental health care and services are organised by the Department of Health Care in the Ministry of Social Affairs, which is coordinating Social and Health Care offices in local governments and projects financed by them, mental health care services offering institutions (hospitals, nursing homes etc.). Medical institutions and services are financed by health insurance, rehabilitation work and nursery is covered by Ministry of Social Affairs and by the budgets of local governments. Tallinn, Tartu and Viljandi psychiatric clinics all have departments (inpatient and outpatient) for children and adolescents. In 2009 an Infant and Toddlers Psychiatry outpatient service was opened in Tallinn Children's Hospital.

4.3. Funding

In an amendment of the CAMHEE questionnaire the Ministry of Social Affairs answered that in the past 5 years

Table 4.2.1. Availability of services

	0%	1-25%	26-50%	51-75%	76-100%
Child psychiatric appointments			x		
Psychologist appointments			x		
Social service appointments for children				x	
Family therapy/counselling appointments		x			
Infant-specific services		x			
Adolescent-specific services				x	
Group therapy		x			
School counselling				x	
Pharmacological treatment			x		
Psychosocial rehabilitation for adolescents		x			
In-patient beds on child psychiatric ward		x			
In-patient beds on general psychiatric ward			x		

Table 4.2.2. Access to specially designated mental health services

Group	0%	1-25%	26-50%	51-75%	76-100%
Minority groups			x		
Migrant population	x				
Orphans					
Children living in poverty				x	
Runaways/homeless		x		x	
Refugees/disaster-affected population	x				
Seriously emotionally disturbed	x				
Victims of bullying					
Early school leavers					
Unemployed youth				x	

there has been a small increase - funding allocation to child and adolescent mental health. Concrete numbers are not available to the authors. Our first opinion was the result of our own and other coalition participants' real practical experience.

The Ministry of social Affairs insists that within the rehabilitation service money provided for children's (social) rehabilitation services has increased by at least half. Rehabilitation services have become more flexible and correspond more to individual needs. The quantity of services for disabled and risk-behaviour children's families has also risen considerably. Price of day in child psychiatric inpatient care has also risen.

This means that there was a small increase in evidence-based and community-oriented / family-focused services in the past 5 years. There was also a small increase in evidence-based MH promotion activities. The Ministry of Social Affairs is referring to trainings organised by the National Institute for Health Development. In the past 5 years there has been a small increase in treatment and care resources in residential institutions. Orphanages are funded per place. As the cost per place has risen in the last years, it could be said that in general more funds have been received by orphanages. However, employee pay makes up 70-80% of the budget. So it is likely that most of the increase went towards raising pay rates.

4.4. Training of professional workforce

The University of Tartu and University of Tallinn have graduate, postgraduate and doctoral programmes in psychology, social work and special education. Tartu University also has a Faculty of Medicine, where psychiatry is taught on the level of postgraduate specialist medical training. There is no official profession of child psychiatry in Estonia, almost all those working as child psychiatrists received their qualification during the Soviet time, but now, for younger people it is possible to earn accreditation from the Estonian Psychiatric Association to work with children and adolescents if you have completed the required training. Training in these professions includes CAMH issues.

Tartu Health Care College also offers training leading to qualification as a mental health nurse.

5. Monitoring and evaluation of the actions for the promotion and prevention in mental health

The last large programme specifically centred on mental health was the above mentioned "Health Programme for Children and Adolescents". There is continual collecting on state level of some general data on mental health service and care policies. The results are published by the Ministry of Social Affairs. More monitoring is done in the area of drug and alcohol abuse prevention.

6. Research and dissemination

The Ministry of Social Affairs collaborates with the National Institute of Health Development and Health Insurance Fund for research and publication of results.

Examples include:

The Estonian-Swedish Mental Health and Suicidology Institute participates in the European Commission (FP7) funded international project "Saving and Empowering Young Lives in Europe" (SEYLE) 2009-2011, and undertook a local project in the town of Haapsalu "Prevention of (pre)suicidal behaviours in schoolchildren" in 2004 - 2005.

The National Institute of Health Development took part in the Health Behaviour in School-aged Children (HBSC) study 2005/2006

Dissemination of results

Universities and colleges have conferences and advanced training courses, where results of new research are presented.

There are some professional societies and associations, who regularly organise seminars, training and information days for their members and other specialists in the CAMH field: the Estonian Psychiatrists Society's Child Psychiatry Section, Estonian Child Psychologists Society, Estonian Crisis Programme for Children and Youth, Estonian Psychoanalytic Child Psychotherapy Society, Estonian Child Support Centres; Estonian School Psychologists Society, Estonian Autism Association and so on.

Care related issues

The National Institute of Health Development has a Training and Knowledge Centre, which deals primarily with informal training for health care and social welfare professionals.

The following training programmes have become well-known:

- training for children's home educators
- training for PRIDE foster families
- care givers training for the personnel of social welfare institutions
- training for activities therapists' assistants to improve the performance of rehabilitation teams
- a certification programme for hospital managers

In addition to the provision of training programmes, the Centre also publishes the Estonian Journal of Social Work.

7. Challenges, opportunities and advances in the field

Key recent advances

- Increased activity of child psychiatrists.

- Continual development of the Psychiatry Department of the Children's Hospital of Tallinn (opening an infants and toddlers psychiatry service) and a Child and Adolescent Department of Psychiatry Clinic in Tartu (renovation and repair of department and opening of addiction section).
- Continual development of the system of rehabilitation services
- ESPAD research on a regular basis
- Implementation strategy for the developmental plan of public health for 2009-2020
- National Drug Prevention Strategy (2005-) 2012.

Difficulties and proposals for further development

- The most important barriers to action in CAMH care in Estonia are:
- There is no systematic approach, i.e. policy on child mental health
- Lack of prepared specialists
- Underdeveloped health care services
- Limited dissemination of information
- Lack of financial resources

The most important barriers to action on child and adolescent mental health promotion or mental disorder prevention in Estonia are:

- There is no systematic approach in this area
- Limited public knowledge about mental health problems
- Governmental responsibility is fragmented
- Tense family relations, insufficient communication skills, lack of training and counselling system for parents, insufficient network initiatives to reduce health risks for children in problematic families.
- Insufficient availability of the assistance provided by child psychologists, child psychiatric treatment and diagnostic services, social workers, school psychologists and speech therapists.
- No integrated solution for the educational and treatment needs of children with special needs.
- The evidence-based information environment on the protection and promotion of child development and health for parents, teachers and other child specialists needs further improvement and development.
- The routinely collected aggregated child and

adolescent health statistics do not provide information on different target groups (segregated by the level of education, socio-economic situation, nationality) and cannot be used to plan preventive interventions for different target groups.

8. Summary and conclusions

More support is needed for education and training programmes for specialists in mental health. CAMH-related work in Estonia is active and specialists and institutions specifically for this field exist. Clearer objectives and a tighter collaboration among different state institutions, research, medical and non-governmental organisations is needed. Wider publicity is also needed. State operated medical statistics should be started again. Monitoring in this field should be increased along – with increasing the availability of information. Resources from the European Union Structural Funds could be used to build children's mental health centres in the different regions in Estonia and also to educate specialists.

Estonian society has become strongly polarized in the last seventeen years and Estonian social cohesion indicators are much lower than in the Nordic and Western European countries. There are large health disparities between different population groups and health indicators are strongly linked to sex, education, ethnic background and income level.

Social inequality has a defining influence on the health of children and adolescents. Parental poverty inevitably affects children. Socio-economic conditions experienced in childhood are better predictors of adult health outcomes than social status during adult years. Social exclusion, poor living conditions, poverty and risky health behaviours are frequent indirect causes of childhood illness and death. Adequate and timely intervention would help us prevent the creation of a new generation of socially and economically excluded people.

FINLAND

Prepared by Päivi Santalahti, Matti Kaivosoja and Jorma Piha

1. Introduction

1.1. Policy at a glance

In Finland there is no White Paper issued on Child and adolescent mental health (CAMH) policies. There are several laws aiming to improve services for day-care, CAMH-services and child protection, and Finland joined the Convention on the Rights of the Child (1989) without any reservations. The Ombudsman for Children started in Finland on September 1st 2005, and a national board to support the work of the Ombudsman was set up in 2006. The current Government has two policy programmes, which are dealing with issues related with CAMH prevention, promotion and care.

Municipalities are responsible for providing CAMH and child and adolescent psychiatry (CAP) services, and, in allocation of economical resources, CAMH issues are not a high priority at this level. Within specialised medicine the expenses of CAP services are only around 2 % of all expenses. In the state budget the economic resources to develop CAMH and CAP services has been patchy. Municipalities do not always fulfil their obligations according to laws or national recommendations for children's services, for example, in school health services and child protection services. There have been numerous policies, programmes and projects, some of which are excellent, and yet the questions have arisen of "what is given priority?", "who is responsible?", "who is responsible for co-ordination?" and "are time-tables realistic?" (Fogelholm 2008).

Alcohol consumption has risen, affecting many families negatively. Numbers of children taken into custody by child protection services and living away from their own home, many in institutions, has risen. Proportionally, a greater number of families with small children, and especially families of single mothers, are found among those with low-income now compared with the beginning of the 1990s.

There are several reports (e.g. WHO 2005, STM 2007) dealing with the high rate of family violence in Finland. The majority of cases involve children having to witness violent acts between their parents (or caregivers), but there are cases where children are victims too. Family

violence is closely linked with the Finnish tradition of alcohol use and is one of the main concerns in the field of CAMH promotion.

1.2. Process to prepare the country story

The country report was prepared by the following persons:

- Dr Päivi Santalahti, Child psychiatrist, Researcher, Turku City Child Guidance Clinic and University of Turku
- Dr Jorma Piha, Professor, Chief physician, University & University Hospital of Turku
- Dr Matti Kaivosoja, Child psychiatrist, Chief physician, Central Hospital of Keski-Pohjanmaa and University of Turku

2. What we know about children and adolescents in our country and their mental health

2.1. Prevalence of mental disorders in children and adolescents

The exact prevalence rates can be obtained from the results of scientific epidemiological research reports. In Finland child psychiatry and adolescent psychiatry are two separate disciplines, a fact which influences research activity.

In 1989 a nationwide epidemiological study was conducted consisting 6017 children born in 1981. The sample was representative of the whole child-population of that age. Initially, questionnaire-screening of symptoms

(Rutter questionnaires for parents and teachers and Child Depression Inventory questionnaire I for children) was carried out and thereafter representative samples of screen-negatives and -positives were interviewed (both a parent and a child). According to this extensive study, 5.2% of children had general anxiety, 2.4% specific fear, 6.2% any depression, 4.7% conduct disorder or oppositional defiant disorder and 7.1% ADHD. Of all the children 7.5% had a severe psychiatric disturbance that had lasted for more than 3 years. Only 3.1% of the children had visited health professionals for psychiatric problems during the previous three months (Almqvist et al 1999a). Several longitudinal studies have been carried out based on this large sample, but they used mainly questionnaires and registry data in the later stages. In South-West Finland comparable cohorts, using exactly same sampling, procedure and methods but only collecting questionnaire data (not interviews), were collected in 1999 and 2005. An increase was found of girls' depressive symptoms and a small decrease in boys' conduct disorder symptoms. In the later cohorts much more help was sought from professional sources than in the initial study year, 1989 (Sourander et al 2008).

In a study of adolescent psychiatric epidemiology, the 12-month prevalence of major depressive episode was found to be 5.3% among 15- to 19-years-old youths. (Haarasilta et al 2001).

A school health survey on trends in youths' well-being and real differences is collected annually by STAKES (Luopa et al 2008). The survey includes questions on depressive symptoms. Around 10% (10% – 13%) of 14-18 year-old youths are found to have depressive symptoms,

considered to indicate moderate to severe depression. Increasing trends in girls' depressive symptoms have also been found.

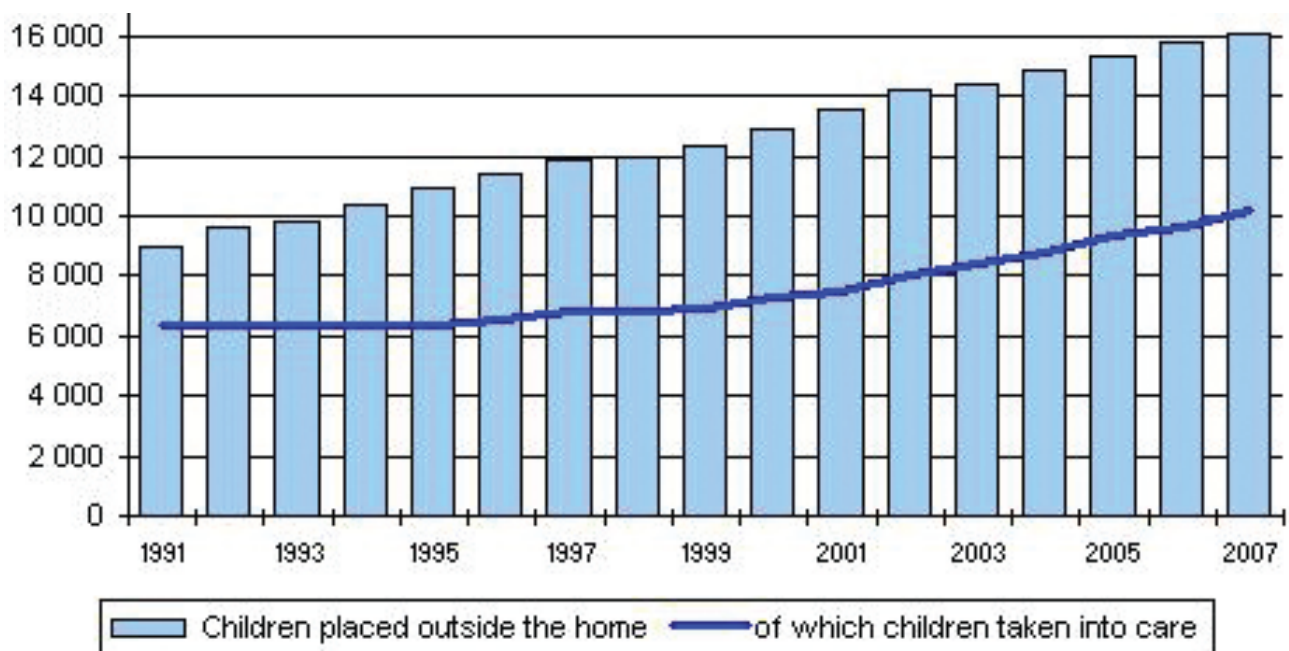
Information is also available from the hospital discharge register (STAKES), and registers of prescribed drugs and funding of rehabilitation costs and allowances for sick and disabled children (KELA, The Social Insurance Institution of Finland). However, these numbers cannot be used to get a picture of prevalence rates. For example, number of antidepressants used for young people and psycho-stimulants for children with ADHD have increased remarkably, which does not indicate growing prevalence rates, but reflects changes in care and treatment practices.

2.2. Vulnerable child population

The most striking phenomena from the existing statistics is the sharply increasing trend in numbers of children who are involved in child protection services, taken into care by child protection services and living away from their own homes, many of them in institutions (Tilastokeskus (Statistics of Finland) and Stakes 2007) (Figure 1).

There are several sources for the number of children experiencing bullying, but it is difficult to draw conclusions from the trends of the phenomena. Numbers depend on the age of the target children and the questions used. There have been long-term and intensive research projects on bullying in Finland and the anti-bullying programme KiVa-koulu (the acronym can be translated as nice-school) is wide-spread.

Figure 1. Children and young persons placed outside the home in 1991-2007

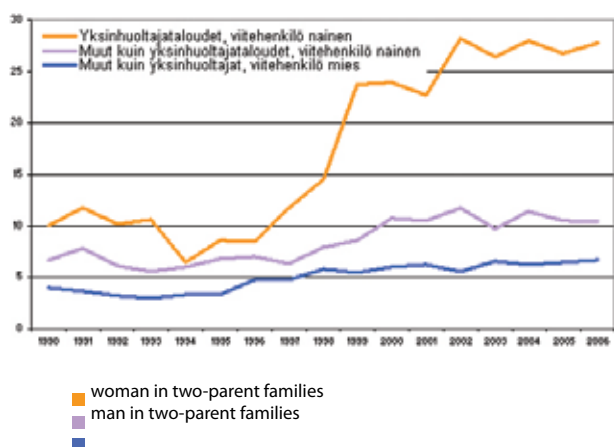


Child poverty (relative) has increased since beginning of the early 1990s. Especially families with children have been disadvantaged by the last years of economic politics and social policy. In 2006, 8.5% of the children lived in families which received individually targeted income support (Tilastokeskus (Statistics of Finland) and Stakes 2007). Proportionally, more families with small children, and especially families with single mothers, can be found now in a low-income group compared with the beginning of the 1990s Tilastokeskus (Statistics of Finland) 2007 (figure 2, below).

Regarding young people's lifestyles, alcohol consumption is worrying. 23% of pupils in the 8th and 9th grades (14-16 year olds) drunk heavily at least once a month in 2004 (Luopa et al 2008).

The number of early school-leavers is very low in Finland. In 2005/2006 only 60 children of age 7-16 years was registered as outside of the formal educational system. (Tilastokeskus (Statistics of Finland) and Stakes 2007)

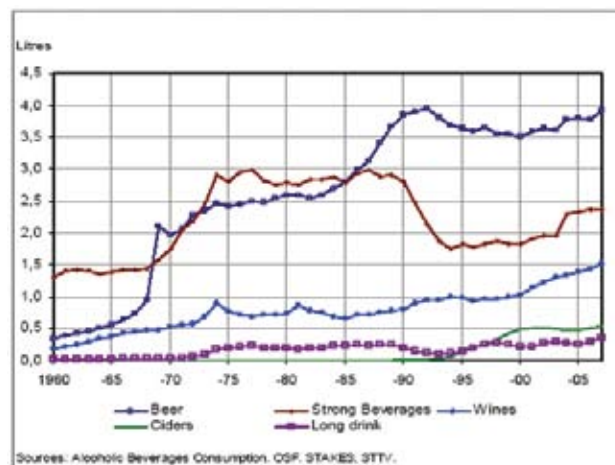
Proportion of low-income persons (60% from median value)



Tilastokeskus (Statistics of Finland): Tulonjakotilasto 2006

We did not find statistical data on homeless children or children who are abandoned due to parental migration for employment. nor have we come across this phenomenon in our clinical work. On the other hand, what is obvious from clinical work, is the great number of children with alcoholic parents. The amount of alcohol consumption has increased (Figure 3).

alcohol as pure alcohol.



Official Statistics of Finland and STAKES. Statistical Summary 17/2008
<http://www.stakes.fi/tilastot/alkoholitilanne>

2.3. Positive child and adolescent mental health

Systematic data about young people's well-being is collected annually by the National School Health Survey and by the youth barometer (Myllyniemi 2007). According to youth barometer, most young people are quite satisfied with their lives. When young people 15-29 years of age, were asked to rate on a scale from 4-10 (10 as best), how satisfied they were with your life at the moment, 55% gave an answer of 9 or 10 and 37% 8. The mean value for satisfaction in one's health was 8.7. 52% of the respondents reported that they meet their friends daily and 39% weekly.

Summary and conclusions from the part 2

The existing data indicates that quite big changes can happen in children's life circumstances, as is reflected in the number of children taken into care for their own protection and the increasing numbers of children living in low-income families. Most data collected systematically is about use of services. Some data is systematically and repeatedly collected about youths (School health survey) but there is no systematic data on children's (under 12 years of age) psychiatric symptoms or well-being collected.

3. Actions for promotion and prevention in mental health

3.1. Policies and programmes for CAMH

3.1.1. Specific policies and large-scale

Figure 3. Dokumented per-capita consumption of

programs for CAMH

In Finland there is no White Paper issued on CAMH-policies. The Ministry of Social Affairs and Health is preparing a plan to promote Mental Health and to prevent Substance misuse up to the year 2015. Also a new Health Service law is in preparation (according to current plans, it will be effective from the beginning of 2011).

The current Government has two policy programmes, which deal with issues related to CAMH prevention, promotion and care: The Policy Programme for well-being of children, youth and families and Policy Programme for Health Promotion. The National Development Plan for Social and Health Care Services - Kaste Programme 2008-2011 – put forward 6,3 million Euros for the year 2009 to enhance services for children, adolescents and families.

There have been two central legislation changes to improve availability of CAMH-services. A Decree on Mental Health (1247/1990) was issued in 1990. From the beginning of 2001 a major change took place and a new chapter concerning child and adolescent mental health was added (1282/2000). Since then, Health Care Centres have the responsibility to plan and integrate CAMH services within their own catchment area. Also the Mental Health Decree requires that CAP and CAMH evaluation must be started within 3 weeks of referral and necessary treatment within 3 months after referral. However, the given time-limits are not adhered to in all parts of the country.

The Finnish Parliament accepted that Finland join the Convention on the Rights of the Child (1989) without any reservations. According to Article 37c, children interred for psychiatric reasons or on legal grounds should be kept separate from adult patients or prisoners. This led to establishment of more than 10 new inpatient psychiatric units for adolescents during the 1990s.

There are several mental health promotion and prevention programmes, some of them regional and others targeted for specific groups or problems. The Ostrobothnia Project (years 2005-2014) – the largest regional programme at present - is a development project of mental health and substance misuse work, aiming to promote and improve well-being within three hospital districts of Ostrobothnia – 10% of the Finnish population live in the area. The target population is the residents of the area, their life cycle, the service system around them and their environment. The Ostrobothnia Project has also special targets for CAMH¹. The Ostrobothnia Project, together with Education Department of the State Provincial Office, has organised several workshops in the area to develop the psychosocial services of schools, co-operation of psychologists, school nurses, social workers and educational staff. Several hundred professionals

participated these workshops and their conclusions have been published (in Finnish) by the State Provincial Office. Also, the Ostrobothnia Project organised Mental Health First Aid (MHFA, see www.mhfa.com.au) training for teachers of several schools as a pilot study. After the well-known and tragic school shooting instances, these MHFA courses have been fully booked. To raise awareness of depression in young people, the project organised a campaign. Symptoms and signs of depression were presented in radio commercials and at schools, where children were asked to write, draw or in any other way to describe their mood changes. The resulting children's work was gathered together as exhibitions in various municipalities. This exhibition circulated in all public libraries of the area. In addition, the project has organised training with The Efficient Child and Family Programme (see next chapter) in collaboration with STAKES.

The Efficient Child and Family Programme organised by STAKES (since 2002) is a nationwide development and training programme for professionals who work with children and families at high risk. The programme aims to develop working methods that help provide support to families and children and prevent disorders in children when a parent has mental health problems or a severe illness. The methods are intended to be used by social and health care professionals, different co-operating partners and organisations. The programme aims to strengthen the preventive approach and build up co-operation between services for adults and children. The programme is a research, development and implementation project that covers large part of the whole of Finland (<http://info.stakes.fi/toimivaperhe/EN/index.htm>).

The anti-bullying intervention KiVa-school ("Nice-school") is a wide-spread programme based on intensive research on bullying phenomenon. The programme aims to reduce bullying at schools and is financially supported by Ministry of Education <http://www.kivakoulu.fi/index.php>

3.1.2. Other general policies related to CAMH

Well-functioning health and social services, including appropriate day-care, family policies supporting families with children, and an educational system providing equal opportunities, are essential for CAMH promotion and prevention.

In Finland mothers receive a maternity allowance of 105 working days and thereafter, one parent receives 158 working days of parenthood-allowance plus 60 additional days if more than one child was born. Fathers receive 18 working days paternity-allowance. The Ministry of Social Affairs and Health and labour market organisations have implemented a project to support fathers staying home with small children. As an additional supportive measure, fathers can receive 12

³<http://www.pohjanmaahanke.fi/Default.aspx?id=519312>

extra working days parenthood-allowance if the father, instead of the mother, is using the 12 last days of the time given for normal parenthood-allowance. A parent has the right to care-leave until a child is three years old and part time care-leave until the child finishes his/her second school year. In cases where the child is severely sick or disabled there are additional rights.

Children's day-care has been developed in Finland gradually since the 1970s. Parents can take their children to day-care centres or to home-care, in which one adult takes care of several children in a home environment. The Act on children's day-care issued in 1973 states that the aim of the day care is to support children's families in bringing up children in such a way the way that the children develop well-balanced personalities. Day-care, is thought to play a role in this by offering continuous, safe and warm human relationships, activities supporting children's broad-based development and an environment supporting child's needs. Day-care promotes children's physical, social and emotional development and their aesthetic, intellectual, ethical and religious growth, taking into consideration primary care-givers' (parents/guardians) own conviction. In 1996, the law made it a subjective right for every child under school age to have access to day-care. Limits on the sizes of groups and minimum criteria for the education of personnel were given. A change to the law in 1996 stipulated that each municipality must have specialist kindergarten teacher services to support children with specific needs. The Advisory Board to the Government for Early Childhood Education and Care up to 2020 highlights the multidimensional character of support necessary for the comprehensive development of well-being in children as the basis for early childhood development and care (Varhaiskasvatuksen neuvottelukunta 2008). However, the day care system has not only seen improvements. Since the 1990s the sizes of day-care groups have increased, putting children under increasing stress (Taskinen 2007) and diminishing optimal developmental conditions.

Maternity centres and well-baby clinics are used by almost all families (99.8% of all mothers visit maternity centres). Work is mainly carried out by public health nurses. The mother meets a doctor on every fifth visit. When asked about their experience, mothers and fathers felt that their physical well-being was well cared for but expressed a wish for a greater emphasis on psychosocial aspects. (Taskinen 2007)

Home assistance from the social sector, for families needing extra practical help, for example in cases where a mother is sick, has reduced remarkably during last two decades. In 1990, a total of 52,300 families with children received home assistance compared with only 13,400 in 2004 (Taskinen 2007).

The duration of compulsory education in Finland is 9 years, from 7 to 16 years old (children with special needs can have it increased to 11 years), and almost all school-

age children go through the same school system (the number of private schools being very small). There are small numbers of drop-outs (under 1 %: for example, in 2006 178 young people did not complete school by the age of 17). After the compulsory education years, the transition to further education or working-life is less successful: In 2004, 5% of 17-year-olds did not participate in education or the labour market.

The state of school health services has been discussed publicly and at length during recent years, especially following the tragic school shootings in 2007 and 2008. A recent study shows that only one-third of the municipalities studied are fulfilling the national recommendations concerning pupils' health check-ups by the school health services (Rimpelä et al 2008).

According to the new Act on child protection, which came into force on the 1st January 2008 (Child Welfare Act), the health status of every child placed in care away from home must be evaluated and health records kept during the placement. The new Act pays much attention to the health problems of children in care. More than 25 % of the paragraphs of the law address the responsibilities of health care professionals. According to law the well-being of children must be put on the agenda of the city council of every municipality regularly. At least once in four years each city council has to evaluate the well-being of resident minors and plan for the well-being of children and adolescents. The plan must be made and carried out using the local authorities' budgets.

The Central Union for Child Welfare in Finland conducted a study in August-September 2008 asking professionals working in child protection about their views on the implementation of the current law. Positive findings were that a great hidden need for child protection work was uncovered. On the other hand, it was reported that there are too few resources in child protection services and that duties given by the law to the municipalities are not being fulfilled within the given time-limits. 41% of lay-people considered the services in their home municipality to be adequate and 90% had the opinion that taxes could be higher, if necessary to secure these services (Central Union for Child Welfare in Finland, 2008).

The Ombudsman for Children started in Finland (and the law of the ombudsman accepted) on 1st September 2005. The Ombudsman promotes the realization of children's rights and interests at the general political decision-making and legislative levels. She works in collaboration with other officials, organizations, child research and other interest groups dealing with issues concerning children. One aim is to improve collaboration among all those involved in child policy through better coordination. A National Board to support the work of the Ombudsman started on 1st September 2006. The Board has members from universities, several ministries (for example, the ministries of education, finance, foreign affairs and internal affairs) and from most important

non-governmental organisations within child policy. The Board evaluates progress within various sectors of society, new legislation or proposals and issues statements.

3.2. Availability of programmes for CAMH promotion and mental disorder prevention

In Finland, municipalities (around 350 as of the beginning of 2009) are responsible for organising basic services and there is no national data on which kinds of programmes exist in various parts of the country.

4. Organization and resources for implementation

4.1. Institutions and organizations

Mental health promotion and disorder prevention is the task of basic level services (health care centres (close to 300) and social sector agencies (around 350)) as well as of specialised medicine (child and adolescent psychiatric clinics (20 clinics for children and 20 for adolescents)). In particular, maternity and well-baby clinics and the basic school health care system are the most important agents in the public sector. In practice, specialised medicine institutions focus more on service delivery.

From the beginning of 2009 a new National Institute for Health and Welfare (THL), will be one of the main bodies in promotion and prevention in CAMH (the institute was established by merging the National Public Health Institute (KTL) and the National Research and Development Centre for Welfare and Health (STAKES)).

Also there are several Non-governmental organisations (NGOs), which are active in promotion and prevention in CAMH (e.g. Mannerheim league for Child Welfare, Save the Children Finland, Central Union for Child Welfare in Finland, Finnish Association for Mental Health, National Family Association promoting mental health in Finland)

4.2. Services

In Finland, child and adolescent mental health evaluation and treatment operates on two levels, the basic level services (see 4.1.) and specialised medical services (see 4.1.). Municipalities are responsible for arranging CAMH-services, such as social services, school psychologist appointments, family counselling, which are widely available throughout the country, except some special services (infant-specific services, psychosocial rehabilitation, group therapy).

There are 20 hospital districts in Finland with psychiatric out-patient and in-patient services for children and adolescents. Child and adolescent psychiatrist appointments, psychopharmacological treatments and

in-patient beds are widely available.

Finland is, in many ways quite a homogeneous country and does not really have any significant problematic subgroups (such as minority groups, orphans, children in poverty, homeless children). The number of migrant populations and refugees is increasing but the population is still quite small (2 % of the whole population). With the help of interpreters, these special groups use the same services as the main population.

4.3. Funding

From the beginning of 2000 extra state funding has been provided to develop CAMH services all over the country. However, the process has been extremely hesitant due to the fact that the decision concerning the funding is made anew every year and, therefore, each year it was unclear if the support would continue. This uncertainty has hindered all long-term planning and development.

There has only been a small steady increase in funding for CAP services in certain regions. The cornerstone of CAP services is in-patient wards – there are more than 600 hospital beds for children and adolescents; which is a very high number compared with other European countries. In some hospital districts there are efforts to decrease the number of CAP beds, and consequently to invest in open care facilities.

The funds for CAMH and CAP services are not “earmarked” and are not identifiable in the national nor in the municipal budgets. In the national budget, CAMH/CAP funding is included in the health care budget. On the regional level each municipality is free to use the state funding according to their own needs (which means that they are free to neglect the CAMH and CAP services if they choose).

4.4. Training of professional workforce

In Finland there are 49 distinct medical specialties. There are four distinct, principal specialties in the field of psychiatry, namely child psychiatry, adolescent psychiatry, (adult) psychiatry and forensic psychiatry.

All medical doctors are able to act as GPs, and CAP-training is part of their medical education. (Adult) psychiatrists and specialists in paediatrics do not necessarily have any formal training in CAP (after graduation as a medical doctor). Nurses do have some education in CAMH issues but the amount of training is quite minimal.

Psychologists have training in CAMH but this varies according to their main interests in psychology. Social workers and teachers do not usually have any CAMH education.

5. Monitoring and evaluation of

the actions for the promotion and prevention in mental health

There is no evaluation of policies for promotion and prevention in mental health as such. However, there are reports, for instance, on the use of services, some systematically collected data on youth and evaluations carried out on some programmes.

6. Research and dissemination

There has been a great deal of research, mainly epidemiological, on child and adolescent psychiatry in last two decades in Finland. It is not possible to describe all Finnish research projects, but below are a few examples of large studies and the articles published on them in international scientific journals.

As described in section 2.1, a large national epidemiological sample (n=6017) of 8-year old children was collected in 1989. Prevalence rates of child psychiatric symptoms and disorders and children's service use are reported in several articles (Almqvist et al 1999b). Also, for example, different informants' views (a child, a parent and a teacher) on a child's symptoms were compared (Puura et al 1998). Several longitudinal studies have been carried out to investigate how psychiatric symptoms and adversities in eight year olds predict later psychiatric symptoms, service use, bullying, substance use and criminality (Sourander et al 2007, Niemelä et al 2006). One longitudinal study examined how the economic recession of the 1990s affected children and their families (Solantaus et al 2004). Corresponding samples of eight year olds were collected in one study area in 1999 and 2005 to find out if there are changes over time in the prevalence of psychiatric symptoms, psychosomatic symptoms, bullying and service use (Santalahti et al 2005, Sourander et al 2008)

In Northern Finland there have been two large-scale birth cohort studies. The child psychiatric research based on these samples has focused on neuropsychiatric disorders and symptoms (Lubke et al 2007). The adolescent depression study investigates depression by comparing and following up 16-year old outpatients and controls (Karlsson et al 2008). The Adolescent Mental Health Cohort Study is following a population sample of 8th graders (14 -15-year-olds) and investigating the occurrence of different psychiatric disorders and the factors associated with them.

Mental health care related issues are studied in several research entities. The study on Psychiatric inpatient care in Finland describes patients and care practices in all child and adolescent hospital wards in Finland (Ellilä et al 2005). Other areas under study are adolescent specialized outpatient service use (Haarasilta et al 2003) and structures (Laukkanen et al 2003, Isojoki et al 2007).

At least three research projects have studied vulnerable groups of children: children placed in children's homes (Hukkanen et al 1999), children with intellectual

disability (Koskentausta et al 2002) and migrant children (Vuorenkoski et al 1998). Several centres are carrying out studies on infants, small children and on early mother-infant interactions both in the general population (Mäntymaa et al 2004) and when a mother has substance use disorder (Pajulo 2001, Savonlahti et al 2004)

Finland has participated in European-level research projects, such as the European Early Promotion Project (Puura et al 2005), Children of Somatically Ill Parents (Schmitt et al 2007) and the Psychotherapy Study on Childhood Depression (Trowell J et al 2007).

Prevention and promotion programmes such as The Efficient Child and Family Programme for Families in which a parent has severe disease or psychiatric problems, the Anti-Bullying Programme KiVa-school and the Schools on the Move-programme also include scientific research.

The five University hospitals and their child and adolescent psychiatric units as well as some Departments of Psychology are involved in information dissemination to keep health care professionals informed about issues on child and adolescent mental health, services, promotion and prevention.

The new National Institute for Health and Welfare (THL) started operations on 1st January 2009, following the merger of the National Public Health Institute (KTL) and the National Research and Development Centre for Welfare and Health (STAKES). One of its key roles besides research and development is information guidance.

In addition, some non-governmental organisations, such as the Finnish Society for Child and Adolescent Psychiatry, The ADHD-association and The National Family Association Promoting Mental Health in Finland organise seminars and other means of information dissemination for health care professionals.

7. Challenges, opportunities and advances in the field

7.1. Key recent advances

There are several laws aimed at improving services for day-care, CAMH-services and child protection, and Finland joined the Convention on the Rights of the Child (1989) without any reservations. The Ombudsman for Children started in Finland in 2005 and a national board to support the work of the Ombudsman in 2006. Special state funding to develop CAMH & CAP services was provided for the hospital districts during the years 2000-2008, but the effect of this was hampered by the amount of money decreasing each year and the continuation of this extra funding was always uncertain. Several good programmes and projects have been started, such as

regional mental health promotion programme The Ostrobothnia Project (years 2005-2014) and The Efficient Child and family programme, a nationwide development and training programme for professionals who work with children and families at high risk.

7.2. Youth involvement

In general, children and adolescents are not involved with the planning and development of national, regional and municipal programmes dealing with CAMH and related fields. However, they have an opportunity to influence decisions indirectly through the ombudsman of children. The ombudsman can contact local and national authorities and her voice is taken into account in the planning and development of initiatives focused on children.

Both the Ministry of Internal Affairs and the Ministry of Education have organised programmes to enhance participation of people in local and regional decision-making. The latter has particularly dealt with participation in the school system while the former was targeted at a wider participation in society. As part of these programmes several municipalities enhanced the participation of children and adolescents. The most important example is the city of Kokkola where extensive childhood politics, at all levels of decision-making, were developed and practiced.

7.3. Difficulties and proposals for further development

Children's primary services should be kept at a high standard and more resources should be allocated to service provision so that municipalities could arrange services to comply with laws and national recommendations. The ambivalent alcohol policy is harmful to children's development: As alcohol consumption has risen, especially following tax reductions, many parents' parenting capabilities have been affected.

Municipalities are responsible for providing CAMH and CAP services, and in the allocation of economic resources, CAMH issues are not a high priority at this level. Within specialised medicine, the expenses of CAP services are only around 2% of all expenses. CAMH and CAP fields need more binding, normative instructions from the Ministry of Health and Social Affairs, and health and social care systems should be better integrated. In the state budget the economic resources to develop CAMH and CAP services should be continuous, not awarded on a year-by-year basis.

Non-medical professionals do not have a basic knowledge of CAP individual development and the determinants of family issues. Basic training should be modified accordingly. Medical (including CAMH & CAP) professionals' training should be modified to

encourage these professionals to take into account the wider determinants of CAMH rather than focus on an individual orientation. Also, the content of the care and use of resources in CAP services could be improved. Adequate and evidence-based methods, when possible, should be used more widely.

8. Summary and conclusions

In Finland, high-functioning health and social services, including appropriate day-care, family policies supporting families with children, and an educational system providing equal opportunities, are essential for CAMH promotion and prevention.

In general, the CAMH and CAP services are well-arranged but there are not enough resources (at both basic and specialised medical level). The service delivery system is based too heavily on in-patient treatment, and more emphasis should be placed on out-patient services.

Over recent years extra state funding has been devoted to develop CAMH and CAP services but the results do not represent these contributions. CAMH and CAP fields need more binding, normative instructions from the Ministry of Health and Social Affairs and health and social care systems should be better integrated. In the state budget, economic resources to develop CAMH and CAP services should be continuous.

The main concerns and challenges are linked with the increase in alcohol consumption and family violence. Also the relative level of child poverty among families of single mothers is most alarming.

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GERMANY, HEIDELBERG

Prepared by Frauke Ehlers, Dennis Gmehlin and Prof. Franz Resch

1. Introduction

The description and analysis of child and adolescent mental health (CAMH) in Germany were carried out mainly at the regional level of the state of Baden-Württemberg. Exceptions from this procedure are clearly marked.

1.1. Policy at a glance

In view of the state of medical care concerning CAMH, it is indisputable that, on an international scale, Germany belongs to the very well equipped countries. This does not only refer to financial resources, but also to the diversity of facilities, supportive measures and projects for children and adolescents.

In the field of CAMH in Germany, two essential systems can be identified as playing a key role. These influence one another, but have been to a large extent two independent parameters for a long time:

1. The medical / psychiatric care system
2. The youth welfare system

The medical / psychiatric care system

The starting point, setting the scene for today's adult-, child- and adolescent-psychiatric care, was the psychiatry enquiry of the seventies, a report on the situation of psychiatry in Germany by an experts' commission consisting of about 200 employees. The report revealed serious defects in the care of mentally ill people. It resulted not only in a restructuring of the larger psychiatric hospitals, but also reformed the health system, e.g. through the introduction of measures to support consultation services, the set up of local care, the promotion of education, ensuring parity of treatment between somatically and mentally ill people, and distinguishing between the care of mentally ill people and people with a permanent mental disability. Many individual improvements were initiated during the subsequent years, having a cumulative and lasting effect on today's situation.

The reformation of the psychiatric hospitals did not only include redevelopment measures. For instance, for child- and adolescent- as well as adult psychiatry a minimum number of staff was recommended, giving a staff-patient-ratio designed to meet and to be related to patients' needs.

Education and advanced training was differentiated. In 1968 a specialised medical doctorate for "Child and Adolescent Psychiatry" was introduced. In 1993 the title was extended and substituted by a new doctorate for "Child and Adolescent Psychiatry and Psychotherapy". Nurses can also acquire an additional qualification in Child and Adolescent Psychiatry in Germany.

The youth welfare system

The establishment of the youth welfare system represented an essential step in socio-political development, especially in the field of CAMH. The system addresses all the obligations and tasks beneficial to young people and their families which are fulfilled by private and public institutions. In 2005 the law concerning the development of youth welfare was enacted. This law aims to improve of the protection of children and adolescents against dangers to their welfare, increasing the burden of responsibility of the youth welfare department, the improvement of youth welfare statistics, a reduction in the administrative expenses, as well as the development of regulations concerning data protection.

The tasks carried out by the youth welfare system include the whole complex of child and adolescent support services:

- all extracurricular work with children and adolescents (e.g., child and adolescent centres, adolescents' clubs and leisure facilities), support given to adolescent self-organisation, professional youth work in the labour market and workplace, international meetings of adolescents, forms of the extracurricular youth education, child and youth work in social activities, sports and games, youth consultation, support of adolescent associations/societies and their unions (e.g. town and district adolescent circles), social work for young people,
- the protection of educational rights of children and young people,
- offers support to families (for example consultation after parental separation or divorce)
- develop a consensual programme of custody and consultation and support in visiting rights in case of parental separation

- child day care (day-care centres, playgroups, day nurseries, child day care)
- assistance with education (among other things educational guidance, full-time care, socio-educational help for families, home education)
- assistance for children and adolescents with mental or physical disabilities
- In addition, there are many ongoing duties, such as attendance at the family court and guardianship court, child and youth custody in case of danger to child welfare, placements in children's homes/care.

One of the essential challenges in the development of care in Germany is to bring both systems - the medical care system and the youth welfare system - together as a single highly-productive cooperation. During recent years, the first collaborative projects were started. It is hoped and recommended that this cooperation will continue to grow.

1.2. Process to prepare the country story

This report was compiled by **Frauke Ehlers, Dennis Gmehlin and Prof. Franz Resch** (Department of Child and Adolescent Psychiatry, Centre for Psychosocial Medicine, University of Heidelberg) with information from the following sources, institutions and persons:

- Policy-documents from Ministries in Baden-Württemberg
- Prof. Tobias Banaschewski, Zentralinstitut für Seelische Gesundheit, Mannheim
- Günther Bubenitschek, head of the Unit for Prevention, Police Department in Heidelberg
- Prof. Manfred Cierpka, Institute of Psychosomatic Cooperation Research and Family Therapy, Centre for Psychosocial Medicine, University of Heidelberg
- Prof. Jörg Fegert, Child and Adolescent Psychiatry, University of Ulm
- Joachim Gerner, Mayor for Social Affairs, Public School and Culture in Heidelberg
- Reiner Greulich, managing director of the Association for Prevention Safe Heidelberg ("SicherHeid") in Heidelberg
- Jörg Maywald, German Association for Childhood (LIGA) and managing director of the National Coalition for the implementation of the UN-convention of children's rights in Germany
- Rieke Oelkers-Ax and Johann Haffner, Department of Child and Adolescent Psychiatry, Centre for Psychosocial Medicine, University of Heidelberg
- Birgit Pfitzenmaier, Stiftung Kinderland
- Prof. Jeanette Roos, College of Education, University of Heidelberg
- Rainer Steen, Public Health Authorities of the Rhine-Neckar-Region

2. What we know about children and adolescents in our country and their mental health

2.1. Prevalence of mental disorders in children and adolescents

Information on the prevalence of mental disorders among children and adolescents in Germany is available at a regional level for the state of Baden-Württemberg (BW). This data is based on a number of epidemiological studies, conducted by different research institutions. Prevalence rates by age can be seen in Table 1.

Table 1. Prevalence rates for different child- and adolescent mental disorders in the state of Baden-Württemberg and Germany

Disorder	Prevalence (%)	Age range (years)	Reference period	Instrument	Data-collection
Anxiety disorders	4 4 5,1	8 13 18	6 months	Structured interview according to ICD9/10	1990-2000 ¹ BW
Affective disorders	1,1 2,3 1,2	8 13 18	6 months	Structured interview according to ICD9/10	1990-2000 ¹ BW
Bipolar disorder (Manic-depressive)	0,7	4-18	12 months	CBCL	2007 ¹ National
Attention-Deficit/ Hyperactivity Disorder (ADHD)	4,6 1,7 1,1	8 13 18	6 months	Structured interview according to ICD9/10	1990-2000 ¹ BW
Conduct disorder	1,7 8,6 6,3	8 13 18	6 months	Structured interview according to ICD9/10	1990-2000 ¹ BW
Eating disorders	♂ 0,7 ♀ 2,3	14-24	12 months	Structured interview according to DSMIV	1994 ⁵ Bavaria
Autism*	0,6-0,7				
(Early onset) Schizophrenia**	0,023				2001 Sweden
Self-mutilation or self harm	10,9 occasional 4 repetitive	15	12 month	Structured interview	2004-2005 ¹ BW
Childhood/Adolescent suicide attempt	Attempts ≥ 1 for 8%	15	Lifetime	Structured interview	2004-2005 ³ BW
Childhood/Adolescent Suicide	2,2 per 100 000 13,2 per 100 000	10-15 15-20	Lifetime Lifetime		2001 ¹ BW
Other common disorder in your country (please specify):	♂ 8,4 ♀ 2,7	14-24	12 month	Structured interview according to DSMIV	1994 ¹ Bavaria
Alcohol abuse and dependence	♂ 2,7 ♀ 0,7	14-24	12 month		
Abuse and dependence of illegal drugs					

* There is no recent study on the prevalence of autism in Germany. These rates are published by the Bundesverband Autismus Deutschland (www.autismus.de/) and correspond with rates published in other European countries.

** There is no recent study on the prevalence of early onset schizophrenia in Germany. This rate refers to the study of Gillberg et al. (2001)

Table 2. Prevalence of specific vulnerable child populations in BW and Germany

2.2. Vulnerable child population

The table below presents available data on the sizes of specific vulnerable child populations in Germany/Baden-Württemberg.

Vulnerable child populations	% of child population (total number)	Age-range	Reference period	Data-collection
Children living in poverty	12	0-17	2006	EU SILC
Homeless children	0	0-17	2007	BW ⁷
Early school leavers ¹	4.5		2003	BW ⁷
Youth unemployment	11.2 13	15-25 15-25	2004 2004	BW ¹ national ⁷

¹Ihle, W., Esser, G., Schmidt, M.H. & Blanz, B. (2000). Prävalenz, Komorbidität und Geschlechtsunterschiede psychischer Störungen vom Grundschul- bis ins frühe Erwachsenenalter. Zeitschrift für Klinische Psychologie und Psychotherapie, 29, 263–275.

²Holtman, M, et al. (2007). Prevalence of the Child Behaviour Checklist-pediatric bipolar disorder phenotype in a German general population sample. Bipolar Disorders, 9, 895-900.

³Brunner, R., Parzer, P., Haffner, J., Steen, R., Roos, J., Klett, M. & Resch, F. (2007). Prevalence and Psychological Correlates of Occasional and Repetitive Deliberate Self-harm in Adolescents. Archives of Pediatrics & Adolescent Medicine, 161(7), 641-649.

⁴Baumann, L. (2004). Selbsttötungen in Baden-Württemberg und im übrigen Bundesgebiet. Statistisches Monatsheft Baden-Württemberg 3.

⁵Wittchen, H.-U., Nelson, C.B. & Lachner, G. (1998). Prevalence of mental disorders and psychosocial impairments in adolescents and young adults. Psychological Medicine, 28, 109-126.

⁶Without at least elementary school graduation. S

⁷tatistisches Landesamt Baden-Württemberg

2.3. Positive child and adolescent mental health

Table 3 presents available national data on prevalence rates for aspects of positive mental health, including resilience factors, family environment and social support. To our knowledge corresponding data is not available for Baden-Württemberg.

Source: Erhart et al. (2007). Der Kinder- und Jugendgesundheitsurvey (KIGGS): Risiken und Ressourcen für die psychische Entwicklung von Kindern und Jugendlichen. Bundesgesundheitsblatt – Gesundheitsschutz – Gesundheitsforschung 50, 800-809.

3. Actions for promotion and prevention in mental health

In Baden-Württemberg, programmes in the field of child and adolescent mental health are not planned separately from other programmes concerning children and adolescents. All programmes are recorded in the annual plans of the ministry of social affairs according to specific legal foundations or laws. The annual plan referring to the situation of children and adolescents in the state of Baden-Württemberg is the “state’s youth plan” based on the “child and youth welfare law for the state of Baden-Württemberg”.

The choice of certain programmes and allocation of funds is based on a special survey (“the youth welfare report”). A number of programmes related to CAMH are described below.

3.1. Policies and programmes for CAMH

Examples of large scale programmes

(1) PARENTING SUPPORT PROVISION

Introduction of the state’s youth plan of the ministry in Baden-Württemberg:

The purpose of child and family politics of the country during the current legislative period is the development of all child friendly activities with the objective of becoming the “The Child-friendly State of Baden-Württemberg”. Here, the essential key activities are:

- the guarantee of parents’ grant provision, effective from 2007;
- the transformation of the child-rearing benefit programme following the introduction of the parents’ grant;
- strengthening the capacity for parental education; and,
- strengthening the support of child care in application of the day care law

Starting in 2007/2008, the country will probably provide a total of approx. 125 million Euros each year for

Table 3. Positive child and adolescent mental health in Germany by sex

Positive child and adolescent mental health	Prevalence (%)	Age range	Instrument	Year of data collection
Resilience (without pathological finding)	♂ 81,7 ♀ 77,8	11-17	KIGGS	2003-2006
Family environment (without pathological finding)	♂ 81,1 ♀ 77,6	11-17	KIGGS	2003-2006
Social support (without pathological finding)	♂ 71,7 ♀ 85,1	11-17	KIGGS	2003-2006

immediate financial aid to families (e.g. for education, the advance of alimony, the multiple birth programme). In addition, there will be substantial expenditure on the appropriate infrastructure for families. Of particular importance is the provision of kindergartens, family homes, support to enable offers of family education and the support of advice centres, as well as other measures to support pro-family and pro-child living conditions. With the introduction of the parents’ grant, paid by the state, for births from 2007 onwards, the state bank will pay out in parallel the national funds for education and the parents’ grant for 2007 and 2008.

In the area of the parental support there are many measures and projects. In the following section a small range of projects are presented:

Project “Good start into child’s life”

This is a model project for the German States of Baden-Württemberg, Bayern, Rhineland-Palatinate and Thuringia with federal centralised evaluation. Coordination and implementation in Baden-Württemberg take place in the Department of Child and Adolescent Psychiatry and Psychotherapy of the University of Ulm.

The main objective of the project is to promote and strengthen the relationship and educational competence of parents, in order to effectively prevent neglect and danger to children’s welfare in the early years.

The most important basis of the model project is the conviction that successful child protection must be established in an interdisciplinary way and can only be sensibly and effectively designed on the basis of existing resources and control structures.

Project “Strength”

The programme “strength” (“STÄRKE”) has the goal to strengthen children and to promote healthy development by strengthening children’s auto-education. The programme is carried out by the municipal association for adolescence and social affairs. Further partners are the youth welfare departments of the municipalities, parental networks and the government of Baden-Württemberg, under the leadership of the federal ministry for labour and social affairs.

Pilot-Project „Counselling in prenatal diagnostics“

The purpose of this model project is to improve the information provided to pregnant women before the beginning of prenatal diagnostic examinations, as well as the inter-professional cooperation in the context of prenatal diagnosis. To achieve this goal, the already existing consultation activity is intensified in eight model locations in Baden-Württemberg, and cooperation is developed between medical and psychosocial professionals. The Institute of Psychosomatic Cooperation Research and Family Therapy, Centre for Psychosocial Medicine, University of Heidelberg has taken over the accompanying research. The promotive measures carried out at the model locations are continuously evaluated; their success is being assessed using pre- and post-measurements.

(2) TO PREVENT VIOLENCE AND AGGRESSION

There are numerous projects in the state of Baden-Württemberg, as well as in Germany as a whole, which are aimed directly at preventing violence against children and adolescents. In Baden-Württemberg there are associations explicitly devoted to this subject. For instance, there is an association founded in Heidelberg in 1999 called "Safe Heidelberg" ("SicherHeid"; www.sicherheit.de), whose board of directors consists of representatives of the town, the police department and schools. For 10 years, there has been a prevention association of the criminal management in the Rhine-Neckar-Region (www.praevention-rhein-neckar.de).

Some research establishments also specialise in the subject of prevention of violence. For different target groups, a few research projects of the Centre for Psychosocial Medicine of the University of Heidelberg, together with both associations mentioned above, will be detailed below.

Kindergarten-Project „I like myself – I am brave“

This project, aimed at the prevention of violence in kindergartens, was initiated in 2003 and is supported by the association "Safe Heidelberg" (SicherHeid) and the municipal criminal prevention in the Rhine-Neckar-Region

It is based on 4 major building blocks:

1. "I like myself" - strengthening of self-confidence
2. "I have friends" - experiencing myself and others, building up of relationships
3. "I can show emotions" - what can I do if I am furious
4. "Create rooms" - rooms can calm you down, interior design against anger

The programme is based on a close cooperation with the parents as well as with schools and adolescents' centres.

"Faustlos"-Programme for kindergartens, elementary and secondary schools

"Faustlos" is a curriculum developed for schools and kindergartens to promote social-emotional competence and to prevent aggressive behaviour. It is the German version of the American programme "Second Step", developed by the Institute of Psychosomatic Cooperation

Research and Family Therapy, University of Heidelberg, and is academically evaluated there. With more than 8.000 institutions all over the country and also in Austria, Switzerland, Luxemburg and Italy it represents a set component of the educational work. The curricula, which are developmentally appropriate for different ages, provide social-emotional competence in the areas of empathy, impulse control and dealing with annoyance and anger in order to prevent aggressive behaviour.

The Heidelberg prevention centre which offers the schooling for the programme also offers seminars for teachers and educators as well as for parents to promote relationship and communicative competence.

School-Project "Classes without violence"

This pilot project, initiated by the prevention association of the criminal management was carried out in 1998/1999 in an elementary school in Baden-Württemberg with scientific steering. Goals of this project were: Conveying of social competence, promoting self-perception of aggression, competence in handling conflicts between other pupils in a pacifying way. With a methodical-didactic teaching concept, orientated towards a target group, and variable teaching content, complemented by other project modules, a positive behavioural influence was achieved with the students of class 8a. According to a study carried out in the advanced technical college for police in Villingen-Schwenningen, the positive effects of the project can still be seen 5 years after the end of the project.

Project "Coolness training for adolescents"

The project "Coolnesstraining" is offered by the association "Safe Heidelberg" (SicherHeid) in a close cooperation and coordination with the child and youth welfare department and the society for conflict management. It is directed at young people who have become obstructive in their social environment, connecting with violent offences and who run the risk of getting socially marginalised.

Goals of the project are:

- improvement of the capacity for action in conflict situations
- improvement of social competence
- promotion of de-escalating behaviour
- prevention of violence and intervention of violence

Methods: Rules of directives are studied by the way of interactive role plays and exercises, which are immediately reflected by the trainers.

Other general policies related to CAMH

As already described in the introduction, youth welfare is a special institution dealing with all psychosocial questions concerning children and adolescents in Baden-Württemberg, as well as all over Germany. In the State's Youth Plan the political measures are described in detail. The "child and youth welfare law" represents the juridical basis of this plan. The main purpose of this

law is to create a positive life environment for children and adolescents, to support their development of independent personalities and, through this, their capability to participate in their community.

Therefore, there are agreed aims, measures and juridical regulations, which refer to all relevant subject areas, e.g. toddler care, child care, adoption, fostering policies, divorce and custody policies.

A few notable and exemplary policies on the subjects of poverty and child care are detailed below:

Poverty, social inclusion and social welfare

The overall objective of the Government's policy on children and adolescents is to give equal opportunities, services and developmental opportunities, independent of social background and geographical location.

Measures implemented were:

- The child-raising benefit of the country: This is paid in addition to child benefit and other family-political benefits and in addition to the parents' grant. This benefit gives immediate financial support to families.
- Multiple-birth-programme: Families with multiple-births (triplets or more) receive a one-off benefit of 2500€ per family from the State of Baden-Württemberg in addition to the usual child-rearing benefit of the state and the country, in order to reduce the various burdens placed on a family after a multiple birth.
- Country endowment "family in need": The job of the endowment is to give quick and adaptable financial support to families or single or expectant mothers who are in need of additional help. Since setting up the endowment system in 1980, approximately 15 000 families have been supported, accounting for spending of 21 million Euros.
- Advance alimony law: This law supports single parents if the other parent, whom the child does not live with, fails or does not completely follow their obligation of maintenance.

Child care/ protection

The State's youth plan of Baden-Württemberg explains: The importance of lawful, pedagogic and structural protection of children and young people is increasing. In particular, against a background of expanding media offers, there is an increasing need for protective measures for children, as well as the prevention of their problematic contact with legal and illegal psychoactive substances. Additionally, the pushing through of children's rights, measures to prevent violence, intermediation of intercultural competence and the support of healthy consumer behaviour, appropriate to age, are duties of the child-welfare system.

Regarding child care, day facilities for children represent an especially important form of support for youth welfare. Their importance regarding the upbringing and education of children is thought to be crucial because of their role in complementing family education and also due to their extraordinarily broad effect. The creation

of enough child-care facilities is a priority in the state of Baden-Württemberg. With an offer of approximately 400,000 kindergarten places, full care for all children is achieved in this central youth welfare area. In future, it is a matter of keeping the situation permanently at this level, of further adapting the operating forms of facilities to the needs of the parents and children, and of continuing to improve the quality of the facilities.

Another important goal in Baden-Württemberg is a dovetailing of kindergarten and elementary school, where both sides form a team around every child to support him or her - together with the parents - in a direct and individual way. In this way, Baden-Württemberg promotes the school ability of children in the year before enrolment in elementary school with the plan "school-ready child". With this plan Baden-Württemberg strictly pursues the ideology of prevention over rehabilitation. The goal is the prevention of postponement and school failure through intensive company and support.

Programmes

The goal setting gives rise to various political measures, support programmes and studies. Two of these programmes are described below, one for each of the subject areas: "education and school programmes" and "urbanization policies".

Education and school programmes

As described above, one of the big challenges for the development of the health system for children and adolescents is the improvement of the interlinking between the facilities involved. Two cooperation projects are described, in which the differences between of youth welfare measures and medical doctrine were put aside; and so offices, schools, politicians, doctors and scientists pooled their competence.

Study on the life-situation and risk behaviour of adolescents in Heidelberg

This study comprises a survey of pupils in grade 9 of all schools in Heidelberg and the Rhine-Neckar-Region (in 2004-2005), in which 5832 adolescents and 3413 parents took part. The study was initiated by the health centre of the Rhine-Neckar-Region and the Department of Child and Adolescent Psychiatry, University of Heidelberg, and has been developed in close cooperation with the Teacher-Training College at the University of Heidelberg.

It was supported by the child office and youth welfare department of the city of Heidelberg and received financial support from the medical faculty, the city of Heidelberg and the health centre, as well as from the charitable foundation "Lautenschläger-Stiftung". The study aims to be an example of "activating" health reporting to show and put into practice support possibilities for the physical and mental health of children and adolescents. The study also shows, for example, that a not unimportant proportion of adolescents report being exposed to multiple risks and dangers. Connections exist between the regular consumption of addictive drugs (tobacco, alcohol, and illegal drugs), self-destructive behaviour and other problem. Fifteen percent of boys

and 10 percent of girls had already come into contact with illegal drugs at this age of 15 years.

Students who consume alcohol or drugs several times a week and who smoke regularly, experience less success at school and show clearly more social and psychological problems, including attempted suicides. One in five girls has experienced serious self-harm (above incidences of cutting themselves). According to self-report, 16% of the grade 9 students smoke daily.

Milestones on the way to help-measures have already been reached: The establishment of "social work in schools" (described below) in secondary modern schools in Heidelberg was one of several projects which arose from the study.

Project "Social work in schools"

In 2002 the city of Heidelberg introduced school social work for three years in all 11 secondary modern schools and special schools. The project has now been extended for 3 more years. The challenge of this school social work is to prevent the exclusion of children and adolescents on account of social disadvantage or individual interferences, and to effectively support their integration at school and in the social sphere. The project represents collaboration between schools, the state (local) school office, the youth welfare system, represented by the "child office and youth welfare department" of the town, child and adolescent psychiatrists, as a scientific accompaniment of the project, and the employment institutions of the school social workers.

The results of the first two years clearly show that the "school social work" has succeeded in making contact with the target group, namely the students with behavioural and academic problems. At school, it appears that since the beginning of the "school social work" project, fewer long-term education measures have been needed and the students, teachers, school principals and parents say

that the project has had a positive influence on levels of violence at school.

Urbanisation policies

Project „The family friendly community“

The German state hopes to include local authorities as important partners in the development of child- and family-friendly policy and support. The genetic family research Baden-Württemberg in the state office has, by order of the ministry for labour and social affairs, created an offer of information and communication affairs on the subject of family-friendliness in local authority districts.

The Internet website⁸ reaches 90% of the Baden-Württemberg local authority districts. It illustrates the spectrum of many successful activities in the municipalities, towns and regions, which have a positive influence on family life. By highlighting examples of practice, info letters and subject-specific reports (e.g., "practical knowledge of family friendliness") the initiative stimulates imitation and offers comprehensive information, developments in family policy and results from research.

Ombudsman for children and adolescents

In Baden-Württemberg there is no ombudsman for questions related to child and adolescent mental health. Indeed, a children's commission exists on the level of the German Bundestag since 1988. This working group consisting of members from many target groups (committee for family, seniors, women and young people) is especially concerned with political issues affecting children. It is the highest parliamentary and extra-parliamentary representation of the interests of children and adolescents.

3.2. Availability of programmes for CAMH promotion and mental disorder prevention

Table 4. Estimation of the availability of programmes related to CAMH

	0%	1-25%	26-50%	51-75%	76-100%
Home-based for infants		x			
Home-based for children		x			
Parenting programmes (general population)					
Parenting programmes (specified at risk population)				x	x
School mental health promotion (e.g. teaching well-being life skills)		x			
School targeted preventive programmes (e.g. anti-bullying)			x		
Drug and alcohol abuse prevention			x		
Promotion/prevention at hospital/clinic		x			
In Churches, clubs, recreation centres		x			
Promotion/prevention via Internet		x			
Protective services					x
Community settings					x
Telephone counselling					x

In Germany there are several programmes concerned with child and adolescent mental health both on a national and regional level. As far as Baden-Württemberg is concerned inter- and intra-regional programmes can be distinguished, with intra-regional programmes being developed and implemented only in one community. Consequently, it is not possible to give exact numbers for the availability of such programmes.

4. Organisation and resources for implementation

4.1. Institutions and organisations

In Baden-Württemberg programmes are implemented on different levels and with the participation of different governmental and non-governmental institutions. The governmental departments, several offices (e.g. youth welfare office, health office), political networks, foundations as well as universities are involved in the development and evaluation of specific programmes with the help of different funds. Organisations which are

often involved in the implementation of programmes can be found below:

- Bundesministerium für Familie, Senioren, Frauen und Jugend (national)⁹
- Ministerium für Arbeit und Soziales (Baden-Württemberg, regional)¹⁰
- Ministerium für Kultur, Jugend und Sport (Baden-Württemberg, regional)¹¹
- Deutscher Kinderschutzbund e.V.¹²
- Bundesarbeitsgemeinschaft der Kinderschutzzentren e.V.¹³
- Liga für das Kind¹⁴
- Landesverband Hochbegabung Baden-Württemberg e.V.¹⁵
- Deutsche Arbeitsgemeinschaft für Jugend- und Eheberatung e. V. (DAJEB)¹⁶

4.2. Services

Availability of services

The table below presents an approximate indication of access to therapeutic services for Baden-Württemberg. Data on access to specific types of therapy is not available, to the best of our knowledge.

Table 5. Availability of services in Baden-Württemberg

	0%	1-25%	26-50%	51-75%	76-100%
Child psychiatrist appointments					x
Psychologist appointments					x
Social service appointments/ child protection					x
Family therapy/ counselling					x
Adolescent-specific services/outpatient centres					x
Group therapy				x	
School counselling				x	
Pharmacological treatment					x
Psychological rehabilitation centres for adolescents				x	
In-patient beds on child psychiatric ward					x
In-patient beds on general psychiatric ward					x
In-patient beds on general psychiatric ward					x

As the data shows, services are widely available and accessible in the area, with all but three types of services (group therapy, school counselling and Psychological rehabilitation centres for adolescents) being 76-100% available.

Access to specially designated mental health services

There are several programmes (e.g. prevention of violence in schools) aimed at specific target groups. However there are no mental health services specifically aimed at early school leavers, homeless children or migrants as health care for these groups is included in

⁹<http://www.bmfsfj.de/>

¹⁰<http://www.sm.baden-wuerttemberg.de/>

¹¹<http://www.km-bw.de>

¹²http://www.dksb.de/front_content.php

¹³<http://www.kinderschutzzentren.org/>

¹⁴<http://www.liga-kind.de/>

¹⁵<http://www.lvh-bw.de/>

¹⁶<http://www.dajeb.de/>

general child and adolescent health care.

4.3. Funding

Generally speaking, resource allocation in both general and specific areas related to child and adolescents' mental health has increased in Baden-Württemberg and in Germany as a whole.

Resource allocation to evidence-based and community-oriented services has shown a small increase in the past 5 years. The same applies to family-focused services. Furthermore there was a small increase in evidence-based mental health promotion activities as well as in treatment and care in residential institutions.

In Germany funds dedicated to children and adolescents' mental health are identifiable in the national budget. Considering the distribution of funds across CAMH services, most of the money granted is for mental health care (~ 60%). About 30% of the budget is allocated to mental disorder prevention. Consequently, about 10% can be estimated to be spent on mental health promotion.

4.4. Training of the professional workforce

In Baden-Württemberg training in child and adolescent psychiatry and psychotherapy forms a specific part of higher education in the field of general mental health, psychiatry and psychology. This applies to both medical doctors and psychologists. Other professions including social workers or social education workers can take optional courses in issues related to child- and adolescent mental health within their academic studies. For nursing staff there is a recognised professional specialisation in child and adolescent psychiatry, too.

As far as medical doctors are concerned, the title of medical specialist for "Child and Adolescent Psychiatry and Psychotherapy"¹⁷ requires an advanced education (at least 5 years) including specific training in paediatrics and in-patient as well as out-patient child and adolescent psychiatry and psychotherapy. The number of child and adolescent psychiatrists in Germany is steadily increasing with a total number of 1311 of whom 662 work in private practice (data from 2007). Similarly, psychologists need additional training to receive the title "Child and Adolescent Psychotherapist". The total number of child and adolescent psychologists is also increasing and reached a total of 2385 in the year 2007. However, it should be mentioned that the quality of both psychiatric and psychotherapeutic care in Germany is quiet heterogeneous. On the one hand, the state of Baden-Württemberg, and in particular Heidelberg, represent areas with extraordinarily good mental health care. On the other hand states in the north-east of Germany are dramatically short-staffed in terms of experts in child and adolescent psychology, psychiatry and psychotherapy (e.g. Sachsen-Anhalt, Mecklenburg-Vorpommern, Brandenburg).

5. Monitoring and evaluation of the actions for the promotion and prevention in mental health

5.1. Mental health service and care policies evaluated

The majority of the evaluation activities refer to specific programmes related to CAMH. Monitoring and evaluation therefore often involves different authorities, including national and regional governmental authorities and research facilities. A comparison of planning and budget as well as actual spending are given in the state's youth plans and the youth welfare reports of the state of Baden-Württemberg.

In-patient care

In Baden-Württemberg psychiatric care capacity for children and adolescents is currently being increased. On the basis of demand analysis, an increase of 15% in both in-patient and out-patient vacancies has been approved in 2008. Within this context, special attention is drawn to the development of more ambulant and outreach methods (such as "home-treatment") as an alternative to hospitalisation.

5.2. Mental health promotion and mental disorder prevention policies evaluated

Reliable data, illustrating the care situation in the area of the early intervention and prevention has been missing, until quite recently. In 2005, the Federal Centre for Health Education asked the University of Heidelberg (Institute of Psychosomatic Cooperation Research and Family Therapy) and the German Association for Infant Mental Health to close this information gap.

The purposes of the project are the registration of the care situation and the evaluation of quality of care in early interventions and prevention initiatives in Germany. With the help of a questionnaire developed for this purpose, all institutions and registered doctors in private practice in Germany are assessed in terms of the consultation or treatment of parents with infant and toddlers, offering treatment for early diagnosis and prevention of behavioural problems and threats to the parent-child-relationship and attachment.

Frequent problem areas are yelling/acting out, sleeping, feeding, resisting, timidity and restlessness of the child and insecurity, excessive demand and mental illnesses of the parents. The data is currently being evaluated.

¹⁷This title and the corresponding training were established in 1992, based on the regulations placed on further education by the German medical association.

6. Research and dissemination

6.1. Key research projects on CAMH

In Baden-Württemberg a number of research projects dealing with different topics related to CAMH are being conducted. The carrying out of such research projects often involves cooperation of mainstream universities, universities of applied science, research institutes and governmental organisations on regional and or national levels.

The research projects presented below are being conducted within several sub-fields including basic research, care-related issues, and prevention of mental disorders and promotion of mental health.

Some scientific research projects that evaluate policy programmes in the field of CAMH have been being described above in section 3.

Child and adolescent psychiatric disorders

Research on schizophrenia in children and adolescents
The early recognition and treatment of schizophrenia in children and adolescents is one of the most important therapeutic goals because of the postulated relation between delayed initiation of treatment and an unfavourable developmental course of illness. The duration of untreated psychosis seems to be significantly prolonged in adolescents compared with adults due to both a protracted development of psychotic features and the failure of families and health workers to take the initial signs of psychosis seriously.

Therefore research is aimed at a better understanding of different pathogenetic factors of schizophrenic disorders. Furthermore, studies deal with the assets and drawbacks of early detection and intervention in psychosis. In this context, special features and problems of pharmacological treatments for children and adolescents are also of importance. Corresponding research projects have been conducted in Heidelberg¹⁸, Mannheim¹⁹ and Ulm²⁰.

Project "IMAGEN²¹ Reinforcement-related behaviour in normal brain function and psychopathology (a psychometric prestudy)"

IMAGEN is an EU-financed project with Kings' College London as coordinating centre and the child and adolescent psychiatric centres in Heidelberg und Mannheim as partners for Germany. The project explores

mental health and risk-taking behaviour in adolescents in Europe. A total of 2000 adolescents will be investigated in a multicentre study conducted simultaneously in Germany, Great Britain, France and Ireland. The project uses state of the art technologies (fMRI, genetic analysis, questionnaires) and combines the research methodologies of medicine, psychology, physics and biology in order to comprehensively investigate the development of human behaviour. The aim of the project is to identify neurobiological and genetic factors shaping psychological experience and behaviour, with special reference to risk-taking behaviour. Hopefully this knowledge will help to prevent mental disorders and improve their treatment.

Care related issues

Study "Case management in child abuse²²"

In this study the Child and Adolescent Psychiatry of the University of Ulm evaluates the effects of expert-assisted management for cases of child abuse and neglect in the German child welfare and healthcare system, as perceived by the case workers themselves. Important conclusions drawn from the study can be summarised as follows: Expert-assisted case management may change the case workers' perception of the evidence for abuse and guide their interventions to provide better child protection. However, modifications of the method should consider improved participation of the child.

Project "INTACT: Individually tailored stepped care for women with eating disorders (www.intact-rtn.eu)"

INTACT is an ongoing multi-disciplinary and inter-sectoral network of 9 European partners which aims to address the challenge of developing new strategies for the prevention and treatment of eating disorders (2007-2011). The 9 network partners (Charles University of Prague (CZ), Universitaire de Saint Etienne (F), King's College London (UK), Semmelweis-University of Budapest (HU), Med. Centre Univ. Utrecht (NL), Minho Univ. Braga (PT), NetUnion Lausanne (CH), Univ. Genève (CH)) and the University of Heidelberg, as coordinating centre, represent a broad spectrum of disciplines (e.g. clinical psychology, psychiatry, social sciences, and genetics) reflecting the multiplicity of factors determining eating disorders. The INTACT network will research and develop innovative strategies and novel e-health tools for the optimisation of health care in the prevention and treatment of eating disorders, by determining the role of genetic, psychological and sociocultural factors and their

¹⁸Resch, F. (2008). Early recognition and early treatment of schizophrenia: chance or dilemma?

Zeitschrift für Klinische Psychologie, Psychopathologie und Psychotherapie, 36(4), 235-244.

Resch, F. (1994). Psychotherapeutic and sociotherapeutic approaches in children and adolescents with schizophrenia. *Zeitschrift für Kinder- und Jugendpsychiatrie und Psychotherapie*, 22(4), 275-284.

¹⁹Early detection and intervention in psychosis, Section Symposium. 10th Congress of the Association of European Psychiatrists, Prag, 28.10.-1.11.2000

²⁰Fegert, J. M. (2002). Ethical and legal Problems in Treating Schizophrenic Patients with Neuroleptics during Childhood and Adolescence. *Child and Adolescent Psychopharmacology News*, 8(4):5.

²¹Reference only in German: http://www.imagen-info.com/mannheim/unser_forschungszentrum

²²Goldbeck, L., Laib-Koehnemund, A. & Fegert, J. M. (2007). A randomized controlled trial of consensus-based child abuse case management. *Child Abuse & Neglect*, 31 (9), 919-933.

interaction. Not all women at risk for eating disorders actually develop the disorder and not all of those who fall ill need the same type and intensity of care. INTACT will innovate by developing individually tailored treatment and stepped care interventions based on research into the process of getting ill, getting well and staying well.

Prevention of mental disorders and promotion of mental health

Project "Saving young lives in Europe (SAYLE)"

SAYLE is a health promoting programme for adolescents in European schools. Its main objectives are to lead adolescents to better health by decreasing risk-taking and suicidal behaviours, to evaluate outcomes of different preventive programmes and to recommend effective culturally adjusted models for promoting health of adolescents in different European countries. In Germany research is coordinated, carried out and evaluated in Baden-Württemberg in the Department of Child and Adolescent Psychiatry, University of Heidelberg.

Project "Mannheim study of risk children (MARC)"²³

The "Mannheim Study of Risk Children" (MARC) carried out by the Zentralinstitut für Seelische Gesundheit Mannheim follows a cohort of children at risk for later psychopathology born 1986-88 from birth to adolescence with assessments at the ages of 3 mo., 2, 4.5, 8, and 11 years. A new wave of research with the cohort at 15 years of age is currently under way.

The research focuses on factors that determine the origin and course of mental disorders during childhood in order to facilitate the possibilities of prevention, early recognition, and early treatment. In addition to factors impeding development (risk and stress factors) factors promoting healthy development (resources and competences) are also being studied. The unique feature of this research is the combination of epidemiological methods with paradigms from developmental psychology (transactional models, behavioural observation) and approaches from basic neuroscience (molecular genetics, neurochemistry, neurophysiology).

6.2. Main bodies involved in information dissemination to keep health care professionals informed

There are different bodies involved in the dissemination of information about children's and adolescents' mental health care, promotion and prevention. In addition to governmental institutions (e.g.: Federal ministry of family, seniors, women and youth; Ministry of social affairs) several political and scientific networks are engaged.

Political networks are involved in information dissemination both on a national (e.g.: "Liga für das Kind"²⁴) and regional level (e.g.: "Stiftung Kinderland"²⁵). Regarding scientific networks, information dissemination is provided by organisations, journals and conferences. The most important scientific organisations in Germany are the DGKJP²⁶ and the BKJPP²⁷. Both are mainly involved in providing up-to-date guidelines for the diagnosis and therapy of disorders. Additional work includes editing journals and providing information about conferences (e.g.: the Conference on Psychotherapy of Children and Adolescents in Heidelberg) and further training. Important journals dedicated to child and adolescent psychiatry are the "Zeitschrift für Kinder- und Jugendpsychiatrie", "Praxis der Kinderpsychologie und Kinderpsychiatrie" and "Forum der Kinder- und Jugendpsychiatrie und Psychotherapie". These Journals mainly contain contributions from research and practice dealing with developmental disorders of children and adolescents as well as therapeutic interventions.

7. Challenges, opportunities and advances in the field

7.1. Key recent advances, barriers or issues in CAMH care

As explained earlier, the CAMH care situation is found to be very good in Germany. Key recent advances in Baden-Württemberg are related to the goals of the state's youth plan (see presentation in chapter 5) and various measures and projects carried out in the child and adolescent area, some of which have been described in this chapter.

An essential challenge for future development is to link the different offers, measures and facilities better with each other and to coordinate and to integrate them in a comprehensive way across work-settings and sectors. As key recent advances in Baden-Württemberg, the CAMHEE expert group looks at the first attempts to establish cooperating projects and structures. Two examples deserve to be mentioned in particular:

Transregio-Centre of Competence in Baden-Württemberg
The Transregio-Centre was developed through the participation of three child- and adolescent-psychiatric university hospitals in the state of Baden-Württemberg (Heidelberg, Mannheim and Ulm) in 2007. The purpose of this collaboration is to create a common platform in the scientific field which allows an exchange in the main research focus areas, to make the coordination and realisation of shared practice and research projects in CAMH easier.

²³<http://www.zi-mannheim.de/941.html>

²⁴<http://liga-kind.de/>

²⁵<http://www.stiftung-kinderland.de/>

²⁶German Organisation for Child and Adolescent Psychiatry and Psychotherapy <http://www.dgkjp.de/>

²⁷Association for Child and Adolescent Psychiatry, Psychosomatic Medicine, Psychotherapy in Germany <http://www.bkjpp.de/>

The Early Intervention Centre for Adolescents and Young Adults in Heidelberg²⁸

Departments of Child and Adolescent Psychiatry and Adult Psychiatry together set up a specialised ward for adolescents and young adults (12-28 years) to overcome the barrier of an 18 year cut off point between both disciplines. The patients receive attention and treatment based jointly on evidence-based guidelines of both child and adult psychiatry. This cooperative ward was established in 2003 and the experience shows that the problems that accompany the strict separation of these disciplines can be decreased with such an initiative. The Heidelberger Early Intervention Centre offers multidisciplinary treatment for adolescent patients with a comprehensive pattern of care, tailored to the requirements of this critical phase of life.

Overcoming the segregation of the youth welfare service from health care is fundamental to improve the interlinking of the services offered. The first cooperation projects have already been set up (see above), and further projects are desirable.

The second challenge, from the point of view of the authoring group, is the differentiation, development and adaptation of the provision of treatment to the changing needs and problem areas in CAMH. Data tends to show that in Baden-Württemberg, as in Germany as a whole, there is an increase in more serious illnesses in field of child and adolescent mental health.

One recent key advance in Baden-Württemberg should be mentioned:

Increase in inpatient beds in Baden-Württemberg in 2008

The Ministry of Social Affairs decided last year to increase the inpatient beds in CAMH. The background for this measure was, above all, that the number of children and adolescents with serious, long-term treatment requirements has risen during recent years.

The Department of Child and Adolescent Psychiatry, University Hospital of Heidelberg, for example, was extended from 5 beds to a total of 22 beds. Therefore, it was possible to establish a new special ward for adolescents with severe personality development disorders. The new ward STEP integrates a psychotherapeutic setting with one for interventions during mental crises.

The third challenge in Germany, from the point of view of the experts' group, is the reversal of the municipalisation and the reorganisation of the youth welfare system.

At the moment, this challenge presents the biggest barriers: The youth welfare system is anchored at the regional level. Through this municipalisation, a very heterogeneous distribution of financial resources is available for CAMH care. In particular, in the relatively poor municipalities there is a greater need of youth welfare, due to the higher incidence of criminal

activity and social problems. But it is precisely in these municipalities that the available budget is often smaller.

In this context it should be mentioned, again, that the state of Baden-Württemberg is one the best supplied federal states, and perhaps even the best supplied state in Germany.

7.2. The key recent advances, barriers or issues within CAMH prevention and promotion

Many of the above mentioned issues also apply to prevention and promotion, and numerous activities in this area have been described in detail in the previous sections.

At this point we would like to point out three achievements which refer to Germany as a whole:

The National Centre for Early Intervention

The National Centre for Early Intervention was founded in 2007 by the Federal Centre for Health Education (BZgA) and the German Youth Institute (DJI). The centre supports the practice of recognising family exposure to risks earlier and more effectively to provide appropriate offers of support. Children should be better protected against dangers by highly effective combination of aid from the health service and the child and youth welfare. To achieve this, the accessibility of risk groups, in particular, must be improved. The first measures are, among other things, the development of a knowledge platform which contains information about the models used up to now and about current practice, as well as the announcement of co-operative research projects.

This common sponsorship is an example of the exemplary development of multi-professional cooperation in the work-field of early help.

KiGGS - The German Health Interview and Examination Survey for Children and Adolescents (2006) (www.kiggs.de)

At the beginning of the new millenium, no representative data on the health and development of children and adolescents in Germany was available. Therefore, the German Federal Ministry of Health commissioned the Robert Koch Institute to design and conduct a nationwide study into the health of the younger generation.

The KiGGS study was designed as a comprehensive, nation-wide, representative interview and examination survey for the age group 0-17 years. Between May 2003 and May 2006, a total of 17,641 participants from 167 communities were enrolled.

The overall objective of the study is to obtain main indicators of physical and mental health, risk factors, health service utilisation, health-relevant behaviour and living conditions in children and adolescents. The study consisted of the KiGGS core survey and five modules carried out with subsamples of KiGGS participants

²⁸Weisbrod, M., Koch, E., Eichstädter, R., Resch, F. & Mundt, C. (2005): Das Heidelberger Frühbehandlungszentrum. Die gemeinsame Behandlung von adoleszenten Patienten durch Allgemeine und Kinder- und Jugendpsychiatrie. Psychotherapie im Dialog 6(3), 314-317.

focussing on mental health, environmental exposures, motor fitness, and nutrition, respectively.²⁹

The Mental Health Module (BELLA) aims to obtain data on mental health problems in children and adolescents and to identify determinants of mental health in different phases of development. Methods and results of the BELLA study have been widely published, e.g. referring to the overall prevalence of mental health problems among children and adolescents in Germany, to specific disorders as self-mutilation and suicidal behaviour or to attention deficit-/hyperactivity disorder.³⁰

Initial results of the KIGGS study have been presented at a public symposium held on 25th September 2006 in Berlin. Approximately 500 representatives of the scientific community, the public health service, health politics, the media and the general public registered for this event.

7.3. Difficulties and proposals for further development

One important precondition for the improvement of child and adolescent mental health in Baden-Württemberg is the improved integration of relevant bodies within the health care system. In this context, improved cooperation between child and adolescent and adult psychiatry is considered to be an important first step.

Moreover, the more systematic and sustainable implementation of available programmes would further promote child and adolescent mental health care.

8. Summary and conclusions

Germany is advanced in the development of the areas of social and medical support, the recovery and preservation of child and adolescent mental health. Baden-Württemberg stands out positively in Germany. The special status of Baden-Württemberg is not only reflected in the care, but also in the areas of economy (low unemployment) and education (5 universities with medical faculties: Freiburg, Heidelberg, Mannheim, Tübingen and Ulm).

However, the lack of integration of youth welfare and medical basic care is still to be criticised, in spite of some progress in this area. Duties of the youth welfare system include consultation, prevention and social work. Quite independently, basic medical care is guaranteed by family doctors, pediatricians and child and youth psychiatrists or psychologists. Consequently, the lack of coordination and interlinking between these areas is the central challenge for the improvement of care for children and adolescents in the state of Baden-Württemberg and Germany.

²⁹More information about study design and methods is given in an article published in BioMed Central Public Health in June 2008: <http://www.biomedcentral.com/1471-2458/8/196>

³⁰Publications on the Bella study are listed: <http://www.kiggs.de/service/english/index.html>

GREECE

Prepared by Gerasimos Kolaitis, Constantinos Fyssas and John Tsiantis

1. Introduction

1.1. Policy at a glance

The main aims of the EU regarding Mental Health are: prevention, care and therapeutic intervention, promotion and awareness, actions against stigmatization.

European actions are developed for better parenting skills, supporting the development of social cohesion, social integration, supporting human rights, and acceptance of difference.

The Greek Ministry of Health and Social Solidarity is responsible for allocating budgets for Mental Health, in line with the aforementioned interventions and guidelines. The national budget for Child and Adolescent Mental Health does not constitute a separate budget, but is part of the overall Mental Health budget.

Non-governmental organisations (NGOs) design and implement mental health projects and services. Most of the services are “relief-oriented” although some are “development-oriented”.

The Government provides less funding for Mental Health compared with General Health and, in fact, there is an even smaller amount of funding available for Child and Adolescent Mental Health.

Unlike most countries, Greece lacks appropriate policies. Consequently, services do not form part of a system, and are therefore quite restricted and face difficulties when there is a need to incorporate new knowledge in a systematic way.

On the whole, parliamentary laws and ratification of European laws constitute policies.

Out of the 54 prefectures, 20 prefectures are without Mental Health services for children and adolescents while the rest of them occupy less staff than is required.

Recently, a major cut in funding, around 40%, took place which threatens many current services with closure. Some of these services (day centres, hostels for adolescents with Mental Health difficulties, services for autistic children etc.) are being pioneered in Greece. Apart from the funding cuts mentioned above, there is also lack of collaboration and co-ordination between ministries, government organisations, and NGOs, which is a major issue.

Child and Adolescent Mental Health services would be dramatically improved if the following were to take place: a) more funding available, b) better education of Mental Health specialists in all areas, c) monitoring and

evaluating services, d) better coordination between organisations, and e) development of relevant policies and laws.

1.2. Process to prepare the country story

Preparation of this country story included consultation of the following experts in child and adolescent mental health:

- Gerasimos Kolaitis, Assistant Professor of Child and Adolescent Psychiatry, Dept of Child Psychiatry, Athens University Medical School
- Sofia Theodoridou, Deputy Director, Ministry of Education, Department of Health Promotion
- Eleni Petridou, Centre Director and Professor, Centre for Research and Prevention of Injuries
- Constantinos Fissas, Scientific collaborator, Athens University Medical School, Dept of Child Psychiatry
- Dimitrios Georgiadis, President, Hellenic Society of Child and Adolescent Psychiatry
- Harisios Asimopoulos, Programmes coordinator, Association for the Psychosocial Health of Children and Adolescents
-

The questionnaire was circulated and face-to-face assistance was provided by Constantinos Fissas.

2. What we know about children and adolescents in Greece and their Mental Health

2.1. Prevalence of mental disorders in children and adolescents

No reliable data on prevalence is available at the regional or national level. The Ministry of Health and Social Solidarity is in the process of conducting an epidemiological study and collect prevalence data on Mental Health.

2.2. Vulnerable child population

It has been estimated that 20.5% of children in Greece are living in poverty and 5.800 children are homeless. About 13% of children are early school leavers: leaving school between the ages of 6 to 17 years old. Between 15% and 25% of schoolchildren have experienced bullying in school. According to data provided by the ministry of justice in 2007, 447 children were in detention.

2.3. Positive child and adolescent Mental Health

There is no available data on positive child and adolescent health in Greece.

3. Actions for promotion and prevention in Mental Health

3.1. Policies and programs for CAMH

3.1.1. Specific policies and large-scale programs for CAMH

Several large-scale programmes have been established in Greece relating to child and adolescent mental health:

Parenting and community training: Since 2006, the Ministry of Education and Religious Affairs runs programmes of briefing and sensitization for parents and programs of training and educating the community. Special training material has been developed for the personnel immediately involved in instructing on these programmes, as well as the creation of special educational material for apprenticeship.

Help-line for children and adolescents: The Association for the Psychosocial Health of Children and Adolescents (A.P.H.C.A.) has established a telephone line for the mental health of children and adolescents. This help-line functions under the operational programme "Health Providence 2000 - 2006" with co-financing at 80% from the European Social Fund.

The Daphne II Programme has the goal of combating violence against children, young people and women (2004-2008). It aims to support organisations that

develop measures and action to prevent or to combat all types of violence against children, young people and women, and to protect the victims and groups at risk.

Needs assessment and awareness-raising interventions on bullying in Schools: The programme has been implemented and co-ordinated by the Association of Psychosocial Health for Children and Adolescents (A.P.H.C.A.) in Greece and three other EU partner countries - Germany, Cyprus and Lithuania. 80% of the programme is co-funded by the European Commission and 20 % by the Greek State: through the Ministry of Health and Social Welfare.

Programme to Reduce Stigma and Discrimination due to Schizophrenia: In 1996, the World Psychiatric Association (WPA) embarked on an International program to Fight the Stigma and Discrimination because of Schizophrenia. The WPA International Programme is designed to dispel the myths and misunderstandings surrounding schizophrenia. Stigma creates a vicious cycle of alienation and discrimination which can lead to social isolation, inability to work, alcohol or drug abuse, homelessness, or excessive institutionalisation, all of which decrease the chance of recovery. The program fights prejudice in all walks of life because it diminishes the quality of life of people with schizophrenia and their families, and prevents them from living and working alongside people without schizophrenia. The WPA program is designed to:

- Increase awareness and knowledge of the nature of schizophrenia and treatment options;
- Improve public attitudes about those who have or have had schizophrenia and their families;
- Generate action to eliminate discrimination and prejudice.

3.1.2. Other general policies related to CAMH

The Deputy Ombudsman for the Department of Children's Rights is Mr. George Moschos. The Greek Ombudsman is by law an Independent Authority, which was set up in 1997, to protect citizens' rights. It is accountable to the Greek Parliament, and its services are free. The post is the highest which specialises for children. The post is the highest which specialises in children's rights.

LAW 2716 - Development and modernisation of Mental Health services and further legislation: The law regulates Units of Mental Health, such as Centres of Mental Health, General purpose centres, Surgeries, Mobile Units, the Psychiatric Departments of General Hospitals for Adults or Children and Adolescents, Psychiatric Clinics of Adults or Children and Adolescents, Psychiatric Institutes of Mental Health, Psychiatric Hospitals, Centres of Specialized Care, Special Centres or the Special Units of Social Rehabilitation and Social Cooperatives of Limited Responsibility.

The Ministry of National Education and Religious Affairs has developed policy for the establishment of consultation centres in order to promote the implementation mental

health programmes. Pilot projects were implemented in schools which studied programmes dealing with Mental Health and interpersonal relationships and educational training for teachers to cope with violence and bullying in schools.

Programmes & Interventions:

Programmes and interventions which have recently or are currently run in Greece include:

- De-institutionalisation and Rehabilitation Programme for the LEROS PIKPA Asylum (1991-1995)
- Counselling Centre for the Mental Health of Children and Adolescents (1995-1999)
- Research - Intervention Programme for the Prevention of Smoking: "Adolescents against cancer" (1995-1996)
- HORIZON Programme "Social Integration of People with Disabilities through Vocational Training and Rehabilitation" (1996-1997)
- "Centre for the Educational and Psychosocial Support of Adolescents" Programme (1998-1999)
- Programme for the Prevention of smoking among adolescents "Action in school" (1998-1999)
- Research - Intervention programme. Mental Health Promotion for Children up to 6 years. Mental Health EUROPE (2000-2001)
- Research - Intervention programme. Mental Health Promotion of Adolescents. Mental Health EUROPE (2000-2001)
- Research - Intervention programme. Mental Health Promotion and Prevention Strategies for Coping with Anxiety and Depression.
- Mental Health EUROPE (2000-2001)

In order to improve Mental Health Promotion in Greece, alongside other European member states, the Department of Psychiatry of Athens University in collaboration with the Section of Primary Care Mental Health, Institute of Psychiatry, University of London, and the Educational Trust for Health Improvement through Cognitive Strategies (E.T.H.I.C.S) started in 2002 to carry out educational programmes targeted at meeting the needs and reflecting the emerging educational principles of Mental Health Promotion. Most of these programmes have been derived from the field of A.P.H (Axiological Promotion of Health), copyrighted by E.T.H.I.C.S -2003, and then adapted to the socio-cultural conditions of the country of implementation (Greece).

For the Academic year 2005 – 2006 the structure and content of the on-going Mental Health Promotion Educational programmes were adapted by Prof. V. Tomaras, Prof. M. Malliori and Lecturer M. Kokkosi, with the coordination of Prof. K. Soldatos, Head of the Psychiatric Department, University of Athens, Eginition

Hospital, Athens. Tutors have been selected among the academic staff of the Department of Psychiatry (Department of Psychiatry of Athens University) and from the broader field of Mental Health experts as well.

Programme "EPICTETUS": Training of health professionals and of community agents on mental health promotion issues and on the development of psychosocial skills, training adolescents and young adults on the development of psychosocial skills, training adolescents in communication skills etc. The training program consisted of topics such as : Skills for the development of positive identity characteristics, Skills for the improvement of adaptation Effective communication skills, skills for the development of creativity, etc.¹

4. Organisation and resources for implementation

4.1. Institutions and organisations

The following institutions and organisations implement programmes on Mental Health promotion and prevention which feature modules or elements of child mental health:

1. Association for the Psychosocial Health of Children and Adolescents
2. Society of social psychiatry and Mental Health
3. To xamogelo tou paidiou
4. Klimaka
5. Scientific Association for regional development and Mental Health
6. University Research institute of Mental Health
7. KETHEA (Therapy Center for dependent individuals)
8. Greek Centre for the Mental Health and therapy of children and families "To perivolaki"
9. E.P.S.Y.P.E.A (Day centre for children with severe developmental disorders)

4.2. Services

A residential care hostel (Melia) is available for a period up to a year for children, aged 5-12 years, whose parents are unable to fulfil their parental role, due to Mental Health problems.

Residential care (Iris) for a period up to 18 months, is available for the treatment and rehabilitation of adolescents with Mental Health problems.²

Day centres, Orionas, provide day treatment and psychosocial rehabilitation activities to adolescents aged 11-16 years with mental health problems.

The daily programme includes the operation of a school

¹ http://www.mentalhealthpromotion.co.uk/10_uk.html

² Association for the Psychosocial Health of Children and Adolescents

programme unit approved by the Ministry of Education, for the educational support of adolescents.

A Counselling Telephone Helpline that offers immediate and anonymous help, support and counselling on issues relating to the Mental Health of children, adolescents and their families. Callers include children, adolescents, parents, educators, health professionals, etc., from the whole Greece.¹

Since 1996, KETHEA (Therapy Centre for Dependent Individuals) developed specialised and long-term programmes to deal with primary prevention of substance abuse. These programs are adjusted to the needs and the special characteristics of those targeted by the programmes, including:

- Training programs for educators (teachers, parents, animators).
- Programmes for organizations and institutions concerned with rearing and socializing children and adolescents.
- Programmes in primary and secondary general and technical education for students, parents and teachers.

The programmes combine elements from various scientific approaches. They give special emphasis to helping children and adolescents develop their social and interpersonal skills, which act as a means of prevention against the development of damaging behaviours, such as addiction. Group work is the main methodological tool, with exercises for the individual's personal development, creative activities, enactment and informative exercises wherever necessary.

A NATIONAL HELP LINE- SOS 1056 is run by the "To xamogelo tou paidiou", which is part of the organisation "Child Helplines International".

Child psychiatric hospital (Attica, Athens):

Community based services (iatropedagogika centres), offer assessment, diagnosis, therapy, interventions, education and hostels for psychosocial rehabilitation. The hospital also offers vocational training.

4.3. Funding

A small increase was reported by many of the Greek respondents to the CAMHEE questionnaire over the last years. Although there is no available data, the wide perception is that the small increase refers to treatment and care in residential institutions. However, over the last year, services suffered major cuts in funding.

Funds dedicated to children and adolescent Mental Health are not identifiable in the national budget.

Most NGOs were reluctant to offer information on budgets.

4.4. Training of professional workforce

Child psychiatry is recognised as an independent field

from general adult psychiatry in Greece.

The training in Child Psychiatry for trainees and specialised doctors includes both theoretical and practical aspects. The practical training aims to give trainees experience in child psychiatric diagnosis, in therapeutic treatment and in bio-psycho-social intervention for children and adolescents. This is achieved through placement of the trainees in the outpatient consultation settings and in-patient units, as well as through their participation in "on call" duties. For trainees, in particular, a training and practice program is established, which consists of their active participation in the department's clinical taskforce. The theoretical training includes clinical and theoretical lectures, interesting case discussions, seminars and journal clubs. It also consists in weekly individual supervision and group supervision on issues of clinical child psychiatry regarding the management and psychotherapeutic treatment of cases. Unfortunately, there is no training in CAMH promotion and prevention issues. Lastly, delays in the establishment of new CAMH departments in the general hospitals creates additional difficulties in the training of Child Psychiatry trainees.

5. Monitoring and evaluation of the actions for the promotion and prevention in Mental Health

The lack of infrastructure and as a result lack of funding leads to actions being implemented without being monitored or evaluated.

6. Research and dissemination

The Ministry of Health and Social Solidarity is in the process of setting up a database to collect epidemiological data. The association for the Psychosocial Health of Children and Adolescents run the project "Daphne Needs Assessment and Awareness Raising program for BULLYING in Schools". The Association is in the process of starting the second phase of the project named Daphne II.

The Association for the Psychosocial Health of Children and Adolescents (A.P.H.C.A.) has established the Telephone Line for the Mental Health of Children and Adolescents. The help line is collecting and analyzing data.

The Association for the Psychosocial Health of Children and Adolescents (A.P.H.C.A.) is one of the first agencies to become active in Greece in the promotion of psychiatric reform and the development of the community care model for the Mental Health of Children and Adolescents.

The Society for Social Psychiatric and Mental Health is a scientific Association, founded in 1981. It has developed a wide network of activities in all sectors that are related to Mental Health and it contributes in

particular to the Psychiatric Reform in our country. The society has established psychiatric mobile units, hostels and day centres, and is actively involved in information dissemination.

Research programmes:

ICARUS PROJECT: European Program supporting Families with a Mentally Ill Parents (1998-2000)

This study represents a cross-country comparison of cooperation between services for community mental health and child protection in 11 states. The cross-country comparisons demonstrate the ways in which differences in structures, resources, expectations and attitudes affect professional responses and the experiences of families. The findings provide information on several levels. A comparison of commonalities and differences highlights the problems that are shared across countries, and alternative ways of responding to them at ground level are needed.³

In the framework of the programme, via the comparison of experiences of professionals in different national systems, the acquisition of more complete comprehension of texture of problems that emerge and the exchange of effective strategies and proceeding on the promotion of health, was understood.

The comparative methodology of programme was based on the active attendance of professionals of particular field of work ensuring him that the knowledge that sprang from the research was based on realistic estimate what it is likely to happen also what is practical. In each country researchers worked with teams of professionals that represented the services of Community mental health and the services of children's providence and protection. Comparative qualitative research aimed at focusing on the differences and the common methods and practices of services and professionals of mental health in the European states. The study was presented in the Bodies of Social Policy of European Union and in the World Organism of Health.

Based on the above research, the Association for the Psychosocial Health of Children and Adolescents, developed a service for this particular population - the **"Melia" Residential Facility**, for children whose parents have mental problems.

When parents have mental problems, the whole family and its way of functioning are affected, in particular children and adolescents. Living with a parent who is suffering from a severe mental disorder is often a harsh, incomprehensible and sometimes frightening experience for young children.

"Melia" Residential Facility for Children is addressed to boys and girls aged 5-12 years, whose parents are unable to fulfil their parental role, due to mental health problems. The average stay varies from a couple of weeks to one year, depending on the needs of each family.

"Melia" Residential Facility is not a hospital structure

and cannot shelter children with acute or chronic child psychiatric symptomatology; moderate and severe mental retardation, as well as autistic symptomatology (severe communication impairments, severe stereotypic and self-injurious behaviour); severe somatic problems (unregulated epilepsy, hemorrhagic colitis, anorexia nervosa, somatic weight loss).

AIMS:

- To create an environment, where children will be able to discover and understand more their own needs and feelings
- To prevent mental illness for all children sheltered in "Melia"
- To provide adequate information to children about their parents' mental disorder and its treatment
- To support parents in their parental roles, in accepting their problem and their need for treatment

The Facility's ultimate goal is:

to help these children return to their homes and be reunited with their families or, if not possible, to help them settle down in a stable residential structure.

TASKS:

- Assessing, identifying and meeting the children's needs, as well as the needs of their parents and families, at mental health and social welfare level
- Hosting, providing care and support to children with mentally ill parents, and meeting their personalised needs for learning, education and creative occupation
- Systematic collaboration between the family and the interdisciplinary team of the Facility
- Interconnecting collaboration with all community services working with the family, and creating a supportive network for the family (adult psychiatric services, child psychiatric services, social welfare services, etc.)
- Monitoring and supporting the interaction between children and parents, and the functionality of the family, when children return home - Providing information, mental education and consultation to families with mentally ill parents, within the community, in case there is no need to shelter the children
- Providing information and awareness-raising in the community about mental illness and parents-children relationship

Education of Professionals of First degree Care In the Prevention of Psychosocial Dysfunctions In Children and Families at High Risk: "European Programme of Precocious Intervention Leonardo Da Vinci. (1999-2001)"

The programme focused on preventive intervention in children and families at high risk of psychosocial

³Hetherington, R. and Baistow, K. (2001) Supporting families with a mentally ill parent: European perspectives on interagency cooperation. Child Abuse Review, Volume 10, Number 5, September/October 2001, pp. 351-365

dysfunction, which is considered particularly important because:

- The existence of conditions of “danger” the first years of life of children may interrupt their development and create a favourable climate for the growth of psychosocial dysfunctions.
- The percentage of emotional disturbances and disturbed behaviour in children and adolescents in this group reaches 20%. However, only small percentage of these individuals (10-15%) use mental health services. It is not clear that this represents the individuals with the greater need of therapeutic intervention.
- The therapeutic intervention in cases of existing disturbances is demanding in terms of time and specialization, but also more effective than generalised care. The lack convenient and effective intervention for precocious disturbances leads to disturbances in adolescent and adult life, increasing the economic and social cost.

The programme represents an inter-country collaboration aiming to create and evaluate international services that will deal with: a) the promotion of health, growth and psychosocial adaptation of children and families, b) the convenient prevention of emotional problems and problem behaviour in children and g) the convenient intervention in these problems.

Participating countries in the programme were: Greece (coordinator country), England, Finland and Cyprus with the additional collaboration of Serbia and Montenegro. Fundamental objectives and efforts carried out in the framework of programme were:

- The writing of handbook for the instructors of workers in primary health care, which is reported in the diagnosis of conditions of risk and the precocious intervention to prevent these.
- The education of workers in primary health care for the recognition of factors that places at risk the smooth development of children and for the application of methods of intervention in families in need.
- The monitoring of workers in primary health care so as to facilitate their work.
- The evaluation of effectiveness of the programme in each country and comparatively across the countries that participated.
- The incorporation of programme methods in primary health care services

The application of this programme in Greece became possible with the collaboration of health Visitors of the ORGANIZATION OF SOCIAL SECURITY, [PIKPA] and the Ministry of health and social solidarity. The results of the study have been published.⁴

In addition, several research projects led or partnered by Greece have published findings on mental disorder prevention in children at risk due to parental somatic illnesses.⁵

The “EU Monitoring and Advocacy Program (EUMAP)” is a European programme addressing the Rights of People with Learning Disabilities: Access to Education and Employment (2004-2005) and has partners in Greece.

Further research is carried out on the ethical and psychological consequences of prenatal genetic screening techniques.⁶

DAPHNE - II European program: Researching and Combating Violence Among Students at School (2006-2008):

In June (the 21st) 2007, following invitation of the Standing Committee on Cultural and Educational Affairs of the Parliament of Greece, the co-ordinator of the project, Prof. J. Tsiantis, presented the following recommendations as part of a memorandum for bullying and delinquency issues in schools:

1. Operation of a telephone help-line which will provide directions, counselling and support in relation to bullying issues for all educational personnel in Greece.
2. Development of a school support system with specialized psychological support services for the psychosocial health of children and adolescents. The aim will be needs assessment, provision of support, crisis intervention and connection with community mental health services.
3. Development of a directive (Ministry of Education) for the provision of official practices for the assessment and management of bullying phenomena.
4. Development and implementation of short-term multilevel prevention and intervention programmes targeting different groups (students, teachers, parents) and/or incorporated in the school programme is considered as crucial.
5. Development and implementation of training programmes and awareness raising seminars for

⁴Puura, K., Davis, H., Papadopoulou, K., Tsiantis, J., Ispanovic, V., Rudic, N., Tamminen, T., Turunen, M., Dragonas, Th., Paradisiotou, A., Visakou, S., Day, C., Roberts, A., Cox, A. (2001). “The European early promotion project: A new service for promoting children’s mental health in primary health care”, *Infant Mental Health Journal*, 2001.

⁵“Mental Health Prevention in a Target Group at Risk: Children of Somatic Ill Parents (COSIP)-Implementation and Evaluation of Innovative Health Services in a European Public Health Perspective” (Participating countries: Austria, Denmark, Switzerland, Greece, UK, Romania, Finland). University Research Institute of Mental Health S. Diareme, J. Tsiantis, G. Kolaitis, S. Ferentinos, E. Tsalamaniotis, E. Paliokosta, S. Anasontzi, E. Lympinaki, D. C. Anagnostopoulos, C. Voumvourakis, G. Romer (2006). Emotional and Behavioural Difficulties in Children of Parents with Multiple Sclerosis: A Controlled Study in Greece. *European Child and Adolescent Psychiatry* 15 (6): 309-318

S. Diareme, J. Tsiantis, G. Romer, E. Tsalamaniotis, S. Anasontzi, E. Paliokosta and G. Kolaitis (2007). Mental health support for Children of parents with somatic illness: A review of the theory and intervention concepts. *Families, Systems and Health* 27 (1): 64-76

⁶Ethical Dilemmas due to Prenatal and Genetic Diagnostics Interdisciplinary Assessment of Effects of Prenatal and Genetic Diagnostics on Couples in Different European Cultures” (EDIG) under the program of “Structuring the European Research Area”. Co-ordinator: Prof Dr M Leuzinger-Bohleber, Sigmund-Freud-Institute and University of Kassel, Frankfurt. University of Thrace and Athens University

Kolaitis G, Christogiorgos S, Vassilopoulou V, Soumaki E, Tsiantis J (2008). Prenatal and genetic diagnostics and trisomia 21: a current debate of ethical and psychosocial implications with reference to Greece. In: *The Janus Face of Prenatal Diagnostics-A European Study bridging Ethics, Psychoanalysis and Medicine* (Eds. Leuzinger-Bohleber M, Engels EM, Tsiantis J). London: Karnac, pp 367-378

teachers and educational personnel of all school levels focusing on the following: a) coping skills and strategies to deal with students who have been exposed to bullying and violent behaviours and acts as victims or/and bullies in the school setting, b) ways to co-operate with parents, c) development of anti-bullying activities with students in the school classroom.

6. The issue of bullying and its management should be incorporated in the school curricula as a subject of psychosocial health.

7. Directive (Ministry of Education) for the promotion of anti-bullying day where the school communities in co-operation with parents and teachers' associations will develop social and educational activities against school violence.

8. Development of extended epidemiological studies focusing on students' and teachers' perceptions and attitudes about bullying.

9. Development and adoption of strategies such as systematic discussion groups, school councils on bullying, and school friendship unions which will incorporate creative activities in their programme is essential.

10. Provision of care and support for victims and bullies to a greater extent is considered as important.

11. Prevention and management of school violence should be incorporated as a subject in the academic curricula and training of teachers.

12. Development and implementation of anti-bullying prevention and awareness raising programmes for parents and the community

Research on child and adolescent mental health, promotion and prevention, has also been carried out in Greece in conjunction with the umbrella organisation Mental Health Europe (MHE).⁷

7. Challenges, opportunities and advances in the field

7.1. Key recent advances

Key recent advances related to child and adolescent mental health in Greece include the establishment of NGOs, (the Association for the Psychosocial Health of Children and Adolescents, University Research institute of Mental Health); establishment of new public services (CAMHEE services, the development of centres for autistic children, day centres for specific populations, establishment of mobile units.

7.2. Youth involvement

Children and adolescents do not participate in the process of policy planning and design although there has been some research on attitudes of children and adolescents towards those with mental health problems. Focus groups were conducted in order to assess attitudes and the scale of "community attitudes toward the mentally ill" was used.⁸

7.3. Difficulties and proposals for further development

To sum up the situation regarding child and adolescent mental health in Greece, there is a general lack of policies, a lack of specialised services, a lack of strategic planning, few trained specialists, a lack of funding, no coordination between services and no available data to identify areas of greatest need and possible effective intervention.

8. Summary and conclusions

A lack of data on the national level, lack of specific policies, lack of governmental co-ordination and lack of sufficient funding constitute the most important obstacles in delivering mental health services to children and adolescents. Research programmes target specific areas of need and interest but do not form a part of general policy.

Stigmatization is still an important issue, which needs to be addressed with specific actions.

Over the last year, a major cut in funding, almost 50% (compared to 2007), has threatened many services. As a consequence, some services were are not fully operational and others were are on the verge of being suspended. Mental Health Europe has issued the following statement about the increasingly critical situation in Greece: "For the last 3 years, the state has systematically failed to maintain the values and momentum of the reforms. This has caused a series of problems and roadblocks regarding the transition from institutional to community care. The community mental health sector fears an unparalleled regression: return of long-term patients to psychiatric hospitals that should have been closed down and generalised incapacity of the psychiatric system to cover the needs.

Mental Health Europe shares the deep concern of a growing number of service users, relatives, professionals as well as representatives of the European Parliament for the future of the public (community) mental health services system in Greece."⁹

⁷G. Kolaitis, J. Tsiantis (2003). Promotion and Prevention in Child, Adolescent and Young People Mental Health: The Greek Experience of Participation in the Mental Health Network Programme of the European Commission. *The International Journal of Mental Health Promotion* 5 (3): 31-35

Kolaitis G., Tsiantis J. (2004). The Mental Health Europe Projects and the Greek Perspective. In: *Handbook for Promoting Well Being of Children and Adolescents and Preventing their Mental Ill Health*. Kedar Dwivedi and Peter Harper (editors). London: Jessica Kingsley Publishers

⁸Taylor and Dear (1981).

⁹<http://www.mhe-sme.org/assets/files/Press%20release%20MHE%20calls%20on%20Greek%20government%20to%20put%20an%20end%20to%20the%20dramatic%20situation%20in%20the%20Mental%20Health%20sector.pdf>

The Ombudsman for Children described the serious problems associated with underfunding, mainly increased risk for service users and decrease in the services provided.

However, very recently the above mentioned difficulties have been solved, and the Ministry of Health and Social Solidarity will continue to fund and support services for children and adolescents.

Although Greece has ratified the "Convention on the Rights of the Child", the Greek state does not deliver certain standards. Specifically, Article 24 states that "States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services" and Article 25 "States Parties recognize the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement".

Despite the above mentioned difficulties, over the last 20 years a lot of services, mostly operated by NGOs, have been developed. Currently 27 NGOs are providing services in the area of mental health, which cover urban as well as rural Greece.

They developed services such as day centres, assessment centres, centres for specific populations (autism, etc.) and activities in order to promote mental health, mainly through lectures and seminars for the wide public.

Some NGOs have managed to secure budgets for research on mental health. Research data has led to the development of services.

Sustainability of funding, collection of reliable data on a national and regional level, and monitoring and evaluation of services are paramount in working with CAMH in Greece. Despite the difficulties and the obstacles, the overall situation regarding CAMH has been improved over the last ten years.

HUNGARY

Prepared by Prof. Maria Kopp and
Dr. Julia Gadoros

1. Introduction

1.1. Policy at a glance

There is no national programme aiming to achieve specific goals for child and adolescent mental health (CAMH) in Hungary, but there are programmes with objectives in line with the promotion of CAMH:

Child and adolescent mental health are affected by the “National Programme to Combat Child Poverty”¹ and the national programme entitled “Sure Start” for infants and toddlers. Child poverty is the most important background factor in the deterioration of mental health among Hungarian children. The National Programme is based on local resources, first of all on the network of municipalities. The communities vary greatly in terms of number of inhabitants, economic conditions and provision of institutions, but there is something common in them all that has justified the local, experimental launch of the Sure Start Programme: the increasing threat of deprivation and the consequent mental health deterioration among children. It is irrelevant for children or their parents whether the reason for social exclusion is institutionalisation, place of work, educational level, lack of material wealth spanning generations or geographical or social isolation – the fact is that breaking the cycle of deprivation appears to be just as difficult in a new housing estate as it is in an isolated village.

This is the reason why special emphasis is placed on a service based heavily on local requirements and founded on those results and resources that were previously available on a local level in the planning of child mental health programmes. The first Sure Start Houses opened in diverse organisational forms according to the particular local needs and the state of the institutions created to meet these needs.

Various challenges and questions arose in the first phase of the programme, to which answers should be sought before decisions are made and a consensus is reached. Fundamental approaches and values require clarification; the necessary resources need to be taken into account and professional motivations and cooperative abilities need to be identified. The introduction and long-term sustainability of the Sure Start Programme requires

the development of a professional support system, the continuous professional support of local programmes, the construction and methodological development of monitoring, evaluation and training systems to ensure compliance with the professional requirements of local Sure Start Programmes in order to reach the goals set.

1.2. Process to prepare the country story

People involved in the creation of this country story:

- **Prof. Mária S. Kopp**, MD, PhD, Professor, Semmelweis university, Institute of Behavioural sciences
- Zsófia Németh, coordinator, National Institute for Health Development
- Dr. Bea Pászthy, MD, PhD, Head of dept, Semmelweis University, 1st Dept Pediatrics
- Dr. Ferenc Túry, MD, PhD, Director, Semmelweis University, Inst of Behavioural Sciences
- Dr. Ágnes Vetró MD, PhD, Head of dept, Szeged University, Child Psychiatry dept
- Dr. Júlia Gadoros MD, PhD, Head of dept, Vadaskert Foundation for Mental Health of children
- Bettina Piko MD, PhD, researcher, Szeged University, Institute of Behavioural Sciences
- Csilla Raduch, Scientific secretary, Semmelweis University, Institute of Behavioural Sciences

There is no network of child mental health promotion in Hungary. Therefore, we approached those people who actively try to promote this field. The professionals listed above are highly motivated to participate in further development of child mental health promotion in the future.

2. What we know about children and adolescents in our country and their mental health

¹Basic document of the national strategy 2007-2032 “Making Things Better for Our Children” adopted by the Parliament on 31 May 2008

2.1. Prevalence of mental disorders in children and adolescents

Unfortunately, there are no regular records kept of mental disorders in children and adolescents, which could provide a clear picture of the mental health of children and adolescents in Hungary.

There is no available source of data on the following child/adolescent mental disorders: anxiety disorders, autism and pervasive developmental disorders, schizophrenia, bipolar disorder (manic-depressive), attention-deficit/hyperactivity disorder (ADHD), learning disorders, conduct disorder (acting out or impulsive behaviour).

However, some data has been collected in respect of depression, self-mutilation or self-harm, eating disorders, and childhood/adolescent suicide attempts and completed suicides.

Two studies have been conducted in the field of childhood and adolescent depression: One study, from 2008, showed a prevalence of 11,5% among adolescents (aged 14-20), according to scores on the Child Depression Inventory; The other study examined 392 children aged 7-14 with the help of the DESCA interview, the results revealing a prevalence of 34,4%.

Data on self-mutilation or self-harm is provided by the National Statistical Office for the year 2007, which are based on medical records.

Eating disorders affect children and adolescents (aged 10-18) with a prevalence of 2%.

A study conducted in 2000 among youth (aged 11-20) in Szeged indicated a prevalence of 1,5% in childhood/adolescent suicide attempts, while the data collection of the National Statistical Office in 2007 shown a rate of 15.6/100.000 for childhood/adolescent suicide.

2.2. Vulnerable child population

There has been no data collection to our knowledge on homeless children, early school leavers, youth unemployment, children in care, asylum seekers, traveller children, juvenile offenders or abandoned children.

However, sociological questionnaires targeting children up to the age of 16 have collected data on children living in poverty, and the results show a prevalence of 10% of children below the age of 16 living in poverty.

The Szeged Youth study conducted in 2000 found that 5.6% of the targeted child sample were sexually abused, and 30.2% physically abused. The participants comprised of a representative sample of middle and

high school students (aged between 10-20 years) living in the metropolitan area of Szeged.

2.3. Positive child and adolescent mental health

Bettina Pikó's work among Hungarian adolescents focuses on their socioeconomic status and psychosocial health, as well as their leisure activities and problem behaviours. The results of her research are published in the *European Journal of Public Health*² and in the *Journal of Adolescence*.³

In the article on "Socioeconomic Status, Psychosocial Health and Health Behaviours among Hungarian Adolescents"² data on 1114 high school students (aged 14-21 years) from the Southern Plain Region of Hungary were used; findings suggest the following: 1., SES self-assessment proved to be a significant predictor of adolescent psychosocial health (psychosomatic symptoms, self-perceived health and depressive symptoms) and health behaviours, 2., parents' schooling and employment status had a limited influence on their children's health outcomes, 3., parents' inactive status (unemployment, retirement) seem to act in a predictive way.

In the article on "Leisure activities and problem behaviours among Hungarian youth"³, leisure behaviours and the relationships between leisure and a variety of problem behaviours were examined in a sample of 1422 Hungarian adolescents. Findings suggest that some aspects of adolescent leisure, such as family or conventional activities, act as protective factors against problem behaviours, while peer-oriented activities or commercial types of leisure contribute to greater risk.

3. Action for promotion and prevention in mental health

In Hungary no strategy is available that addresses mental health promotion of children and adolescents. At the strategy level the above listed documents focus on child health, child poverty or on children in deprived situation but not specifically on mental health. Moreover, after some hopeful initiatives by the government and fruitful discussion with experts, no governmental strategy on mental health promotion has been subsequently adopted for the general adult population. However, it has to be noted that a national institute for child health is in place and is in charge of drafting and implementing programmes to improve children's health. A National Mental Health policy proposal was elaborated by expert groups (LEGOP "National Programme for Mental Health"), but it has not yet been discussed and accepted

²Bettina F Piko & Kevin M. Fitzpatrick(2006) Socioeconomic Status, Psychosocial Health and Health Behaviours among Hungarian Adolescents. *European Journal of Public Health*, Vol. 17, No. 4, 353-360.

³Bettina F. Piko & Alexander T Vazsonyi (2004) Leisure activities and problem behaviours among Hungarian youth. *Journal of Adolescence* 27, 717-730.

by Hungarian politicians. The only accepted national programme is the programme against child poverty: "NATIONAL PROGRAMME TO COMBAT CHILD POVERTY"⁴. Due to a shortage of funds, the national health programme, entitled "Children, Our Common Treasure" (Ministry of Health), is practically at a standstill.

Extreme cases and tragedies in September 2008 have called the attention of the media and the government to a great deficiency in the system, namely, that there is no ombudsman for children's rights in Hungary. As yet, no further measures have been taken, and there is still no office or governmental department to take responsibility for representing children's rights.

3.1. Policies and programs for CAMH

3.1.1. Specific policies and large-scale programs for CAMH

There are national and regional programmes for child and adolescent mental health.

Among the national programmes we need to mention the following:

Programmes for infants and toddlers are covered by the "**SureStart**" (**Biztos Kezdet**) national programme: <http://www.biztoskezdet.hu/dokumentumok.php?level1=47>

"**National Programme to Combat Child Poverty**"⁵
http://www.gyerekesely.hu/component/option,com_docman/task,content/Itemid,3/

"**Children, Our Common Treasure**", a national health care programme for children
<http://www.eum.hu/egeszsegpolitika/kozok-kincsun-kyermek>

"Making Things Better for Our Children"

In 2007 the Parliament adopted a resolution⁶ on the National Strategy 2007-2032 entitled „Making Things Better For Our Children”

http://www.gyerekesely.hu/component/option,com_docman/task,content/Itemid,3/

The **Budapest Institute of Education (OEFI)** attempts to organise programmes for children by providing training and guidance for teachers, thus directly and indirectly supporting the promotion of children's mental health.
<http://www.fppti.hu/szakteruletek/gyermekvedelem/gyvedframeset4.html>

A Mental Health Strategy is provided by the National Institute for Health Development
<http://www.oefi.hu/modszertan10.pdf>

The work of the Vadaskert Foundation, a regional organisation that operates as a hospital as well as an outpatient clinic, is very active in preventing depression and anxiety, respectively suicide and self-harm/mutilation.

www.vadaskertalapitvany.hu

In order to prevent disorders in children associated with parental alcohol and drug problems the following programmes have been launched:

- National Drug Coordination (responsible for the coordination of national drug prevention) <http://www.szmm.gov.hu/main.php?folderID=16338>
- National Strategy combating drug use (Parliament Decree, 2000) <http://www.drogfokuszpont.hu/?lang=2&pid=161>
- National Crime Prevention (Parliament Decree, 2003) <http://www.bunmegelozes.hu/index.html?pid=446>
- Drug Policy by the Ministry of Education and Culture <http://www.okm.gov.hu/main.php?folderID=1719&articleID=1007&ctag=articlelist&iid=1>

No non-governmental policy documents on child and adolescents' mental health have been published as yet.

3.1.2. Other general policies related to CAMH

General policies are described in the following national programmes:

The National Programme to Combat Child Poverty is designed to combat poverty and social exclusion, attempting to facilitate social inclusion and well-being for affected children.

http://www.gyerekesely.hu/component/option,com_contact/catid,5/Itemid,5/

In the fields of social welfare, education and school programmes, day care legislation/policy for pre-school children, and anti-discrimination, the "**Sure Start**" / "**Biztos kezdet**" Programme for children in social discrimination is instrumental.

<http://www.szmm.gov.hu/main.php?folderID=1&articleID=5900&ctag=articlelist&iid=1>

"**Children, Our Common Treasure**" Programme is a national programme designed to promote child protection.
http://www.eum.hu/index.php?akt_menu=3513

There are regional programmes that facilitate the implementation of general policies, such as:

Family friendly workplace policies <http://www.ogyei.hu/szuloihivatas.htm>

Adoption, fostering policies <http://www.ogyei.hu/szuloihivatas.htm>

⁶Parliamentary Resolution 47/2007 (V.31.) OGY

3.2. Availability of programs for CAMH promotion and mental disorder prevention

CAMH promotion and mental disorder prevention programmes are not available in the following areas in Hungary: home-based programmes for children, parenting programmes, school targeted preventive programmes, promotion/prevention via internet or programmes in custodial settings.

In certain areas the availability of programmes ranges between 51-75% e.g. home-based programmes for infants (midwife visits family regularly after birth); churches, clubs and recreation centres. Some programmes are less widely available (between 26-50%) e.g. school mental health promotion (it is officially part of school counselling services), drug and alcohol abuse prevention (in every school there is a drug coordinator), promotion/prevention at hospital clinic. Even less widely available (1-25%) are programmes such as protective services, telephone counselling.

4. Organisation and resources for implementation

4.1. Institutions and organizations

The main organisations that actively provide mental health care and services are the National Institute for Child Health, family counselling centres at district or city level, and the Vadaskert Foundation, which operates an outpatient department and a hospital.

4.2. Services

Service availability varies: Pharmacological treatment is the most available service (at 51-75% availability), available to a lesser degree (26-50%) are psychologist appointments, family therapy, infant- and adolescent-specific services, school counselling, and in-patient beds on a child psychiatric ward. The availability for child psychiatric appointments, social service appointments for children, group therapy, and psychosocial rehabilitation centres for adolescents are minimal (less than 25% availability). In-patient beds on general psychiatric wards are largely not available.

The situation is not any better in the case of specific subgroups of children and adolescents. The NGO "Cordelia" provides services for refugees/disaster-affected populations, as well as migrant populations (1-25%). Some services are available to some degree (between 1-25%) e.g. for minority groups, orphans, children living in poverty and unemployed youth. The television programme "Csellengök" is active in raising awareness about runaway children, and is responsible for what little availability of mental health programmes

exists for runaways. No services are available for children who are seriously emotionally disturbed, victims of bullying or early school leavers.

4.3. Funding

In the past 5 years resource allocation to child and adolescents' mental health in general has not improved, although it may have worsened. After the National Institute of Mental Health was closed in 2008, there has been practically no real financial and organisational backing of mental health in Hungary.

Unfortunately, the funds dedicated to children and adolescents' mental health from the national budget fall very short from covering the programmes that have been designed for this purpose. There has been a great deterioration in funding since 2007. NGOs such as the Vadaskert Foundation are all struggling to meet the ever-growing demands placed upon them.

4.4. Training of professional workforce

Training in child mental health/child psychiatry is not a recognised independent field from general mental health/psychiatry in Hungary.

Training in CAMH issues are provided by the following institutions:

- (I) Semmelweis University, Institute of Behavioural sciences,
- (II) Szeged university, Institute of Behavioural sciences,
- (III) ELTE University Faculty of Psychology, Faculty of Pedagogy,
- (IV) Pecs University Faculty of Psychology,
- (V) Szeged University Faculty of Psychology,
- (VI) Vadaskert Foundation.

There are CAMH-specific courses available for medical doctors as well as paediatricians at undergraduate and post-graduate levels, and training for teachers at post-graduate level. There are also undergraduate courses for primary care doctors (GPs), psychologists, and social workers.

5. Monitoring and evaluation of the actions for the promotion and prevention in mental health

Policies for children and adolescents in the fields of mental health service and care policies, mental health promotion policies, mental disorder prevention are not evaluated and reported. However, an Evaluation Committee was set up in September 2008 consisting of independent experts, with the task of monitoring and evaluating the national strategy "Making Things Better for Our Children".

6. Research and dissemination

The results of Hungarian research conducted in the field of child and adolescent psychiatric disorders have been published in national and international journals. Some of the most important ones are as follows:

Csorba J., Ficsor B., Horváth Á., Nagy E., Bóna A., Sörfőző Zs., Steiner P., Harkány É., Babrik Zs. (2008). Epidemiological investigation of psychiatric diseases of Trans-Danubian adolescent outpatients. *Mentálhygiéné és Pszichoszomatika* IX.1.35-60. (in Hungarian)

Vetró Ágnes, Baji Ildikó, Benák István, Besnyő Márta, Csorba János, Daróczy Gabriella, Dombovári Edit, Kiss Enikő, Gáboros Júlia, Kacsvinszky Emília, Kapornai Krisztina, Mayer László, Rimay Tímea, Skultéty Dóra, Szabó Krisztina, Tamás Zsuzsanna, Székely Judit, Kovács Mária: "Risk factors in childhood onset depression" research design, implementation, proceeding: history of 13 years: Experience in grant preparation, writing, organization in relation to an American NIMH Grant, 2007 (in Hungarian)

Túry Ferenc, Túry Krisztina, Murányi István: A táplálkozási magatartás és egyes zavarai középiskolás diákok között. (Eating related behaviour and disorders among school age children) In: *Kelet-magyarországi középiskolások egészségmagatartása* (szerk: Murányi István), pp 131-141, Kossuth Egyetemi Kiadó, Debrecen, 2008. (in Hungarian)

Bea Pászthy, Peter Švec, Ferenc Túry, László Kovács, Barna Vásárhelyi, Tivadar Tulassay, & András Treszl: Impact of anorexia nervosa on activation characteristics of lymphocytes, *Neuroendocrinology Letters* Volume 28 No. 4, 2007.

Pászthy B., Major M., Mazzag J., Túry F.: A család szerepe a gyermekkori elhízás kialakulásában és kezelésében. (The role of family in the development of childhood obesity and its treatment) *Háziorvos Továbbképző Szemle* 12:292-296, 2007. (in Hungarian):

Many psychological factors play a role in obesity. Individual difficulties in personality development are usually analysed, the therapy focus is less on relational elements. The study summarizes those observations that reinforce the decisive role of intrafamilial relationships in the pathomechanism of obesity. The family environment, the parental style, the effects of the model role and reinforcements of parents may contribute to the development of obesity, partly in eating habits and preferences, partly in physical activity. The role of the family in providing long-term body mass control is essential. These observations bring significant aspects in the therapy of child obesity. Several control studies proved the long-term effectiveness of family therapy interventions in treating child obesity. If family aspects are not taken into consideration in the course of the therapy, there is less chance for positive change.

In mental health care and services provision as well as mental health promotion and mental disorder prevention the National Institute for Child Health, the Ministry of Social Affairs, the Ministry of Health and the local governments play a crucial role in dissemination to keep health care professionals informed.

7. Challenges, opportunities and advances in the field

7.1. Key recent advances

Key recent advances in CAMH promotion/prevention include the establishment in 2008 of the New Hungary development programme financed by the EU Structural Funds that includes a programme element (Sure start) tackling children's welfare and health. Additionally, the National Program to Combat Child Poverty was launched.

7.2. Youth involvement

In Hungary children and adolescents are not involved in implementing child and adolescent mental health programmes, in designing such programs, in decision-making processes, or policies. In order to increase participation of children and adolescents in the development of action for mental health, political willingness, better visibility and a greater awareness of the existing deficits would be necessary.

7.3. Difficulties and proposals for further development

The most important barriers to action in child and adolescent mental health care, respectively health promotion and mental disorders prevention are the lack of funding, capacities, and political willingness.

In order to increase action to improve child/adolescent mental health services there is a great need for new approaches in training, greater awareness, and proper funding.

In order to increase action to improve child/adolescent mental health promotion and prevention of mental health problems/disorders, adequate health policy decisions are needed as well as financial support and data collection on a regular basis and at the national level.

8. Summary and conclusions

In summary there is no accepted national child mental health promotion program in Hungary, but there are similar programmes such as the "National Programme to Combat Child Poverty"⁵ and the national programme,

entitled "Sure Start", for infants and toddlers, which is expected to promote children's mental health as well. These programmes are currently in the preparation phase. In 2008, the National Institute of Mental Health was closed by the government. The new National Mental Health Institute has been recently founded with four faculty members, head Dr. Attila Nemeth at the

Psychiatry Clinic of Semmelweis University. There are active research groups working in the field, such as at the Semmelweis University, Szeged University and the Vadaskert Foundation for Children's Mental Health. There are practically no financial resources allocated specifically to the mental health of children.

LATVIA

Prepared by Māris Grāvis

Introduction

1.1. Policy at a glance

In Latvia a Framework document "On the Improvement of Mental Health of the Population 2009-2014" was adopted by the Committee of Cabinet of Ministers on 14 July 2008 and will be the main strategic document regulating: prevention and promotion in mental health care and, development of modern community based mental health care services. This document also provides guidelines for training general practitioners and other public health specialists on mental health care issues.

In parallel, the Program for Reduction of Domestic Violence for the period 2008-2011 was adopted by the Cabinet of Ministers on 17 June 2008. The program plans to improve legislation, to carry out preventive activities, to raise public awareness and to inform the public of where to turn for assistance. The program will also develop an assistance and rehabilitation system for victims, as well as for violent family members.

Also, the Public Health Strategy - The Action Plan for the period of 2004-2010 was adopted by the Cabinet of Ministers on 09 March 2004. The Action plan includes informational activities at schools, training of teachers on public health issues, research activities on mental health of children and adolescents, and provision of assistance by a psychologist at schools.

The document Equal Opportunities for All is a foundation for all strategies and plans. This policy document was enacted in 1998 and includes a broad program for improving the situation of disabled people in various sectors (e.g. health, social care, education, accessibility, etc.) Plans include creating day care centres for people with mental health problems and for people with intellectual disabilities; developing programs for early integration of children with special needs into mainstream schools; and developing health care and rehabilitation programs.

The most significant problems in mental health care are caused by the decline of the social situation of patients, which in turn limits the possibilities for them to receive adequate treatment. There is a tendency for increasing social exclusion and isolation for people with mental disorders.¹

1.2. Process to prepare the country story

This report was compiled by Māris Grāvis, executive director of the NGO "Rigas city "Child of care"", with information from the following sources, institutions and people:

- Policy-documents from several ministries and state institutions
- Published research
- Latvian Central Statistical Bureau data

People involved in the country profile development:

- Ieva Leimane-Veldemeijere, Resource Centre for People with Mental Disability "ZELDA" director
- Liene Šulce, Resource Centre for People with Mental Disability "ZELDA" Staff lawyer
- Rinalds Muciņš, Ministry of Health, Under-Secretary of State
- Elvīra Grabovska, Ministry of Welfare, Senior task manager at Social Care division of Social Services and Social Assistance department
- Māris Taube, Public Health Agency, Deputy Director- Science and Research
- Daina Upīte, The State Inspectorate for Protection of Children's Rights, Chief of Monitoring department
- Gunārs Sētiņš, Psychiatry clinic of Children hospital "Gaiļezers", Chief of out-patient department
- Ilona Balode, Mental hospital for children "Ainaži", Chief of the Board
- Dace Miškina, Latvian Portage Association, Portage specialist
- Ināra Kovaļevska, Day care centre "Island of Light", Family member

2. What we know about children and adolescents in our country and their mental health

¹Latvian National Action Plan for Reduction of Poverty and Social Exclusion (2004-2006)

2.1. Prevalence of mental disorders in children and adolescents in Latvia

Information on the prevalence of mental disorders among children and young people in Latvia is available at the national level. The data on prevalence rates of

childhood mental disorders is based on GP records, hospital records, and hospital registries. The table below presents the prevalence rates for different childhood and adolescent mental disorders:

Table 2.1 Prevalence rates for different child and adolescent mental disorders

Disorder	Prevalence (%)	Age range	Reference period	Instrument	Data collection
Anxiety disorders	9.42 16.82	0-14 15-17	year	Data collected by Public Health Agency	2006 2006
Depression (moderate to severe diagnosis)	5.97 38.58	0-14 15-17	year	Data collected by Public Health Agency	2006 2006
Bipolar disorder (Manic-depressive)	Not collected				
Attention-Deficit/ Hyperactivity Disorder (ADHD)	Not collected				
Learning disorders	Not collected				
Conduct disorder (act out their feelings or impulses in destructive ways)	Not collected				
Eating disorders	0.63 8.9	0-14 15-17	year	Data collected by Public Health Agency	2006 2006
Autism and pervasive developmental disorders	531.0 461.43	0-14 15-17	year	Data collected by Public Health Agency	2006 2006
Schizophrenia	56.21 178.05	0-14 15-17	year	Data collected by Public Health Agency	2006 2006
Self-mutilation or self harm	Not collected				

In recent years addiction to psychoactive substances among children and adolescents has increased substantially (37.14%). The use of these substances causes mental and behavioural disorders in children and adolescents. The number of children diagnosed with alcoholism continually increases. Also, the number of cases of children suffering cruelty and ill treatment continues to increase.

The most common reasons for referral of children and adolescents to a specialist service in Latvia are behavioural problems, depression (38,58% of 15-17yr olds) and anxiety/phobia. No data is collected on referrals for hyperactivity and attention disorder, because these symptoms are not recognised as a diagnosable disorder and so not specifically mentioned in referral notes.

2.2. Vulnerable child population

The table below presents available data on the prevalence of specific vulnerable child populations in Latvia.

Table 2.2. Prevalence of specific vulnerable child populations in Latvia

Vulnerable child populations	% of child population (total number)	Age-range	Reference period	Data-collection
Children living in poverty	Not collected			
Homeless children	Not collected			
Early school leavers	1803 person 0,45%	6-21	2006	National data of 2006
Children experiencing bullying ²	Not collected			
Youth unemployment	14 %	15-18	2006	STATE EMPLOYMENT AGENCY DATA
Children in care ⁴	2357 person 0,6 % Age 0-2 = 75 % of all Age 3-6 = 15 % Age – 6-18= 10%	0-18	2006	National data of 2006
Asylum seeker children	Not collected			
Traveller children	Not collected			
Juvenile offenders (cautioned or prosecuted)	Not collected			
Children abandoned due to parental migration for employment	Not collected			

2.3. Positive child and adolescent mental health

There is no available data on prevalence rates for aspects of positive mental health, self-esteem and quality of life in Latvia.

3.Actions for promotion and prevention in mental health

3.1. Policies and programs for CAMH

Specific policies and large-scale programmes for CAMH The Program for Reducing Domestic Violence for the period 2008-2011, adopted by Cabinet of Ministers on 17 June 2008 aims to prevent violence and aggression towards children/adolescents. As mentioned before, the program plans to improve legislation, to carry out preventive activities, to raise public awareness, and to inform the public where to turn for assistance. The program will also develop an assistance and rehabilitation system for victims, as well as for violent family members.

The State Program for Improvement of the Situation of the Child and the Family for 2004 envisages various

measures. To facilitate social integration of children who are victims of violence training will be provided on methods for working with child-victims of violence, to 250 professionals as well as provision of the specialists with methodical materials. The implementation of social rehabilitation programs for children who are victims of violence will be continued.

There is no data collected about non-governmental (private enterprise, research institutes, NGOs, etc) policy documents on child and adolescent mental health that have been published.

Other general policies related to CAMH

Poverty, social inclusion and social welfare

Reducing poverty and social exclusion is an important long-term goal of Latvian social policy.

Unfavourable situations in numerous families with children caused by social problems, limited incomes and other circumstances are reasons for the increase in the number of street children. The Latvian National Development Plan 2007–2013 states that improving the welfare of children and families depends on the accessibility of health care services and the development of a sustainable social security system. The plan has defined tasks for the improvement of public health, the health care system and social services improvement and

²Latvian National Action Plan for Reduction of Poverty and Social Exclusion (2004-2006)

³Definition of bullying according to Olweus (1992).

⁴Living in any residential places other than families.

development.

In 2003, in order to prepare for the work on the first national action plan and Latvia's full participation in the EU's social inclusion process, the Government of Latvia, together with the European Commission, prepared the Joint Memorandum on Social Inclusion (hereafter – Memorandum). An integrated and multidimensional approach to tackle poverty and social exclusion problems has been used in preparing the Memorandum, and this approach was also used in the development process of the National Action Plan for Reduction of Poverty and Social Exclusion (2004-2006).

A National Strategy Report on Social Protection and Social Inclusion 2008–2010 has been developed which describes priorities during this period. Along with others families with children are one of the priorities. There are plans to support families with pre-school-age children by ensuring partly state funded lunches; improve the financial support system for families with children; improve the state provided maintenance guarantee payment system; develop a financial support system for foster families; improve the financial support for guardians in order to improve the quality of life of children who have lost parental care; ensure financial support for adoptive parents; improve services provided by out-of-family child care institutions; improve accessibility and quality of alternative out-of-family child care; develop and improve family support and coordination systems; improve the state support mechanism for local municipalities for ensuring accessibility of services necessary for young people; enhance the opportunities for young people to participate in physical activities thus promoting a healthy lifestyle and useful way of spending leisure time for young people in regions; improve accessibility of services to families for solving conflict; and, improve family support systems in local municipalities.⁵

Child care/ protection

The purpose of the PROTECTION OF THE RIGHTS OF THE CHILD LAW is to set out the rights and freedoms of children and their protection, taking into account that a child as a physically and mentally immature person has the need for special protection and care. This law also regulates the criteria by which the behaviour of a child shall be controlled and the liability of a child shall be determined, regulates the rights, obligations and liabilities of parents and other natural persons and legal persons and the State and local governments in regard to ensuring the rights of the child, and determines the system for the protection of the rights of the child and the legal principles regarding its operation. Protection of the rights of the child is an integral part of State policy. The State and local governments shall organise and monitor the protection of the rights of the child throughout the territory of the State. This law states that the rights of the child shall be protected so as to achieve the following objectives:

- 1) the development and reinforcement of the orientation of a child toward values corresponding to the interests of society;
- 2) orientation of a child to work as the only morally supportable source for obtaining resources for livelihood and welfare;
- 3) orientation of a child toward the family as the fundamental value in social organization and one of the principal values of society and of individuals;
- 4) orientation of a child to a healthy life style as an objective precondition for the survival of the nation; and
- 5) the safety of the child, as well as maximum protection of the health and the life of the child, paying particular attention to such during public events or visits to a public recreation activity, sports or recreation location accessible to children, armed conflict, fires or other emergency situations (floods, storms, increased radiation levels and the like).

The Framework document "Latvia - Suitable for Children", adopted by Cabinet of Ministers on 31 March 2004 sets out the following priorities:

- Promote child health and provide accessible high-quality health protection to all.
- Provide the necessities for a comfortable, healthy environment
- To carry out preventive initiatives to improve health protection and to provide effective rehabilitation, prevent smoking and the use of alcohol, drugs and other toxic substances
- Provide each child with preschool and obligatory education, to improve a lesson and education process and result quality.
- Promote education of interests quality and availability, to promote the children of culture availabilities in all Latvia according to age, to develop the by infantile creative capabilities, social and physical activity.
- To prevent any violence against child - sent by infantile, in public, educations and in other establishments.
- Prevent and to punish child sexual exploitation and trade, to guarantee safety of victims.

Each year Cabinet of Ministers adopts State Program for Improvement of Situation of Child and Family. This act is planning document, which purpose is to promote a child and family position get better, carrying out purposeful on defence of infantile rights.

For year 2009, the priorities of this document are:

And sets out the following tasks:

- form conformable infrastructures what suits families needs in self-governments;
- provide high-quality infantile supervision possibility in promoting circumstances;
- develop and to perfect social support systems in self-governments.

⁵National Strategy Report on Social Protection and Social Inclusion 2008 – 2010

Education and school programmes

Every citizen of the Republic of Latvia and every person who has the right to a non-citizen passport issued by the Republic of Latvia, every person who has received a permanent residence permit, as well as citizens from Member States of the European Union who have been issued a temporary residence permit and their children, have equal rights to acquire education, regardless of their property or social status, race, nationality, gender, religious or political convictions, state of health, occupation or place of residence.⁶

A framework document for the development of Education for the period 2007-2013, was adopted by Cabinet of Ministers on 27 September 2006. This document outlines educational system development for the coming seven years and directs their execution, as action results, policy results and indicators. The main targets of this document are:

- To create teaching assistant roles in pedagogical work to support pupils (1-6 grade.) with learning problems.
- To improve the social circumstances of pupils who enter professional education by increasing their grants.
- To prepare a structured model of the agriculture studies programs according to agriculture necessities and to implement it in the higher education system.

Latvian legislation defines in detail the accessibility of education to people with intellectual or mental disability, and offers several options; however, at the moment this is not implemented in practice. Lack of adequate specialists, untrained personnel and premises which have not been adapted to meet the needs of children with disabilities are the main obstacles to the integration of children with intellectual or mental disability into comprehensive schools.

Day care legislation/policy for pre-school children

A shortage of day-care places and families' financial situations are the principal reasons why some children do not attend a day-care institution.

In big cities to compensate for insufficient day-care institutions local governments make cash payments to families, but still most families are waiting for a place in kindergarten.

There are no specific national planning documents foreseen referring to day care legislation for pre-school children.

Family friendly workplace policy

In their present social and economic situation families cannot solve many problems appearing as a result of the rapid public changes. Social and economic instability, uncertainty about the future, substantial changes in costs, new possibilities and demands diminish families' capacity to adapt to the new circumstances, and this is

publicly visible in the growing prevalence of antisocial tendencies.⁷

The Conception on State Policy on Family and Action Plan for 2004-2013 has been developed and this document mentions that integrated family support policies are not incorporated in the state which would aim to improve the role of the family and maintain domestic traditions, to increase health and promote a social and economic environment for family development. Present actions are directed at an individual level and general family problems are unnoticed. Employment is the main factor which facilitates families' social and economic integration and prevents social isolation. Therefore, special support for families is necessary in the case of unemployment, especially, if both parents are unemployed. The main targets of this document dedicated to workplace are:

- To promote, that both parents use the rights outlined in the Work law to make use of maternal/paternal leave in order to take care of new infants;
- To promote support activities for mothers and fathers after maternal/paternal leave;
- To promote part time work possibilities for both parents;
- To promote preschool establishments and extended day groups in schools;
- To promote parent-friendly work hours in state and self-governments;
- To support organized activities out of school, which promote child development and at the same time decrease the time which children are without the supervision of parents.

Adoption, fostering policies

The Conception on Foster families was adopted by the Cabinet of Ministers on 10 December 2003. The purpose of this document is to create pre-conditions for development of a foster families movement in Latvia, to decrease the number of children living in institutions.

Divorce and custody policies

Policies are moving in the direction of equal rights for both parents; mother and father. At the same time it becomes more common for parents to not live together.

There are no specific planning documents dedicated to this topic, but the Program for Reducing Domestic Violence for the period of 2008-2011 and the Conception on State Policy on Family touch on this topic.

Urbanisation policies

The Framework document on Regional Development was adopted by the Cabinet of Ministers on 02 April 2004 and it aims for the development of the social and economic situation in common Latvia and in separate regions to approach the level of the European states.

In Latvia 69% of all state populations live in the cities. There are no special planning documents concerned

⁶Education Law

⁷Conception on State Policy on Family

with urbanisation policies directly linked to CAMH.

Housing

As mentioned before, in Latvia 69% of all state populations live in the cities,, and this situation creates a deficit of housing possibilities.

The Housing Policy Conception was adopted by Cabinet of Ministers on 30 July 1996 and its long-term goal is to fight the problem of people not having a place to live and to create possibilities for each person to obtain a dwelling based on free market, life and dwelling standard.

Anti discrimination

The National Program for Promoting of Tolerance was adopted by the Cabinet of Ministers on 24 August 2004 and the National Program "Social Integration in Latvia" was adopted by the Cabinet of Ministers in 2001.

Ombudsman for children and adolescents

The Ombudsman of the Republic of Latvia is an official elected by the Parliament, whose main tasks are encouragement of the protection of human rights and promotion of a legal and expedient State authority, which observes the principle of good administration. There is no independent Ombudsman for children, but the Ombudsman of the Republic of Latvia has a specific CHILDREN'S RIGHTS DEPARTMENT.

3.2. Availability of programmes for CAMH promotion and mental disorder prevention

This is still a very complicated issue in Latvia. Planning documents show that, like most EU countries, the main objective of the social services and social assistance system is to ensure social services are adequate for the needs of the population of the municipality as much as is possible within the shortest possible time, primarily considering the opportunities for the customer to receive the service at his/her place of residence. But in reality in Latvia large institutions are maintained where 100 or more people with intellectual or mental disability live together, and services are provided to them which do not correspond to the principle of integration. Major investment is necessary for improving the situation.

It is not an easy task to quantify specifically the availability of programmes for child and adolescent mental health promotion and mental disorder prevention in Latvia. The failing of common information and wide spread services do not allow the collection of correct data about such programmes. To clarify the availability of programmes for child and adolescent mental health promotion and mental disorder prevention a round table discussion was organised where those specialists mentioned in point 1.2 participated.

The table below presents round table collected data about the availability of programmes for child and adolescent mental health promotion and mental disorder prevention in Latvia:

Programmes	Not available	1-25% available	26-50% available	51-75% available	Widely available	D/K
Home-based for infants		x				
Home-based for children	x					
Parenting programmes				x		
Parenting programmes (specified at risk population)	x					
School mental health promotion (e.g. teaching well-being life skills)		x				
School targeted preventive (programmes (e.g. anti-bullying)	x					
Drug and alcohol abuse prevention				x		
Promotion/prevention at hospital/clinic		x				
In Churches, clubs, recreation centres			x			
Programmes						
Promotion/prevention via Internet		x				
Protective services					x	
Custodial settings (detention centres)	x					
Community settings		x				
Telephone counselling					x	

4. Organisation and resources for implementation

4.1. Implementation of programmes

The most important bodies for carrying out policy, initiating and implementing programs within the field of mental health promotion and prevention are:

- THE MINISTRY OF HEALTH OF THE REPUBLIC OF LATVIA and
- THE MINISTRY OF CHILDREN, FAMILY AND INTEGRATION AFFAIRS OF THE REPUBLIC OF LATVIA.
- THE MINISTRY OF WELFARE OF THE REPUBLIC OF LATVIA is responsible for social service promotion and establishment.

There is no specific document for CAMH, but legislation in Latvia obliges ministries to include the NGO sector. However, NGO participation in decision making is weak because NGO don't have enough resources: knowledge, time, money, and people.

In Latvia the Public Health Agency is responsible for general mental health.

Public Health Agency functions:

- undertake public health monitoring;
- undertake surveillance of infectious diseases and other illnesses, and also monitoring of environment factors, which cause disease;
- give methodological support to medical institutions about public health questions;
- co-ordinate the management of the extraordinary situations during the appearance of threats to public health;
- manage coordination functions for the World Health Organization in the international health protective conditions area;
- estimate habits of populations, which affects

their health;

- inform society about factors which affect their health and about healthy lifestyles;
- provide recommendations to the state organs, to self-governments, to NGOs, other legal persons and individuals in response questions, connected with public health;
- participate in international health promotion activities, programs, projects and research as well as in schools and self-governments projects concerning public health.
- None of the four bodies doesn't have a specific program dedicated to initiating and implementing programs within the field of mental health promotion and prevention for children and adolescents.

4.2. Services

The municipalities should play an essential role in prevention and in the provision and coordination of services to children and adolescents suffering from mental health disorders. But in reality there are more hospital based services than services in municipalities. School counselling is one service which is based close to families and acts as alternative to services offered in hospitals.

Availability of services

The table below presents only an approximate indication of access to therapeutic services. To the best of our knowledge data on access to specific types of therapy is not available. To clarify availability of services for children and adolescents a round table discussion was organised where those specialists mentioned in point 1.2 participated.

Table 4.2.3. Availability of services

	0%	1-25%	26-50%	51-75%	76-100%
Child psychiatrist appointments					x
Psychologist appointments				x	
Social service appointments/ child protection			x		
Family therapy/ counselling		x			
Adolescent-specific services/outpatient centres		x			
Group therapy	x				
School counselling					x
Pharmacological treatment					x
Psychological rehabilitation centres for adolescents		x			
In-patient beds on child psychiatric ward					x
In-patient beds on general psychiatric ward					x

Access to specially designed mental health services

The following table looks at specific subgroups of children and adolescents who have access to specially designed and tailored mental health services or promotion/

preventive action. As data for most of these groups is not available, an approximate indication of access to specially designed services is given, based on the round table discussion where those specialists mentioned in point 1.2 participated.

Table 4.4.2. Access to specially designed mental health services

Group	0%	1-25%	26-50%	51-75%	76-100%
Minority groups			x		
Migrant population	x				
Orphans					
Children living in poverty				x	
Runaways/homeless		x		x	
Refugees/disaster-affected population	x				
Seriously emotionally disturbed	x				
Group					
Victims of bullying					
Early school leavers					
Unemployed youth				x	

4.3. Funding

Resource allocation to CAMH in general, as well as to specific areas of child and adolescent mental health, has increased slightly as a consequence of entering the European Union. Funds dedicated to CAMH are not clearly identified but rather mixed in with other funds in the most recent national budget. Mostly, funds dedicated to treatment are within the Ministry of Health budget, funds dedicated to education are within the Ministry of Education and funds dedicated to social care institutions are within the Ministry of Welfare. For NGOs working exclusively on advocacy issues the main donors are still international organisations and foundations. For NGOs providing social services, e.g. day care, residential services, etc. the main donor is regional/municipal budget, in several cases also with the state as co-funder.

4.4. Training of the professional workforce

Training in child mental health/child psychiatry is recognised as an independent field from general mental health/psychiatry. The total number of child or adolescent psychiatrists is 51.

At the moment 2 universities offer postgraduate studies in mental health:

University of Latvia, Medical Faculty

Riga Stradins University, Medical Faculty, Public health

5. Monitoring and evaluation of action for promotion and prevention in mental health

The Framework document "On the Improvement of Mental Health of the Population at 2009-2014" will enter into force only from 2009 and only after that and after approval of the Action Plan can the planning of evaluation and reporting be started.

During previous periods no evaluation of promotion and prevention in mental health is available.

6. Research and dissemination

There are no specific research projects for each of these themes in children's mental health, but wider documents and statistics on mental health are published where you can find smaller sections on these issues.

In 2006 "A report of the assessment of the mental health system in Latvia using the World Health Organization - Assessment Instrument for Mental Health Systems (WHO-AIMS)" was published. However it does not specifically concern children's mental health.

Child and adolescent psychiatric disorders

The Ministry of Health of Latvia, Mental Health Government Agency has published "Mental health care in Latvia", Statistics Yearbook, Chapter "Mental health care for children".

Care related issues

Monitoring on Closed Institutions in Latvia, Latvian Centre for Human Rights, includes information on visits to children's mental hospital and social care homes for children and adolescents, Riga, 2006.

6.1. Main bodies involved in information dissemination to keep health care professionals informed:

- Ministry of Health - Development of policy documents and legislation – e.g. Framework document “On the Improvement of Mental Health of the Population at 2009-2014”, Patients’ Rights Law, Law on Medical Treatment etc.
- State Agency “Public Health Agency”. Main objectives of the Agency are:
 - a. to ensure surveillance, investigation and assessment of the health status of the population and health risk factors;
 - b. to coordinate implementation of the public health strategy;
 - c. to establish standards for effective methodology and public health practice, as well as to facilitate their implementation.

Public Health Agency also regularly informs border public on various public health issues (also mental health) through informative journal and video-clips.

- Riga Centre of Psychiatry and Addiction Disorders

Centre disseminates informative booklets, video-clips etc. on addiction issues.

The objectives are:

1. to provide patients with high quality and specialized professional psychiatric aid in mental and behavioural disorder diagnostics, therapy prevention and psychiatric rehabilitation;
2. to facilitate use of medical compulsory treatment in specialised guarded psychiatric ward;
3. to provide informative and consultative support for state and local administration authorities on mental health care issues;
4. to provide consultations to other medical institutions in the area of mental health care;
5. to provide psychiatric rehabilitation services to patients;
6. to provide forensic psychiatric and psychological examinations;
7. to provide the basis of clinical education for accomplishment of state and local authorities orders for preparing professionals;
8. to carry out psychotropic substances and alcohol intoxication tests;

7. Challenges, opportunities and advances in the field⁸

7.1. Key recent advances, barriers or issues in CAMH care

The key recent advances in care of children and

adolescent’s mental disorders are:

- More access to compensated medicine, additional diagnoses included in the list of compensated medicines. There was an additional resource allocated for this purpose.
- Building of a new mental hospital for children has been started in Ainazi. The new hospital will be opened in May 2009. It is planned to not only invest in building, but to offer also new therapies. In the future the hospital plans to provide not only inpatient services, but also out-patient services for the Vidzeme region (Central part of Latvia).

The most important barriers or issues that impede action on CAMH care are:

- Stigma. Stigmatization is still the major barrier in Latvia.
- Access to information. Parents, families and users lack information on their rights, available services, etc.
- Lack of services and developed structure of mental health and social care services.
- Lack of qualified human resources.
- 7.2. The key recent advances, barriers or issues within CAMH prevention and promotion
- The most important recent advances affecting action on child and adolescent mental health promotion or mental disorder prevention in Latvia are:
 - Adoption of the Program for Reduction of Domestic Violence for the period 2008-2011
 - Activities in the prevention of drug and alcohol addiction

The most important barriers within the field of CAMH promotion and prevention are:

- Lack of funding for prevention. There is no independent, distinct funding for prevention.
- Lack of insight. Until now all efforts have been directed towards treatment and not to prevention in Latvia. Therefore best practice from other countries would be very useful for Latvia – e.g. how to develop a mental health care system and how to use existing resources more effectively.

7.3. Difficulties and proposals for further development

There is no doubt that more resources should be directed towards prevention and promotion in mental health. There should be more services but also development specialised perspectives and attitudes relating to child and adolescent mental health. But big barriers and issues still exist.

⁸These questions are answered by a group of 4 researchers at SINTEF Health Services who do research/evaluations within the area of CAMH.

The most important sectors for the promotion of child and adolescent mental health care in Latvia are:

Health sector: preparing of human resources, currently Latvia lacks qualitative specialists in children's mental health care and more emphasis should be placed on preparing child psychiatrists; and, the capacity and competence of general practitioners should be raised.

Education sector: it is important to work with families through schools and the education system.

Social/non-medical sector: it is important to raise capacity regarding children's mental health care among non-medical professionals e.g., social workers, psychotherapists, etc.

Service provision it is necessary to open new services for child and adolescent mental health in prevention and promotion as well as in mental health care.

8. Summary and conclusions

In Latvia not much has been achieved in the field of mental health during the last 10 years. Prevention and promotion are still the second role after medical care and treatment. There are still missing services related to child and adolescent mental health. It is necessary to run more accessible and effective services, better train more professionals in child and adolescent mental health, and to offer opportunities such as special scholarships for training in this field.

There is big hope that the next few years will be a turning point and targets and goals in planning documents will be reached, but at the same time there is need for large financial resources to do it. Best practice examples from other countries of effective promotion and prevention programmes as well as best practice regarding the development of community mental health care services e.g., care at home, centres for leisure activities, information posts, web pages, phone help-lines, support groups, etc., should be researched and those activities chosen which best fit for our situation.

LITHUANIA

Prepared by Sigita Lesinskiene and Marija Veniute

1. Introduction

1.1. Policy at a glance

CAMH policy issues in Lithuania are integrated into 3 main systems: health care, social care and education. CAMH issues are discussed at national and local levels including local municipalities. Officially CAMH policies are referred to in governmental and non governmental sectors, e.g. the National Health Board is an advisory body for the parliament where CAMH issues are considered. The Children's' Rights Ombudsmen's institution functions under the Seimas (Parliament); several institutions responsible for CAMH policy development and implementation function under the Government of Lithuania (e.g. the Drug Control Department, the State Tobacco and Alcohol Control Service). One of the key CAMH policy coordinating institutions is the State Mental Health Centre, functioning under the Ministry of Health. The State Mental Health Centre is the principal body responsible for implementation of the State Mental Health Strategy.

The Ministry of Health is directly in charge of provision of mental health services for children and families in need. The social care sector (Ministry of Social Security and Labour) is responsible for development of social care services/programs for children and families facing mental health problems. The education sector, embodied by the Ministry of Education and Science, takes responsibility for ensuring education of children with special needs as well as general assurance of good mental health in pre-school and school institutions. Other sectors implement CAMH policy according to their competencies, for example, the police, national defence system etc. Mental health care strongly depends on mutual intersectoral collaboration especially among three key institutions: the Ministry of Health, the Ministry of Social Security and Labour and the Ministry of Education and Science. Due to this some CAMH issues are successfully solved while others remain stagnated due to the pitfalls in intersectoral collaboration, unclearly defined and/or overlapping functions, as well as lack of clarity in defining responsibilities in provision of long term care and support for children and families.

In 2007 the State Mental Health Strategy was approved and an action plan was drafted. The mental health

strategy comprehensively covers the main aspects of mental health promotion, prevention and care. Nevertheless, lack of political will to implement the strategy is reflected through the lack of adequate funding of the approved action plans.

A list of all collected CAMH policy documents were enclosed in Annex 1 in the Country profile questionnaire.

1.2. Process to prepare the country story

This report was compiled by CAMHEE WP4 team members: **Sigita Lesinskiene**, MD, PhD, Child and Adolescent Psychiatry, Associate Professor, Vilnius University, and **Marija Veniute**, PhD, Public Health Researcher, MTVC and Vilnius University.

Information about the CAMHEE project goals and objectives, with specific focus on the Country Profile, was disseminated among the major governmental institutions, NGOs and other CAMH related sectors and bodies in the country. A group of country experts was convened to discuss the situation of CAMH in Lithuania on the basis of the most comprehensive analytical data on infrastructure, policies and practices in CAMH. On 10 June 2008 in close cooperation with the Children's Rights Ombudsman in Lithuania, a round table discussion was organised where 30 country experts from various fields working in CAMH participated and presented the CAMH related activities of their institutions, analysed strengths and weaknesses and provided suggestions for improvement of CAMH promotion, prevention and care. Seeing the importance of intersectoral cooperation significantly high interest was expressed by country experts to continue CAMH round table discussions regularly (twice per year, under the organisational support of Children's Rights Ombudsman).

The WP4 working group has collected a huge amount of information about practices, activities, projects and other initiatives which are carried out in the field of CAMH by governmental and non-governmental institutions.

Experts involved in the country coalition:

- Delegated representative from Rima Baškienė, Policy Development Advisor to Chairman, Lithuanian Parliament, Commission of family and child affairs.
- Romualdas Žekas, Head of Health policy Secretariat, National Health Board under Parliament.
- Rimantė Šalaševičiūtė, Ombudswoman for Children's rights, Children's Rights Ombudsman Institution of the Republic of Lithuania.
- Anžela Slušnienė, Senior specialist in Mental health, Ministry of Health of the Republic of Lithuania.
- Aldona Jociūtė, Head of the department for coordination of healthy schools network, State Environmental Health Centre.
- Audra Mikalauskaitė, Deputy Director of Children and Youth Affairs Department, Ministry of Social Security and Labour.
- Edita Maščinskaitė, Senior specialist of Special needs Education Department, Ministry of Education and Science.
- Inga Bankauskienė, Head of Department, Drug control department under the Government of the Republic of Lithuania.
- Vida Leonienė, Senior specialist in drug control policy and strategy, Drug control department under the Government of the Republic of Lithuania.
- Ona Davidonienė, Director, The State Mental Health Centre.
- Jurgita Sajevičienė, CAMHEE project coordinator, The State Mental Health Centre.
- Kristina Matuzienė, Advisor to Ombudswoman for Children's rights, Children's Rights Ombudsman Institution of the Republic of Lithuania.
- Irma Čižienė, Director, National Centre for Special Needs Education and Psychology.
- Sigita Kemerienė, Head of Psychology Department, National Centre for Special Needs Education and Psychology.
- Gražina Šapalaitė, Advisor on social affairs, Association of Local Authorities in Lithuania.
- Dana Migaliova, Head of NGO "Viltis" Welfare Society and CAMHEE WP7 co-leader, Lithuanian Welfare Society For People With Intellectual Disability "VILTIS".
- Natalija Olesova, NGO "Viltis" board secretary and CAMHEE WP7 coordinator, Lithuanian Welfare Society For People With Intellectual Disability "VILTIS".
- Sandra Pačinė, Lawyer of NGO "Viltis" Society Lithuanian Welfare Society For People With Intellectual Disability "VILTIS".
- Vita Danilevičiūtė, Head of Psychiatry Clinic, Vilnius University, Faculty of Medicine.
- Albinas Bagdonas, Professor of General Psychology, Vilnius University, Faculty of Philosophy, Department of General Psychology.
- Rasa Barkauskienė, Head of Psychology Department, M. Riomeris University .
- Antanas Goštautas, Professor of Psychology at the Department of Theoretic Psychology, Vytautas Magnus University, Faculty of Social Sciences.
- Inga Žvinytė, Senior specialist , Ministry of National Defence, Crisis Management Centre.
- Nomedas Cibarauskienė, Head of prevention department, Vilnius City Police Headquarters.
- Virginija Karalienė, Child and Adolescent Psychiatrist, Lithuanian Society for Child and Adolescent Psychiatry.
- Vida Matulionienė, Child and Adolescent Psychiatrist, Association of Mental Health Centres in Lithuania
- Raminta Aleliūnaitė, Psychologist, Youth Psychological Aid Centre.
- Jurgita Misiūnaitė, Psychologist, NGO "Vaiko Labui".

2. What we know about children and adolescents in our country and their mental health

2.1. Prevalence of mental disorders in children and adolescents

Information on the prevalence of mental disorders among children and adolescents is available at national

and regional levels. Most relevant data on prevalence rates are from epidemiological studies conducted by research institutions and published in scientific literature. Data from two large epidemiological studies are still in the process of analysis and evaluation.

Table 2. Prevalence of mental disorders in the general population of children and adolescents

Disorder	Prevalence (%) to 1 decimal place (or not available code)	Age range (yrs)	Reference period (week, month, year, lifetime)	Instrument and version used to measure	Year of most recent data collection
Attention-Deficit/Hyperactivity Disorder (ADHD)	5,3%	7-11	2003	ADHD rating scales	2003
Autism and pervasive developmental disorders	0, 59% for Asperger syndrome, 0, 12% for autistic disorder	7-16	2000	Autism and Asperger syndrome rating scales	1999
Childhood/Adolescent Suicide	23 cases or 3.4/100000 children	1-17	per 2006 year	Data of Statistics Lithuania	
Mental retardation	0,31% for moderate and severe mental retardation	5-15	1986	Clinical evaluation	1985

2.2. Vulnerable child population

Table 3 below presents available data on the prevalence of specific vulnerable child populations in Lithuania. Population level data on vulnerable child populations

are mainly available due to multi-country international surveys, most often initiated by international organisations in collaboration with local partners.

Table 3. Prevalence of specific vulnerable child populations

Vulnerable child populations	% of child population (or not available code)	Age-range	Reference period (week, month, year, lifetime)	Instrument and version used to measure
Children living in poverty	31.4 %	0-17	2006	Data of Statistics Lithuania
Homeless children	67 children / 5 % of the homeless	0-20	2001	Population and Housing Census 2001
Early school leavers	8.7 % of population aged 18-24	18-24	2007	Data of Eurostat
Children experiencing bullying	36 % of boys and 32 % of girls	11, 13 and 15 years old school children	2002	Research of Health Behaviour in School-Aged Children, coordinated by WHO
Youth unemployment	9.8 %	15-24	2006	Data of Statistics Lithuania
Children in care (living in any residential places other than families)	5994 children/ 0.83 %	0-17	2006	Data of Statistics Lithuania
Asylum seeker children	165 children	0-17	Per 2007 year	Data of migration Department under the Ministry of the Interior
Traveller children	1183 gipsies	0-19	2001	Population and Housing Census 2001
Juvenile offenders (cautioned or prosecuted)	3600 children aged 14-17 or 1.7 %	14-17	Per 2006 year	Data of Statistics Lithuania
Children abandoned due to parental migration for employment	916 children	0-17	2007	Children, who were identified in need of support due to parents emigration abroad

2.3. Positive child and adolescent mental health

A comprehensive assessment of children well being has been performed by UNICEF Innocenti Research Centre. The report attempts to measure and compare child well-being under six different headings or dimensions:

material well-being, health and safety, education, peer and family relationships, behaviours and risks, and young people's own subjective sense of well-being – those are the indicators relevant to children's lives and

children's rights. As regards Lithuania, not all indicators are available; nevertheless, an overview of available data of children and adolescents wellbeing is reflected¹.

As regards children mortality, in Lithuania indicator on deaths from accidents and injuries under 19, is 31,7/100 000 children under 19. As regards peer and family relationships, in Lithuania 51,7% of young people find their peers "kind and helpful", aged 11, 13, 15.

As regards risk behaviour, data on smoking cigarettes, drinking, using cannabis, adolescent fertility and reproductive health are present:

- In Lithuania 12% of students age 11, 13 and 15 smoke cigarettes at least once a week (in comparison to 13% in UK);
- In Lithuania 25% of students age 11, 13 and 15 report having been drunk two or more times (in comparison to 20% in Denmark)
- In Lithuania 18% 15 year-olds who report having had sexual intercourse.
- In Lithuania around 6% of students age 11, 13 and 15 report having used cannabis in the last 12 months;
- In Lithuania 75% of 15 year-olds used a condom during their last sexual intercourse;
- Teenage fertility rate: births per 1,000 women age 15-19 – in Lithuania – 33 births per 1000 women aged 15-19.

Concerning experiences of violence, high enough prevalence is observed among children and adolescents:

- In Lithuania around 60% of young people age 11, 13 and 15 report having been involved in fighting in the previous 12 months;
- In Lithuania 65% of young people age 11, 13 and 15 report being bullied in the previous 2 months;

As regards health behaviour, several indicators reflect, that:

- In Lithuania 70% of young people age 11, 13 and 15 who report eating breakfast every school day;
- In Lithuania 20% of young people age 11, 13 and 15 who report eating fruit every day;
- The mean number of days on which young people age 11, 13, and 15 report being physically active for one hour or more of the previous/typical week – in Lithuania is 4,3;
- In Lithuania less than 5 % of young people age 13 and 15 who report being overweight (e.g. in comparison to 15% in UK).

As regards health, data from surveys on Lithuanian children's health reflect that, 33 % of young people age 11, 13 and 15 rate their health as 'fair or poor'.

Data on subjective well being of Lithuanian children and adolescents show that:

- In Lithuania 75 % of young people age 11, 13 and 15 rate themselves above the middle of the life satisfaction scale;
- In Lithuania 25% of students age 11, 13 and 15 report 'liking school a lot'.

WHO/HBSC FORUM on Social cohesion for mental wellbeing among adolescents released a report in 2007, where information on Lithuanian mental health and well-being status among adolescents is presented and overview of research, policies, practices and partnerships concerning youth mental health status. Official statistical data on youth mental health, general health and well-being, addiction and risk behaviour, violence, abuse and bullying, suicidal behaviour are present.

The report concludes, that „Lithuanian experience clearly demonstrates that child and youth health must remain high on the political agenda. A comprehensive approach that integrates the state, parents, school, NGOs, youth organizations, mass media and various initiatives to promote child and youth health is the way to address the problem. Data from various studies carried out in Lithuania over the past two decades point to the necessity of more intensive international collaboration for a country in transition. Due to increases in access to risky information through the fast expansion of information technologies, there is a need to develop carefully planned education programmes tailored to the interests of children and young people which are supported by the entire social, economic, political and educational environment"².

There are many research projects constantly going on within the field of CAMH comprising self-esteem and quality of life. They are conducted in universities and research institutes (mainly in Vilnius, Kaunas and Siauliai), medical, pedagogical, psychological and sociological fields, supported by funds, universities and municipalities. There are systematic research projects on adolescent mental health, comprising values in young people, smoking and alcohol prevention, lifestyle, suicide prevention, risk and well-being factors of mental health disorders in primary school children, investigation of quality of life of children with acute and chronic diseases, etc.

3. Actions for promotion and prevention in mental health

CAMH policy issues in Lithuania are integrated into 3 main systems: health care, social care and education. CAMH issues are discussed on national and local levels including local municipalities. Constructive cooperation with the Ministry of National, Police Headquarters, the State Environmental Health Centre and the Drug

¹Child poverty in perspective: An overview of child well-being in rich countries, Innocenti Report Card 7, 2007, UNICEF Innocenti Research Centre, Florence: http://news.bbc.co.uk/1/1/shared/bsp/hi/pdfs/13_02_07_nn_unicef.pdf

²WHO/HBSC Forum 2007 Report Social cohesion for mental well-being among adolescents. Copenhagen, WHO Regional Office for Europe, 2008. <http://www.euro.who.int/Document/E91921.pdf>

Control Department is developing. The Children's Rights Ombudsman Institution of the Republic of Lithuania is working very actively and collaborating with other related organisations, governmental and nongovernmental agencies.

A list of policies related to CAMH and service provision is presented in Annex 2 of the Country profile questionnaire.

Programs (many) in the field of CAMH are planned and implemented most often in the frame of one Ministry, more often at the regional levels. The importance of longer term (several years) implementation of projects in order to get and reinforce good results was highly stressed by the country experts. Some programs are very successful and long term funding and implementation is very important.

Some CAMH issues are successfully solved while other remain stagnated due to the pitfalls in intersectorial collaboration, unclearly defined and/or overlapping functions, as well as lack of clarity in defining responsibilities in provision of long term care and support for children and families, lack of experienced specialists etc.

3.1. Policies and programmes for CAMH

Specific policies and large-scale programs for CAMH

Seimas (parliament) of the Republic of Lithuania approved the governmental Strategy on Mental Health³ and an intersectoral working group was created to prepare an implementation programme for this strategy. A plan of measures for 2008-2010 was drafted in June 2008, but is not yet implemented.

The National Mental Health strategy

Aims

- to improve CAMH care by implementing prevention, treatment and rehabilitation programmes in order to strengthen mental health protective factors in children, families and communities and to prevent negative outcomes of mental health problems; The main focus should be devoted to CAMH; child emotional and social development; parenting programmes; prevention of suicide; prevention of dependency disorders and violence and other health problems of young people;
- to support state and local level mental health promotion and prevention programs as an inseparable part of public health, education and social programs; firstly by ensuring continuous

funding in the respective areas: 1) teaching parenting skills to risk group parents especially at early infancy and childhood; 2) CAMH promotion at schools and community;

- to develop and finance effective evidence and European values based prevention, treatment and rehabilitation programs, in order to improve the mental health of children, families and communities, strengthen psychological resilience for prevention of social exclusion and promoting social integration of vulnerable groups;
- to strengthen the role of family physicians and their ability to provide care for the majority of patients with mental health problems; also to support family physicians in completing higher training of family physicians in the field of mental health, to improve their skills, competencies and motivation to diagnose and treat mental disorders.
- To develop psychotherapy services;
- To promote development of modern outpatient services for the treatment of specific and widely prevalent mental disorders (e.g. eating disorders, first psychotic episode in adolescence and youth); also to provide crisis intervention services and other outpatient care and rehabilitation services;

To date, none of the respective aspects have been developed further or implemented despite the fact that 1.5 years have passed since the approval of the policy document.

Financial support coming from EU should be used more constructively and lacking services or programmes for children and adolescents should be established. Building professional skills of specialists in multidisciplinary teams, improving teamwork skills and provision of services should be prioritised.

Other general policies related to CAMH.

There are several general policies specifically targeting CAMH issues, e.g. Child and youth socialization programme (approved in 2004), covering social and educational requirements, prevention of delinquency and drug addition⁴.

In 2008 the National programme on prevention of violence against children and children support 2008-2010 was adopted. This programme covers various complex means for prevention as well as postvention of psychological, physical and sexual violence⁵. Eventually more comprehensive prevention means are foreseen in National programmes on prevention of violence against children and children support^{6,7}.

⁴Child and youth socialisation program. Dėl vaikų ir jaunimo socializacijos programos patvirtinimo http://www3.lrs.lt/pls/inter3/dokpaieska.showdoc_l?p_id=296403&p_query=savi%FEudybi%F8%20programos&p_tr2=2

⁵National programme on prevention of violence against children and children support 2008-2010. Dėl nacionalinės smurto prieš vaikus prevencijos ir pagalbos vaikams 2008-2010 metų programos patvirtinimo http://www3.lrs.lt/pls/inter3/dokpaieska.showdoc_l?p_id=319006&p_query=paty%E8i%F8%20ir%20smurto%20prevencija%20programos&p_tr2=2

⁶National programme on prevention of violence against children and children support 2008-2010. http://www3.lrs.lt/pls/inter3/dokpaieska.showdoc_l?p_id=261846&p_query=savi%FEudybi%F8%20prevencijos%20priemoni%F8%20patvirtinimo&p_tr2=2

⁷National programme on prevention of violence against children and children support 2005-2007. Dėl nacionalinės smurto prieš vaikus prevencijos ir pagalbos vaikams 2005-2007 metų programos patvirtinimo: http://www3.lrs.lt/pls/inter3/dokpaieska.showdoc_l?p_id=255201&p_query=savi%FEudybi%F8%20prevencijos%20priemoni%F8%20patvirtinimo&p_tr2=2

Ministry of Social affairs initiated policies and action plan in order to combat poverty and social exclusion⁸, where CAMH is stressed as an important area of intervention. Recently in Lithuania a significant attention has been devoted for drug addiction issues since drug addiction appeared as an urging topic. Policies on prevention of drug addiction cover extensive interventions for children, adolescents and youth: annually measures of the National Drug control and drug abuse prevention programme are adopted and implemented intersectorally^{9,10}. Regulations for CAMH services for Lithuania were created and approved in 2000¹¹ on the Principles of Organisation, Description and Provision Requirements of Psychiatric and Psychotherapeutic Services for Children and Adolescents. Together with medical normative MN 114:2005 for the Medical Doctor Child and Adolescent Psychiatrist¹² these two Orders became a standard for CAMH services providing guidelines, requirements and recommendations.

3.2. Availability of programmes for CAMH promotion and mental disorder prevention

There are several programs concerned with CAMH including small programs implemented by municipalities and larger programs at regional or national levels. Many programs are successfully implemented by NGOs alone or in cooperation with governmental institutions.

Issues identified

Home based programs for infants and children should be elaborated and more widespread in the country. Paediatric nurses are visiting families with newborn babies, but aspects of mental health of the newborn and family are not referred adequately.

Parenting programmes are not common or widely available.

School mental health promotion and school targeted drug and alcohol abuse prevention programs are developed and implemented but not systematically in the whole country.

Promotion/prevention at hospital/clinic programs are developed and implemented but not equally throughout the country.

Churches, clubs, recreation centres are developing and implementing their own programs, in some places there is good cooperation between these sectors and educational, health or social institutions.

Protective and custodial services have programs in the field of CAMH, intersectoral cooperation could be more

active and constructive.

Community settings are developing their programs, but there is lack of sharing information, initiatives and experience with other communities and municipalities. A system of telephone counselling for children and young people exists and is well functioning throughout the country.

Promotion/prevention via internet programs are gradually developing but fragmented depending on the institution or sector and could be implemented more actively. The police have created initiatives for children and adolescents, comprising a friendly internet programme¹³, animated cartoons, socialisation programs for children and adolescents, summer programs and specialised programs for at-risk families etc.

Some good examples:

The State Environmental Health Centre has a department for coordination of the healthy school network. There is good cooperation between the Ministries of Health and Education in implementing this project.

There are 3 projects successfully implemented in Šiauliai University:

- The EQUAL program 2004-2008: two family oriented and disabled oriented initiatives, funded and administrated by the Ministry of Social Security and Labour.
- The STREP program 2006-2009 (EC FP6): Socrates/Comenius 2.1. "Children as Researchers in Primary Schools in Europe".
- The Child support Centre (NGO in Vilnius) is successfully implementing the 2008-2011 program against violence¹⁴

Many programs are funded and conducted by the Drug Control Department under the Government of the Republic of Lithuania.

The National Centre for Special Needs Education and Psychology 2005-2008 implemented project for school droppers/early school leavers¹⁵.

Many projects were successfully implemented by the NGO "Viltis" (Lithuanian Welfare Society) for people with intellectual disability, comprising of early rehabilitation, education, social integration, employment and international cooperation.

The program "Zippy's Friends" is successfully implemented in Lithuania (coordinated by the Ministry of Education and Science) in cooperation with other countries.

Many programs are successfully implemented by NGOs or NGOs in cooperation with governmental institutions. State Mental Health Centre is coordinating and

⁸Measures for the year 2005-2006 of the National action plan (2004-2006) against poverty and social exclusion.

⁹2007 year measures of the National Drug control and drug abuse prevention programme 2004-2008. Dėl nacionalinės narkotikų kontrolės ir narkomanijos prevencijos 2004-2008 metų programos įgyvendinimo 2007 metų priemonių patvirtinimo: http://www3.lrs.lt/pls/inter3/dokpaies-ka.showdoc_l?p_id=312126&p_query=psichikos%20lig%F8%20prevencija%20priemon%EBs&p_tr2=2

¹⁰2008 year measures of the National Drug control and drug abuse prevention programme 2004-2008.

Dėl nacionalinės narkotikų kontrolės ir narkomanijos prevencijos 2004-2008 metų programos įgyvendinimo 2008 metų priemonių patvirtinimo http://www3.lrs.lt/pls/inter3/dokpaieska.showdoc_l?p_id=312015&p_query=psichikos%20lig%F8%20prevencija%20priemon%EBs&p_tr2=2

¹¹Order No. 730 of December 14, 2000 of the Minister of Health of the Republic of Lithuania

¹² Order No. V-577 of July 13, 2005 of the Minister of Health

¹³www.policelub.lt

¹⁴<http://lt.pvc.lt/>

¹⁵www.sppc.lt

implementing the EU Public health program Child and adolescent mental health in enlarged EU: development of effective policies and practices (CAMHEE) project 2007-2009 that involves 35 partners from EU countries.

4. Organisation and resources for implementation

4.1. Institutions and organisations

The main institutions and organisations that implement programs on mental health promotion and prevention in children and adolescents are on national and/or local levels including local municipalities. The Ministries of Health, Education and Science, Security and Labour are most actively involved in coordination and implementation of these programs, usually involving various related governmental institutions and NGOs.

The Drug Control Department, State Tobacco and Alcohol Control Service under the Government of Lithuania are also actively implementing related programs. The State Mental Health Centre, functioning under the Ministry of Health, is also involved.

4.2. Services

Gradual acceptance of a biopsychosocial paradigm after regaining independence in 1990 necessitated creating new services and therapeutic approaches within child and adolescent psychiatry (CAP) and CAMH in Lithuania.

A network of 41 Early Habilitation Services (EHS) provides help for children with developmental disabilities (aged 0-4 years) and their families.

Further outpatient follow-up care is provided and available at the Mental Health Centres (MHC) which are primary mental health institutions located in every region (73 in the country). The teams in MHCs consist of a psychiatrist, a child and adolescent psychiatrist, a psychologist, a social worker and a nurse.

There are 5 in-patient units across the country (approx. 100 beds) but there is big gap in day care services (2 only).

A crisis intervention program has started in Vilnius with a 7 days duration in-patient program.

A network of 60 Pedagogical Psychological Services (PPS) functioning on the municipality level, is funded through the educational sector and also serves as an opportunity to provide complex help for children and families comprising intersectoral cooperation. In some municipalities cooperation between MHCs and PPS is successful, in some cases it should be built more constructively.

Normative acts, legislation and necessary regulations serve as a strong basis for adequate service delivery providing guidelines, requirements and

recommendations and enhancing positive changes. Regulations for child and adolescent inpatient services for Lithuania were created and approved in 2000¹⁶. Together with the medical normative for Doctor Child and Adolescent Psychiatrist this order became a standard for child psychiatric services providing guidelines, requirements and recommendations. Implementation of the regulations and quality assurance remains the main goal for further development of the services.

4.3. Funding

CAMH services are mostly funded by a public funded insurance system (i.e. less than 1% from general budget of the medical sector) together with a small share of out of pocket expenditure for private practice.

Lack of adequate financing and low salaries in the field of CAMH creates the large problem of a growing deficit of experienced specialists, especially those with good practical skills in working with children, adolescents and families. Participants in the local expert group noted a lack of child psychiatrists, psychologists, social workers and child psychiatric nurses, especially in the regions of the country. Administrations of the related services should think more positively and flexibly seeking to find and keep specialists in the field of CAMH, and should systematically invest in their professional growth.

Resource allocation for CAMH in general tended towards small increases in resources but these were insufficient to achieve considerable quality and quantity change. Resources allocated to the field of CAMH compose of mental health budget from insurance money, education and social affairs budget allowances, programs funded by government or municipalities. State budget, regional/municipal budgets, international organisations/foundations, private for-profit and also some individual donations are the main sources in the field of CAMH.

Although mental health and emotional well being are declared as a priority for the Ministry of Health, looking at the proportion of financial investment a lack of political will to invest in CAMH is obvious.

4.4. Training of professional workforce

Training in child mental health/child psychiatry is a recognised independent field from general mental health/psychiatry but is incorporated into the larger course of psychiatry with child and adolescent psychiatry and psychotherapy as separate credits. Child and adolescent psychiatry is a separate speciality and has a 4 year residency program after the general medical studies in two universities (Vilnius and Kaunas). A current task is to unify the training programs of the two universities according to the guidelines of the UEMS (training log-book for specialist training in Child and Adolescent Psychiatry/Psychotherapy, 08 Dec 2000).

There are 83 licensed child and adolescent psychiatrists who work in clinical work. Child and adolescent

¹⁶Order No. 730 of December 14, 2000 of the Minister of Health of the Republic of Lithuania on the Principles of Organisation, Description and Provision Requirements of Psychiatric and Psychotherapeutic Services for Children and Adolescents

psychologists are not separated and specialised from general clinical psychologists, and can work with children and adults with the one licence. Primary care doctors have no training in child psychiatry during their residency program, paediatricians and psychiatrists have one 3 or 5 month course during 4 years of training.

CAMH issues are incorporated into the training curricula of several specialists on a university level. There are several universities that have programs for psychologists, social workers, nurses, teachers, public health specialists etc. There is good availability of higher education in the field of CAMH promotion and/or mental disorder prevention and service provision, but during the training there is little attention paid to practical skills in working with children, adolescents and their families. The number of credits and hours vary in each university.

Postgraduate studies in multidisciplinary mental health work are lacking and child psychiatric nurses and social workers are especially neglected. This has the direct impact of low quality of team work at the primary care level.

During the discussions of the country expert group the suggestion was raised to join students working in the field of CAMH and coordinate their investigations, share information among universities, specialties etc.

5. Monitoring and evaluation of the actions for the promotion and prevention in mental health

Surveys initiated mainly by the Ministries of Social Security and Labour, Education and Science and Ministry of Health or in the framework of national programs (listed in the above sections) serve as a basis for the evaluation of CAMH policies in mental health care and service provision, mental health promotion and prevention. Evaluation hereinafter is mainly meant by monitoring of implementation of activities, while professional evaluations (of process, outputs and outcomes) is lacking. Evaluations are usually performed using various methodologies mainly on the initiative of those who are implementing specific programs or the

initiative of the scientific and academic community.

6. Research and dissemination

There are many research projects going on within the field of CAMH in Lithuania. During the discussions of the country expert group the suggestion was raised to join students working in the field of CAMH in various universities and to find ways of coordinating their small research projects and investigations, to join forces and find ways for multidisciplinary cooperation involving students, and also to share information about big research projects universities, specialties etc.

Below some of the main research projects conducted by several universities and sub-fields are presented.

One of the biggest projects was an epidemiological project on child mental and behavioural disorders, undertaken by Vilnius University in 2003-2005. The target group was children 7-16 years old in 15 urban areas, 10 towns and 22 rural schools. Information about 3334 children was received and data establishing prevalence are still being analyzed in cooperation with Norwegian colleagues and Prof. R. Goodman (UK). Two main publications were prepared from the data of this study^{17,18}, other papers are in the process. Another important research project was undertaken in Vilnius University analysing the relationship between Lithuanian preschool children's (2-5 years old) emotional and behavioural problems with social demographic factors¹⁹.

Publications

There is a range of publications investigating various aspects of developmental disorders in children. There are also several research projects that were investigating development of services and service delivery and data were published internationally and nationally^{20, 21, 22, 23, 24}. Many studies have been successfully performed at the M. Riomeris University in Vilnius by the team of researchers under the leadership of Prof. Rita Zukauskienė. This team has produced a number of national and international publications in the area of CAMH - there are several

¹⁸Girdzijauskienė S., Lesinskienė S., Gintilienė G., Pūras D., Butkienė D. Risk and well-being factors of mental health disorders in primary school children. *Public Health (in Lithuanian)*, ISSN 1392-2696, 2007, Vol. 4(39), 27-33.

¹⁹Jusienė R., Rainienė S., Barkauskienė R., Bieliauskaite R., Dervinyte Bongarzoni A. The risk factors of emotional and behavioural problems in preschool age. *Public Health (in Lithuanian)*, ISSN 1392-2696, 2007, Vol. 4(39), 46-54.

²⁰Lesinskienė S., Ranceva N., Vitkute-Maigienė L., Stacevic I., Mitrauskas M., Cincikiene L. Dynamics of inpatient child psychiatric care in the time-frame 1995-2005 (Vilnius University Child Developmental Centre). *International Journal of Psychiatry in Clinical Practice*, 2008, 12:4, 247-255.

²¹Lesinskienė S., Jegorova N., Ranceva N. 2007. Nursing of young psychotic patients: analysis of work environments and attitudes. *Journal of Psychiatric and Mental Health Nursing*, ISSN 1351-0126, 2007, 14, 758-764.

²²Lesinskienė S., Šenina J., Ranceva N. 2007. Use of the HoNOSCA scale in the teamwork of in-patient Child psychiatry unit. *Journal of Psychiatric and Mental Health Nursing*, 2007, 14, 727-733

²³Pūras D., Lesinskienė S., Povilėnaitė S., Blažys V., Chaffin M. Child and adolescent mental health emergency services in Lithuania. *International Journal of Emergency Mental Health*, ISSN 1522-4821, 2001, Nr. 2(3), 73-76.

²⁴Simonsen L., Pūras D., Lesinskienė S. Analysis of children mental health services, provided in mental health centres (In Lithuanian) // *Public Health*, ISSN 1392-2888, 2003, Nr. 4(23), 33-38.

international epidemiological surveys were Lithuanian data on various CAMH issues are analyzed in the wider international contexts^{25, 26, 27, 28, 29, 30, 31}.

Studies on various aspects of psychosocial adjustment among adolescents has been performed in Kaunas, Vytautas Magnus University under the leadership of Prof. Antanas Goštautas^{32, 33, 34, 35, 36, 37, 38, 39}.

Psychosocial adjustment of adolescents having health problems (disorders) was studied extensively. One of the studies analyze how different health disorders have specific impacts on adjustment of adolescents or do disorders in general cause adjustment difficulties, limiting adolescent's physical and social activity. This study aimed to identify peculiarities of psychosocial adjustment difficulties among hospitalised adolescents with neurological and physical disorders and secondary school students⁴⁰.

Factors related to the length of solution-focused brief therapy working with adolescents⁴¹. The objective of the study was to identify factors related to the number of solution-focused brief therapy sessions required to solve adolescents' problems. The study was conducted in foster care and health care institutions.

Promotion of mental health:

Health promoting schools network programme, performed by Environmental health centre in Vilnius⁴². Health promotion feasibility study among preschool age children and schoolchildren; the study is performed at Kaunas University of Medicine, Institute of Biomedical Research, Department of Social Paediatrics; The impact of schoolchildren's lifestyle and social environmental factors upon child health – this study is performed at Kaunas University of Medicine, Institute of Biomedical Research, Department of Social Paediatrics; Quality of life of children with disabilities - this study is performed at Kaunas University of Medicine, Institute of Biomedical Research, Department of Social Paediatrics. The main bodies involved in information dissemination to keep health care professionals informed:

- National Health Board under the Parliament of Lithuania⁴³,
- State Mental Health Centre⁴⁴,
- Ministry of Health⁴⁵,
- Ministry of Education and Science⁴⁶,
- Ministry of Social Security and Labour⁴⁷,
- State Patients Fund⁴⁸, Dissemination activities cover publications and press releases mainly

²⁵Ivanova MY, Achenbach TM, Rescorla LA, Dumenci L, Almqvist F, Bilenberg N, Bird H, Broberg AG, Dobrea A, Döpfner M, Erol N, Fornas M, Hannesdottir H, Kanbayashi Y, Lambert MC, Leung P, Minaei A, Mulatu MS, Novik T, Oh KJ, Roussos A, Sawyer M, Simsek Z, Steinhausen HC, Weintraub S, Winkler Metzke C, Wolanczyk T, Zilber N, Zukauskienė R, Verhulst FC. The generalizability of the Youth Self-Report syndrome structure in 23 societies. *J Consult Clin Psychol*. 2007 Oct;75(5):729-38.

²⁶Zukauskienė R, Pilkauskaitė-Valickienė R, Malinauskienė O, Kratavičienė R. Evaluating behavioral and emotional problems with the Child Behavior Checklist and Youth Self-Report scales: cross-informant and longitudinal associations. *Medicina (Kaunas)*. 2004;40(2):169-77.

²⁷Testing the 8-syndrome structure of the child behavior checklist in 30 societies. Ivanova MY, Dobrea A, Döpfner M, Erol N, Fombonne E, Fonseca AC, Frigerio A, Grietens H, Hannesdottir H, Kanbayashi Y, Lambert M, Achenbach TM, Larsson B, Leung P, Liu X, Minaei A, Mulatu MS, Novik TS, Oh KJ, Roussos A, Sawyer M, Simsek Z, Dumenci L, Steinhausen HC, Metzke CW, Wolanczyk T, Yang HJ, Zilber N, Zukauskienė R, Verhulst FC, Rescorla LA, Almqvist F, Weintraub S, Bilenberg N, Bird H, Chen WJ. *J Clin Child Adolesc Psychol*. 2007 Jul-Sep;36(3):405-17.

²⁸Epidemiological comparisons of problems and positive qualities reported by adolescents in 24 countries. Rescorla L, Achenbach TM, Ivanova MY, Dumenci L, Almqvist F, Bilenberg N, Bird H, Broberg A, Dobrea A, Döpfner M, Erol N, Fornas M, Hannesdottir H, Kanbayashi Y, Lambert MC, Leung P, Minaei A, Mulatu MS, Novik TS, Oh KJ, Roussos A, Sawyer M, Simsek Z, Steinhausen HC, Weintraub S, Metzke CW, Wolanczyk T, Zilber N, Zukauskienė R, Verhulst F. *J Consult Clin Psychol*. 2007 Apr;75(2):351-8.

²⁹The Strategy and Attribution Questionnaire: Psychometric properties of a Lithuanian translation in an adolescent sample. Zukauskienė R, Sondaite J. *Scand J Psychol*. 2004 Apr;45(2):157-62.

³⁰Adolescents' social strategies: patterns and correlates. Sondaite J, Zukauskienė R. *Scand J Psychol*. 2005 Aug;46(4):367-74.

³¹Evaluating behavioral and emotional problems with the Child Behavior Checklist and Youth Self-Report scales: cross-informant and longitudinal associations. Zukauskienė R, Pilkauskaitė-Valickienė R, Malinauskienė O, Kratavičienė R. *Medicina (Kaunas)*. 2004;40(2):169-77.

³²Antanas Gostautas et al. Personality correlations with depressiveness among adolescents. *Medicina* 2003; 39 (2): 186-93.

³³Gostautas A, Pakrošnis R, Cepukienė V, Pilkauskienė I, Fleming JS. Factors related to the length of solution-focused brief therapy working with adolescents. *Medicina (Kaunas)*. 2007;43(8):630-6.

³⁴The peculiarities of use of addictive substances among students during 2005-2006. Goštautas A, Povilaitis R, Pilkauskienė I, Jakusovaite I, Statkeviciene S. *Medicina (Kaunas)*. 2007;43(2):153-60.

³⁵Gostautas A, Pranckevičienė A, Matoniene V. Changes in depression and quality of life during inpatient treatment of depression. *Medicina (Kaunas)*. 2006;42(6):472-8.

³⁶Gostautas A, Pakrošnis R, Krišcionaitė S, Endziniene M, Sergutina I, Glamba V. Psychosocial adjustment difficulties among hospitalized adolescents with neurological and physical disorders. *Medicina (Kaunas)*. 2006;42(4):321-31.

³⁷Gostautas A, Perminas A. Impact of the relationship between smoking and stressogenic behavior (type A behavior) and their cumulative effect on development of myocardial infarction and mortality (25-year follow-up data). *Medicina (Kaunas)*. 2004;40(3):265-71.

³⁸Markevičiūtė A, Gostautas A, Pilkauskienė I. Possibilities of group psychological correction of depressiveness among adolescents. *Medicina (Kaunas)*. 2003;39(7):689-99.

³⁹Markevičiūtė A, Gostautas A, Pilkauskienė I. Personality correlations with depressiveness among adolescents. *Medicina (Kaunas)*. 2003;39(2):186-93 (in Lithuanian).

⁴⁰<http://en.scientificcommons.org/34451774>

⁴¹<http://en.scientificcommons.org/34450721>

⁴²<http://vasc.sam.lt/>

⁴³http://www3.lrs.lt/pls/inter/w5_show?p_k=1&p_r=692

⁴⁴www.vpsc.lt

⁴⁵www.sam.lt

⁴⁶www.smm.lt

⁴⁷www.socmin.lt

⁴⁸www.vlk.lt

- State Drug Control Department⁴⁹,
- State Mental Health Centre⁵⁰,
- Academic institutions
- NGO "Viltis"⁵¹, and numerous others NGO's
- Lithuanian Society for Children and Adolescents Psychiatrists⁵².

Dissemination is performed via annual institution activity reports, specific information via internet, publications of books, booklets, posters, organisation of public campaigns, competitions for children, conferences, publications in the press, public activities and other activities.

7. Challenges, opportunities and advances in the field

7.1. Key recent advances

Key recent advances in CAMH care and in prevention of mental disorders and promotion of mental health in children and adolescents:

Developed a network of CAMH, like EHS and PPS services throughout the country give possibilities to get systematic and complex help for children and adolescents closer to their living place (are community based and are more widely defined in the section on services). Prepared normative acts, legislation and necessary regulations serve as a strong basis for adequate service delivery providing guidelines, requirements and recommendations and enhancing positive changes. The Ministry of Health identified Mental Health as a priority field. The Governmental strategy in Mental Health⁵³ and Governmental implementation program for 2006-2008⁵⁴ were elaborated (but still not implemented).

Active professional organisations (Lithuanian Society for Child and Adolescent Psychiatry, Lithuanian Association for Rehabilitation of Persons with Developmental Disorders, Lithuanian Paediatric Society, Lithuanian Welfare Society for Persons with Mental Disability "Viltis" and others. These organisations are working intensively and organise various professional events, seek solutions for optimal development of the system of child and adolescent mental health services, submit recommendations to the Ministries of Health, Education, Social Affairs and other institutions. There is good collaboration with the Children's Rights Ombudsman of the Republic of Lithuania and other governmental and nongovernmental agencies.

Many preventative programs and research projects were implemented in the sectors of Education, Health, Social Affairs and the Drug Control Department of the Government of the Republic of Lithuania, National Health Board under the Parliament, Police prevention

departments, universities and NGO's.

Many national and international conferences have been organised including the media and with multi-sectoral participants. CAMH issues are broadly discussed in Lithuanian media: radio, TV, newspapers, magazines, charity projects. This raises awareness of the field and disseminates information. This process is really vibrant and active in the country.

In 2008 the National Health Board, Clinic of Psychiatry (Medical Faculty of Vilnius University), Lithuanian Society for Children and Adolescent Psychiatrists and Children's Rights Ombudsman of the Republic of Lithuania have successfully organised the Republican Conference "Child mental disorders: possibilities for prevention and treatment" in the main hall of Lithuanian Parliament. This was attended by 360 participants from various sectors.

The initiative from CAMHEE WP4 to gather together a country expert group was very supported by the participants, many people from various CAMH related institutions participated very willingly and suggested continuing to organise such meetings and round table discussions periodically (twice per year). The Children's Rights Ombudsman of the Republic of Lithuania agreed to host these meetings.

7.2. Youth involvement

Children and adolescents are included in the process of policy decision-making/ programme planning, design and implementation/development of CAMH policies to some extent, but not systematically. Some institutions (mostly in the Education sector) and NGO's actively involve children, especially adolescents when implementing national, regional and municipal programmes.

A good example is the Parliament of Schoolchildren of Lithuania⁵⁵.

7.3. Difficulties and proposals for further development

Lack of political will to implement the Mental Health Strategy is reflected through lack of adequate funding of the approved action plans. The Ministry of Health identified Mental Health as a priority field but lack of funding and inactivity in creating new or lacking CAMH services reflects scant attention to the complex needs of children and adolescents.

Lithuania does not have any specialized adolescent psychiatry unit and no specialized units for 0-3 and 3-7 year old children. Day treatment programs as well as specialized programs for young children, those with autistic disorders and adolescents should be implemented to ensure seamless integration of child

⁴⁹www.nkd.lt

⁵⁰www.vpsc.lt

⁵¹www.viltis.lt

⁵²<http://www.lvppd.lt>

⁵³Order No.X-1070 of April 3, 2007

⁵⁴Order No. 1020 of October 17, 2006

⁵⁵<http://www.lmp.lt/>

psychiatric services in the country. There is significant lack of long-term residential programs for delinquent children/adolescents with conduct disorders, alcohol/drug dependence, and also for children/adolescents with serious emotional disorders, developmental trauma etc. Lack of occupational training for autistic adolescents and adults, absence of specific programs in general schools for children with autistic spectrum disorders, hyperkinetic disorders (ADHD) and related problems. Education of children with special needs remains a complicated area. More flexible cooperation among the Ministry of Health and the Education and Social Welfare systems creating a system of mixed funding together with effective ways to stimulate municipalities should be elaborated. Programs in kindergartens and schools could be implemented in cooperation between the Education and Health sectors, this would create the possibility for flexible approaches with utilization of present resources and avoid establishing costly services.

In the educational system a lack of psychologists and knowledge of multiprofessional team-work in school is prominent together with a lack of specialised training for class tutors and a focus on results and knowledge but not on values and personal growth of schoolchildren.

Intersectoral cooperation remains the most complicated area. Flexible mechanisms for mixed intersectoral funding still are not developed. Descriptions of responsibilities at the municipal level and regional or national level and in different ministries are mixed or not clearly defined and strategies for infrastructure requires elaboration. Constructive intersectoral cooperation and political support/understanding in this process is crucial, but there is lack of understanding or will to change the situation.

Implementation of the regulations and quality assurance remains the main goal for further development of services. Consideration of quality assurance and not only quantity is very necessary and is still lacking in the daily work of administrators.

A better system of differentiation of service provision for each particular case is needed and should be implemented. Responsibility for short and long term results or consequences should be defined. A system of case managers could be implemented in the municipalities.

Training programs for multidisciplinary teams, especially child psychiatric nurses, psychologists, social workers should be organised systematically. Increased salaries and plans to employ and retain qualified personnel are needed and more attention should be paid during the training process to practical skills working with children, adolescents and families. Training in teamwork skills should be systematic.

There is ongoing debate in the Ministry of Health about the competencies of adult psychiatrists and child/adolescent psychiatrists and the potential for adult psychiatrists to provide primary mental health care for children and adolescents in the country. The Lithuanian Society for Child and Adolescent Psychiatrists is strongly against this and are trying to keep child/adolescent psychiatry as a separate specialty and sustain prepared

and applicable normative acts, legislation and necessary regulations for child and adolescent psychiatry and services.

Municipalities via Public Health programmes are financing projects in the field of CAMH. Lack of information and joint initiatives, and occasional competition among institutions or NGO's creates an obstacle to implementing programs and/or ensuring their continuation. Nobody is responsible for sharing good examples or initiatives with other municipalities or coordination of implementing these programs throughout the country. National programs are usually getting reduced funding from that which was initially planned and that suppresses continuous and complex implementation of the planned actions. Long term systematic community care programs together with mental health promotion and prevention of mental disorders should be elaborated and widespread in the country.

Municipality level and ministries should find more flexible ways for implementing the tasks. Increased funding and setting long term projects, (more than one year) is needed in order to get and sustain long term positive results. Systematic information and raising of public awareness is also crucial. Love and respect of children should not only be declared but also realised in constructive decisions and actions. Actions toward constructive help but not punishment should prevail in the system of Social Affairs and Children's Rights.

The foster care system is still in an early stage of development. Recently existing network of orphanages and special care institutions and the costs themselves serve as an obstacle to creating a more flexible and modern foster care system. Strengthening of the family institution as a system is very important in the society. Parent training programs should be elaborated and widespread throughout the country.

8. Summary and conclusions

Delivery of adequate child psychiatric service is strongly dependant on administrative support; presence of qualified personnel; adequate financial funding; relevant guidelines and regulations for the organisation of a multidisciplinary teamwork; building-up the therapeutic environment; personnel outsourcing; and, creation of a system for professional training. This process has stalled for the moment with very little attention paid to the quality assurance that requires personal involvement of administrators and specialists, and there is a deficiency of qualified specialists.

The importance of interdisciplinary collaboration and clarification of the responsibilities across governmental and nongovernmental sectors and agencies solving CAMH related problems should be stressed. The whole range of overlaps and still existing lack of clarity in concepts and definitions in the field of CAMH adhere difficulties in finding constructive ways of intersectoral cooperation. Importance of the interdisciplinary

collaboration and clarity of responsibilities among governmental and NGO sectors solving CAMH related problems should be stressed. More CAMH promotion and prevention programs could be created and implemented in kindergartens, and primary and secondary schools together with increasing the number of professionals working there and increasing funding.

Financial support from EU should be used constructively but political will to invest into CAMH is crucial. Political will and governmental resolution to grasp the nettle would provide opportunities to optimise and further develop the field of CAMH services appropriately for the benefit of our country.

NORWAY

Prepared by Marian Ådnanes

1. Introduction

1.1. Policy at a glance

In Norway, a White Paper issued in 1997 proposed important mental health policies regarding the organisation and content of mental health services and care (St.meld. nr 25, 1996–1997). The paper gave rise to a 10-year national mental health Escalation Programme with a number of strategies and measures targeting national, regional and local levels in Norway (St prp nr 63, 1997–1998). The overall goal of the programme, which is coming to its' end in 2008, have been to create adequate, coherent, well-functioning and user-friendly services at all levels for people suffering from mental illness.

In parallel with the Escalation Programme, a strategy plan for the period 2003-2008¹ presents how the Government plans to strengthen and develop action for improved mental health among children and adolescents through 100 different measures to be performed at different levels of services, schools, volunteer organisations or directed at parents. The strategy plan is an expression of intention of a total policy for a joint strategy in enhancing children and adolescents' mental health, and the plan has been developed by the Ministry of Health and the Directorate for Health in collaboration with several other ministries. The professional foundation for the plan has been developed by the Directorate for Health in collaboration with the NGO; Voksne for barn (Adults for Children) and Lærings- og mestringssenteret (Centre for learning and coping).

The strategy plan has a clear health promotion and preventive profile, and emphasises strengthening children and adolescents' own resources and abilities to cope with challenges in life. Focus is on the significance of the local community. The plan also points at particular challenges for the services towards children and adolescents who already have a mental health problem or disorder.

1.1. Process to prepare the country profile

This report was compiled by **Marian Ådnanes**, senior researcher at SINTEF Health Research, with information from the following sources, institutions and persons:

- Policy-documents from several ministries and the Norwegian Directorate for Health
- Published research
- The Regional Centre for Child and Adolescent Mental Health (RBUP)
- Statistics Norway, SSB
- The Norwegian University of Science and Technology, NTNU
- SINTEF Health Research
- Sonja Heyerdahl, Dr.med./senior researcher, connected to The Regional Centre for Child and Adolescent Mental Health (RBUP)
- Randi Talseth, General Secretary at the NGO; Voksne for Barn/ Adults for Children

2. What we know about children and adolescents in our country and their mental health

2.1. Prevalence of mental disorders in children and adolescents in Norway

Information on the prevalence of mental disorders among children and young people in Norway is available at a regional level. The source of data on prevalence rates of childhood mental disorders is epidemiological studies, made by research institutions. The table below presents the prevalence rates for different childhood and adolescent mental disorders:

The most common reasons for referral of children and adolescents to a specialist service in Norway are hyperactivity and concentration-problems (22 %), behavioral problems (19 %), sadness, depression (17 %) and anxiety/phobia (8%). In the period 1998-2007, the greatest increase has been in referrals for hyperactivity and concentration-problems (12-22 %). Among pre-

¹The Government's strategy-plan for children and adolescents' mental health...together on mental health" (2003)

²SAMDATA, 2008. (yearly monitor of specialist mental health services at SINTEF Health Research)

school children (0-6 years old) the most frequent reason for referral was behavioral problems for survey years 1998, 2002 and 2007.

The specialist service give priority to patients with a severe depression, with suspected psychosis, serious eating disorder, serious social disorders/ discrepancy in pre-school-children, serious post traumatic stress disorders.

Table 1. Prevalence rates for different child- and adolescent mental disorders

Disorder	Prevalence (%)	Age range	Reference period	Instrument	Data-collection
Anxiety disorders	3.8	7-9	Month	DAWBA	2003
Depression (moderate to severe diagnosis)	0.2	7-9	Month	DAWBA	2003
	2.6 /6.1 MDD (DSM IV)	14-16	Present/lifetime	Kiddie SADS	1999/2000
Bipolar disorder (Manic-depressive)	Not collected				
Attention-Deficit/ Hyperactivity Disorder (ADHD)	1.7	7-9	Month	DAWBA	2003
Learning disorders	Not collected				
Conduct disorder (act out their feelings or impulses in destructive ways)	CD 0.5 Other disruptive 0.3 ODD 2.5	7-9	Month	DAWBA	2003
Eating disorders	AN 0.1	7-9	Month	DAWBA	2003
Autism and pervasive developmental disorders	0.5	7-9	Month	DAWBA	2003

MDD: Major Depressive Disorder; CD: Conduct Disorder; ODD: Oppositional Defiant Disorder; AN: Anorexia Nervosa

¹ Referrals to specialist mental health services

2.2. Vulnerable child population

The table below presents available data about the prevalence of specific vulnerable child populations in Norway.

Table 2. Prevalence of specific vulnerable child populations in Norway

Vulnerable child populations	% of child population (total number)	Age-range	Reference period	Data-collection
Children living in poverty	2,6 % (26306)	0-17	2001	SSB ³
Homeless children	0			
Early school leavers	15%	15-18	2002-2007	Survey
Children experiencing bullying ⁴	23%	11-18	"last month" 2007	Survey
Youth unemployment	7.2 %	15-24	Jan.-March 2008	SSB
Children in care ⁵	1.4 % (15970)	0-17	2006	SSB
Asylum seeker children	0.02% (222)	0-17	2007	SSB
Traveller children	Data not collected			
Juvenile offenders (cautioned or prosecuted)	0.5 % (5650)	15-17	2006	SSB
Children abandoned due to parental migration for employment	0			

³T Statistics Norway.

⁴ Definition of bullying according to Olweus (1992).

⁵ Living in any residential places other than families.

2.3. Positive child and adolescent mental health

The table below presents available data on prevalence rates for aspects of positive mental health; self-esteem and quality of life.

formulated in the Government budget for 2008 are presented yearly in a separate publication⁷; “Efforts directed at children and adolescents”. For 2008, 27 different programs from the different ministries are presented here.

Table 2. Child and adolescents’ positive mental health in Norway

Positive child and adolescent mental health	Prevalence (%)	Age range	Reference period	Instrument	Data-collection
Self-esteem	57	8-16	The past week	KINDL	1997
Quality of Life	72	8-16	The past week	KINDL	1997

Source: Helseth, S.; Jozefiak, T. The Norwegian version of the KINDL. <http://www.kindl.org/>

3. Actions for promotion and prevention in mental health

3.1. Policies and programs for CAMH

Specific policies and large-scale programmes for CAMH

The national mental health Escalation Programme, referred to in the introduction (1998-2008) includes seven main aims: to empower clients; increase public awareness of mental health issues through education programmes; strengthen community-based prevention and early intervention services; expand specialised mental health services for adults, adolescents and children; improve the mental health workforce; improve accessibility of accommodation and housing for clients of mental health services; stimulate education and research.

In order to implement this policy⁶, the Ministry has established a consulting group, represented by all major user organisations, whose aim is to discuss all major issues arising with relevance to the mental health programme. Government funds have been made available to strengthen the users’ organisations. New laws adopted by Parliament, aim to improve the rights of patients, including the right to take part in the planning and coordination of their own services, and the right to decide where to receive treatment. Specialised services are now required by law to establish systems for monitoring patients’ and users’ experiences and views of services. A new system for quality assurance is being implemented for specialised services. This system primarily focuses on indicators measuring users’ experience and satisfaction with services. A similar system is planned to be developed for community based services.

The Governments’ priority programmes and support schemes directed at children and adolescents as

Examples of large scale programmes

“Mental Health in School” is a school-based national intervention initiative to prevent the development of emotional and behavioural problems in adolescents. The program started in 2000, and is financed and driven by the Norwegian Directorate for Health and Social Affairs in cooperation with Norwegian Directorate for Education and Training and five NGOs in the field of mental health. The main goals are: To provide both students and staff with basic knowledge on 1) issues related to mental health, 2) how to cope with their lives, 3) where to get help and support, 4) how they can contribute in supporting others and 5) how to be a good friend. The programme is being evaluated by SINTEF Health Research, and the first publication from the evaluation will be published in March 2009. The evaluation included just over 4000 students in the 2007 data-collection, and just below 3000 in 2008.

Preventing disorders in children of parents with mental health and alcohol/drug problems

Since the end of the nineties, there have been several initiatives both within hospitals and municipal-services directed at children and adolescents whose parents have either a mental health illness or alcohol/drug-problems. In order to give long-term help to this group, the government in 2007 decided on a multi-year action plan for identifying and following up these children (in 2007: 15 million NOK⁸/ 1,7 million €; in 2008: 20 million NOK/ 2,27 million €). The intention is to give early intervention, long-term follow up, better information to children and adolescents, to strengthen guidance/ counselling and competence within the services, to increase research activity, disseminate experiences and stimulate volunteer organisations for mental health action. Measures directly for the benefit of the children are emphasised.

⁶ <http://www.regjeringen.no/upload/kilde/hod/red/2005/0011/ddd/pdfv/233840-mentalhealthweb.pdf>

⁷ http://www.regjeringen.no/upload/BLD/Rapporter/2008/Satsing_paa_barn_og_unge_47.pdf

⁸ Norwegian Kroner

In April this year the Ministry of health and care started to work with the proposition for a law that will emphasise children's need for information about their parents' mental illnesses and will take precedence over client confidentiality. The intention is that health institutions providing specialist care will have health personnel with a responsibility to follow up children of mentally ill parents, drug addicts, seriously somatically ill or injured patients.

Other general policies related to CAMH

Poverty, social inclusion and social welfare

The overall objective of the Government's policy on children and adolescents is to give equal opportunities, services and developmental opportunities, independent of social background and geographical location.

Report no. 39 to the Norwegian Parliament from the Ministry of Children and Equality ("Years of growth and living-conditions for children and adolescents in Norway", 2001-2002)⁹ To strengthen developmental conditions for children and adolescents, among other things by ensuring all children have the opportunity to participate in and to influence their environment, is a central goal in the policy presented in this report. In Report no. 6 to the Norwegian Parliament, from the Ministry of Labor and Social Inclusion ("Plan of action for combating poverty", 2002-2003)¹⁰, The plan includes measures for the inclusion of children and adolescents. For example, the report points to the need for schools, volunteer organisations and the local communities to provide activities and culture where one does not have to pay a high amount to participate.

In Report no. 9 ("Work, welfare and inclusion", 2006-2007)¹¹, also from the Ministry of Labour and social inclusion. The report presents the following measures aimed at children and young people: Increased efforts to prevent young people from dropping out of upper-secondary schooling, improvements of the school health services (part of the Escalation Plan for mental health), measures to increase the participation in society of children and young people with immigrant backgrounds, free primary/lower-secondary schooling.

Report no. 20 to the Norwegian Parliament from the Ministry of Health and Care services ("National strategy for equalization of social differences in health")¹² presents a broad and long-term strategy for reducing differences in health. Early intervention is considered necessary in order to prevent social inequalities in health. The government aims to create safe developmental conditions through kindergartens, schools and services of high quality for children and youth independent of social differences.

Child care/ protection

Report no. 40 to the Norwegian Parliament, from the Ministry of Children and Equality ("About the child- and adolescent protection" 2001-2002)¹³ includes 70 measures: early and adequate interventions are considered important to prevent problematic behaviour, more preventive child- and adolescent protection that emphasises the family and the local environment when solving the problems. At the same time, the "best for the child" is always the fundamental rule.

When situations arise which present a threat against the basic needs and rights of the child, the child welfare system shall take the role of parents for shorter or longer period, on behalf of society. The system shall give preventive help to children and families as far as possible. At the same time, intervention outside the home is an equally important part of the role of a modern child care system. Help from the child protection department is now supposed to happen in collaboration with users and with other services. A single coordinating service has been proposed in order to coordinate the different services.

Education and school programmes

Report no. 16 to the Norwegian Parliament from the Ministry of Education and Research ("...nobody left behind. Early Intervention for Lifelong Learning", 2006-2007)¹⁴ states that everyone has a potential for learning. The measures to promote social equality that are presented in this white paper aim mainly to ensure that everyone acquires the necessary knowledge and basic skills at primary and lower secondary school and that as many persons as possible complete upper secondary schooling, with good results. It is also important for all to develop social, cultural and ethical knowledge and skills as well as the ability to cooperate and think critically. Everyone must develop knowledge and insight that will enable them to take part in democratic processes and to take responsibility for their own lives.

Day care legislation/policy for pre-school children

The social differences in access to the education system have been reduced by providing for more day-care institutions, (as well as introducing ten-years of compulsory schooling for everyone and the right to upper secondary education). A shortage of day-care places and the families' financial situations are the principal reasons why some children do not attend a day-care institution. The National Childcare Survey also indicates that some parents (approximately 5%) do not want day-care places for their children. One alternative is the so-called "cash benefit scheme" which acts as a supplement to day-care for parents with children between one and three years old who do not use a day-care centre or who combine

⁹St.meld. nr. 39 (2001-2002). Oppvekst og levekår for barn og ungdom i Norge.

¹⁰St. meld. nr. 6 (2002-2003). Tiltaksplan mot fattigdom.

¹¹St. meld. 9 (2006-2007). Arbeid, velferd og sosial inkludering. Summary of this report in English at: http://www.regjeringen.no/Rpub/STM/20022003/006EN/PDFS/STM200220030006000EN_PDFS.pdf

¹²St. meld. nr. 20 (2006-2007). Nasjonal strategi for å utjevne sosiale helseforskjeller.

¹³St. meld. Nr. 40 (2001-2002). Om barne- og ungdomsvernet.

¹⁴St.meld. nr. 16 (2006-2007)... og ingen sto igjen. Tidlig innsats for livslang læring.

part-time day care with a reduced cash benefit. The cash benefit is of more importance to immigrant families' income than to families in the population as a whole, because on an average the cash benefit represents a higher share of those families' total income. While the cash benefit is directed at both mothers and fathers, one now sees a lower share of women with children between 1-2 years in the work-force.¹⁵

Family friendly workplace policy¹⁶

In Norwegian politics, the family is arguably the unit which has been the subject of the most reforms in the welfare state in recent years. Norway has several arrangements intended to help parents combine work and taking care of children; subsidised day-care and "after-school-arrangement"(SFO), the right to paid time off when the children are ill, cash benefit (when the child is between 1-3) and paid parental leave are among these. The arrangements are gender neutral, and can be used by both parents. However, absence from work due to children is still very skewed with mothers still taking the majority of parental-leave, more often working part-time and representing 96 percent of cash benefit-receivers. Mothers and fathers are eligible to receive benefits for 44 weeks with full salary compensation or 54 weeks with 80% salary compensation. Each parent can be at home on paid leave for ten days per year if a child (up to the age of 12) or a child carer is ill. They are entitled to flexible working hours and reduced working hours.

Adoption, fostering policies

The general adoption and fostering policy is that adoptive and foster parents and children shall have the same rights as biological parents and children.¹⁷ The period for parental leave is 3 weeks less, 51 weeks with 80 % rate or 41 weeks at full pay.

Divorce and custody policies

The Norwegian policy expresses three important principles related child support payment: 1) the child's need for provision is to be shared between parents according to economic ability and as fairly as possible, 2) the regulations shall encourage care from both parents, and 3) private agreements about the child support payment can be arranged.

Report no. 19 to the Norwegian Parliament ("Evaluation of new regulations for child support")¹⁸ summarised developments in recent years as slowly moving in the direction of it being more common for children to live with the father, . At the same time as it becomes more common for parents not to live together, one sees a small

decrease in the total number of child support payment' cases treated within the work and welfare-service. This decrease is connected to the reform within child support payment legislation.

Urbanisation policies

In Report no. 31 to the Norwegian Parliament from the Ministry of Local Government and Regional Development ("The big city report. About development of big-city policy", 2002-2003)¹⁹ the government states that they will provide an active and positive policy that lays the groundwork for industrial and commercial development and good developmental and environmental conditions for children. Report no. 31 contains a chapter where challenges related to children and adolescents are presented: the need for full day-care, integration of immigrant children, the multicultural school (challenges in terms of language and culture that have to be met), the inclusion of parents, the school as an important arena for attitudes, juvenile crime - measures to meet the different challenges.

Housing²⁰

In the report no. 23 to the Norwegian Parliament from the Ministry of Local Government and Regional Development ("About housing policy", 2003-2004) the long-term goal is to fight the problem of persons not having a place to live. This is done through the institution "Husbanken" (The Norwegian State Housing Bank) and a particular strategy adopted by this institution: "On the way to a house of your own".

Ombudsman for children and adolescents²¹

Norway was the first country to establish a commissioner, or ombud, with statutory rights to protect children and their rights since 1981. Act No 5 in March 1981 defines the Ombudsman as an independent, non-partisan, politically neutral institution. Although the Ombudsman is administratively under the jurisdiction of the Ministry for Children and Family Affairs, neither the Norwegian Parliament nor the Government have the power to instruct the Ombudsman.

The Ombudsman is regarded as an active participant complying with the UN Convention on the Rights of the Child both on a national and international level, which has now been incorporated into the Human Rights Act of 1999. The duties of the Ombudsman are to promote children's interests to public and private authorities and to investigate the developments of conditions which children grow up in. The Ombudsman has the power to investigate, criticise and publicise matters important to improve the welfare of children and youth.

Summary of this report in English at:

http://www.regjeringen.no/Rpub/STM/20062007/016EN/PDFS/STM200620070016000EN_PDFS.pdf

¹⁵Source: SSB, Statistics Norway: <http://www.ssb.no/ssp/utg/200406/04/>

¹⁶Source: Green paper: "Gender and wages. Facts, analyses and policy instruments for equal pay" (2008) from the Ministry of Children and Equality.

¹⁷Booklet on the rights of parents of small children: http://www.regjeringen.no/upload/BLD/Veiledning%20og%20brosjyrer/2007/270636_the_rights_of_parents_of_small_children_2007_english.pdf

¹⁸St.meld. nr. 19, (2006-2007). Evaluering av nytt regelverk for barnebidrag.

¹⁹ St.meld. nr. 31, (2002-2003). Storbymeldingen. Om utvikling av storbypolitikken.

²⁰ St. meld. nr. 23 (2003-2004). Om boligpolitikken.

²¹ Source: <http://www.barneombudet.no/english/> Annual report in English: http://www.barneombudet.no/sfiles/8/50/1/file/The_Ombudsman_for_Children_-_Annual_report_2006.doc

The Ombudsman's office takes on the role of a politician on behalf of the children and the role of an activist when a special case needs attention from the authorities and the media. In the next instance, however, the office may function as the advisor for children, parents, professionals and organisations regarding children's interests. Initiating projects and research is another way to collect information concerning children. In addition, many institutions as well as the media turn to the Ombudsman for information. An increasing part of the organisation's workload stems from the aspect of communications, which represents another challenge for the future.

4.2. Availability of programmes for CAMH promotion and mental disorder prevention

It is not an easy task to quantify specifically the availability of programmes for child and adolescents' mental health promotion and mental disorder prevention. Hence, this account must be considered an approximate measure.

Home-based programmes for promotion/ prevention are not common as part of public health services in Norway, except for public health nurses visiting families with newborn babies. The so-called Home-Start Family contract represents this kind of service, run on a volunteer basis. This is a family support program where volunteers visit families with at least one pre-school-child, for 2-4 hours a week. It is the family who defines for themselves the kind of support they need.

Parenting programmes are quite common and widely available. The Government's action plan from 2003-2008 contains several actions directed towards parents: a) The parent's guide programme; a DVD called "Interaction for parents/persons caring for children of school-age", where the goal is to stimulate discussion and reflections between adults and children, b) Parental guidance for families with minority background, c) Romani-childrens' placements in kindergarden and school, d) a thematic book directed at parents about youth and drugs, e) Thematic book directed at parents about eating disorders, f) Strengthening of peer-work among parents, g) Support for life together – mostly courses and gatherings for couples, h) National telephone-help-line for parents, i) Better collaboration between home and school.

School mental health promotion is also quite widely available, first and foremost through the school health services, but also through different local, regional or large-scale national programs like "Mental health in school" currently being carried out in a large number of Norwegian schools (initiated and supported by the Norwegian Directorate for Health and Social

Affairs in cooperation with Norwegian Directorate for Education and Training and five NGOs in the field of mental health).

School targeted preventive programmes directed at smoking, drinking, drugs, problematic behaviour, social competence etc. are widely available in Norwegian schools, and supported by public money. Prevention of drugs and alcohol are for the most part directed at schools.

Promotion/prevention programmes at hospitals/clinics are not very common among the measures offered there. This is primarily due to the fact that almost all specialist mental health services are delivered on an out-patient basis in Norway.

Churches, clubs, and recreation centres are widely available for children and adolescents in Norway.²²

Promotion/prevention action via Internet is quite common, for example via webpages of the NGO; Mental Health Norway²³, via the Health directorate²⁴ and via the webpage www.forebygging.no, a knowledge-base for drug prevention and health promotion in collaboration with different research communities and directed towards teachers and parents²⁵, or giving information about measures.²⁶

Custodial settings (detention centres). According to Statistics Norway²⁷, around ten persons below 18 are in prison at any time in Norway. New imprisonments during the year for this age group were 74 for in 2006, 17 to prison-sentence and 57 to custody. The average length of stay in prison for these children and adolescents in 2004 was 60 days. Almost 80 percent of these were in custody, and most of them for a short period. In September 2007, approximately six of every ten inmates were foreign citizens. The Government's goal is to reduce prison for young criminals. Except for work and education programmes, the most important promotion measures inside prisons are: "contact-officers" (for support, motivation, mapping of resources and needs etc.), "future-plan" and "program-activity."²⁸

The community settings represents the most important arena for CAMH promotion and mental disorder prevention in Norway, and includes the kindergartens, schools, organised leisure activities, public health centres, school health centres and other primary health- and social services. The availability of these is not a problem.

Telephone counselling. Several help-lines either for children and adolescents or for parents have been established the last years, for example through the NGOs Mental Health Norway and "Adults for Children".

²²See for example: http://www.ungogfri.no/no/Lenker/Fritidsklubber_i_Norge/

²³<http://www.sidetmedord.no/>

²⁴<http://www.unghelse.no/>

²⁵<http://skole.forebygging.no/>

²⁶<http://www.forebyggingstiltak.no/>

²⁷Statistics Norway (in English) – see table 54 at: http://www.ssb.no/english/subjects/03/05/a_krim_tab_en/ and from home-page "Punished" at: http://www.straffet.com/kriminalomsorg/forebygging/program_norge.htm

²⁸From the home-page "Punished" at: http://www.straffet.com/kriminalomsorg/forebygging/program_norge.htm

4. Organization and resources for implementation

2.1. Implementation of programmes

The most important body for carrying out the policy, initiating and implementing programs within the field of mental health promotion and prevention for children and adolescents is The Norwegian Directorate for Health.²⁹ The Directorate is a specialist director and an administrative body under the Ministry of Health and Care Services, that administer it, and the Ministry of Labour and Social Inclusion. Its societal mission is to improve the whole population's social security and health through comprehensive and targeted efforts across services, sectors and administrative levels. The Directorate for health is a specialist body both in the area of public health and living conditions and in the area of health services responsible for monitoring these areas. On this basis, the directorate offers advice and guidance on strategies and measures aimed at central governmental authorities, regional and local authorities, the health enterprises, voluntary organisations, the private sector and the population. Comparing knowledge and experience in professional matters and setting national standards of behaviour in certain areas are key roles of the directorate.

The directorate provides expertise to the authorities, various sectors, the service providers, interest organisations, research and development circles and the media. It is the authority responsible for applying and interpreting laws and regulations in the health sector, and for the implementation of politics in accordance with the guidelines from the ministry, and contributing to international work.

Table 4. Availability of services

	0%	1-25%	26-50%	51-75%	76-100%
Child psychiatrist appointments					x
Psychologist appointments					x
Social service appointments/ child protection					x
Family therapy/ counselling					x
Adolescent-specific services/outpatient centres					x
Group therapy					x
School counselling					x
Pharmacological treatment					x
Psychological rehabilitation centres for adolescents	x				
In-patient beds on child psychiatric ward					x
In-patient beds on general psychiatric ward	x				
Infant-specific services/early intervention					x

²⁹ From a presentation (in English) at:

http://www.shdir.no/portal/page?_pageid=134,67714&_dad=portal&_schema=PORTAL&navigation2_selectedItemid=2014&navigation2_parentItemid=2014&navigation1_parentItemid=2014&piref134_67727_134_67714_67714.artSectionId=1738&piref134_67727_134_67714_67714.articleId=19347&language=english

2.2. Services

Specialist mental health services for children and adolescents are provided to 95 percent of patients on an outpatient basis, usually delivered at units attached to general hospitals. There are currently 334 beds available for inpatient treatment (2007), giving a bed ratio of 3 per 10000 inhabitants (0-17 years of age).

The municipalities play an essential role in prevention and in the provision and coordination of services to children and adolescents suffering from mental health problems or illness, with General Practitioners (GPs) responsible for referrals to specialist services. Public health nurses are extremely important in this area, and have increased in number throughout the escalation period. Public health centres for children and adolescents respectively and school health services are important in the identification of problems at an early stage and contribute to the recovery of children and adolescents. For children and adolescents with mental health problems, the Educational-Psychological Service provides active support to other services and to schools and kindergartens.

Availability of services

The table below presents only an approximate indication of access to therapeutic services. Data on access to specific types of therapy is not available, to the best of our knowledge.

Child psychiatrist and psychologist appointments. In general the availability of services related to children and adolescents' mental health care and treatment is relatively good. The greatest problem is the waiting time for specialist mental health care. The number of children treated within the specialist mental health services (therapists) is 49479 which is 4,5 % of the total population of children and adolescents. The specialist mental health services are multidisciplinary with psychiatrists, psychologists and college-educated specialists holding relevant postgraduate studies.

Social services (e.g. child protection) in the municipalities are widely available. The number of children subject to child-protection measures is approximately 3 % (3686 children).

Adolescent-specific services (outpatient) are first and foremost represented by school health centres and youth health centres.

School-counselling is available via the Educational-Psychological Service. All municipalities are obliged to deliver this service.

Pharmacological treatment is accessed through GPs. Approximately 11000 children and adolescents (1,1%) in Norway receive medication.

Psychological rehabilitation for adolescents is not available in specific centres, but rather is an integrated part of ordinary health services.

There are 334 in-patient beds in child psychiatric wards. An important reason for not increasing the number of beds is the development towards more ambulant and outreaching methods, which in many cases represents an alternative to hospitalisation.

Access to specially designated mental health services

The following table looks at specific subgroups of children and adolescents who have access to specially designated and tailored mental health services or promotion/preventive action,. As data for most of these groups is not available, an approximate indication of access to specially designated services is given, based on the authors' knowledge.

Table 5. Access to specially designated mental health services

Group	0%	1-25%	26-50%	51-75%	76-100%
Minority groups		x			
Migrant population				x	
Orphans		x			
Children living in poverty	x				
Runaways/homeless	x				
Refugees/disaster-affected population				x	
Seriously emotionally disturbed					x
Victims of bullying		x			
Early school leavers		x			
Unemployed youth		x			

Source: The author's personal estimate.

4.3. Funding

Resource allocation to CAMH in general, as well as to specific areas of child and adolescents' mental health, has increased as a consequence of the National Escalation Plan.

The Escalation Plan implies investments of 6,3 billion NOK (1 NOK=8 Euro) throughout the plan-period (this implies 8,8 billion in 2008-NOK). Running expenses have gradually been increased to a level that is 4,6 billion NOK over the expense level in 1998, something which implies 6,1 billion 2008-NOK.

In the most recent national budget, 940 million NOK is earmarked for the last year of the Escalation Plan.

A good example of money allocated for CAMH is 1875000 Euro (in the 2008 budget) reserved for preventive

intervention aimed at children with mentally ill parents, or parents suffering from addictions.

The main source of funding for NGOs is the state budget.

4.4. Training of the professional workforce

Training in child mental health/child psychiatry is recognised as an independent field from general mental health/psychiatry, both for medical doctors and psychologists. The number of child or adolescent psychologists in private practice is 494. The total number of child or adolescent psychiatrists is 278, 20 of whom are in private practice.

The training capacity within universities and university colleges has increased during the Escalation Plan period. In particular, the number of students has increased within the multidisciplinary post graduate study in mental health work.³⁰ In addition, special scholarships are on offer and also a number of post-graduate courses funded through the national Escalation Programme. One may assume that increase in training capacity is responsible for the high level of recruitment that has been recently observed across municipalities as well as in the specialist services.

At the moment, approximately 20 university-colleges offer postgraduate studies in multidisciplinary mental health work, with a strong focus on promotion at the primary care level – several of these are now developing courses focusing specifically on children and youth and some of the colleges and universities offer masters' courses within this field.³¹ The study plan builds on the Norwegian Directorate for Health: "Requirement specification for multidisciplinary continuing education within psycho-social work with children and adolescents."

5. Monitoring and evaluation of action for promotion and prevention in mental health

5.1. Mental health service and care policies evaluated

The national Escalation Plan emphasised that specialist mental health care services was a field that needed to be strengthened. In addition to more beds, an increase in the capacity for consultation and support to other health- and social services was needed. The concrete aims as part of the Escalation Plan were: a) 400 more professionals in out-patient clinics, b) a 50 % increase in out-patient clinics' productivity, c) treatment to 5 % of children and adolescents under 18 years, d) more beds (a total of 400 in combination with new forms of treatment; more out patient care, ambulant measures, local low-threshold services and closer collaboration between primary and specialist care).

More professional qualifications

The professional qualifications of personnel in the children and adolescents specialist services are generally high. 29 percent of all personnel have a university degree. 21 percent of these are psychologists, and the rest are psychiatrists or other medical doctors. An additional 51 percent have a college degree. The number of man-labour years has increased by 71 percent since 1998. Of these, out-patient man-labour years have increased by 101% while the increase in in-patient man-years is 47%.

Productivity

During the escalation plan-period, the number of treatment-measures per year has increased by 80 %, from a mean of 249 treatment measures per therapist in 1998 to 448 per therapist in 2007. The Escalation Plan's goal has been surpassed. Increased productivity has first and foremost lead to more treatment measures per patient (a 47 % increase), but also to a 20 % increase in the number of patients per therapist. One treatment measure can be a consultation (therapy, conversation, review) with/of the child or the family (direct measures), but can also be supervision to other services involved, meetings and other in-direct work.

Currently, 4.5 percent of children and adolescents up to 18 years receive specialist services (2007), however, significant differences between the four health regions in the country exists (west, south/east, middle and north of Norway). In order to reach the national goal of 5%, the number of patients receiving treatment would have to increase by 10% from 2007 to 2008.

In-patient care

There are currently 334 beds available for inpatient treatment (2007), and the increase in beds has been only 11 % since 1998. As mentioned in the introduction, this gives a bed ratio of 3 per 10000. The escalation Plan originally planned for 500 more beds. However, this goal was reduced to 400 in the Governmental budget of 2005. There are good professional reasons for this; within the specialist mental health care for children and adolescents, there has been a development towards more ambulant and outreaching methods, and in many cases this represents an alternative to hospitalisation.

5.2. Mental health promotion and mental disorder prevention policies evaluated

The municipalities are considered the most important arena for promotion and prevention. At the end of the 1990s, the services provided by the municipalities were lacking in several respects. There was a lack of funding, a lack of competent personnel, and a lack of competence on the planning, organisation and integration of services.³²

Within the national Escalation Plan at least 20 percent of earmarked funds are to be used for children and adolescents. The general goal is more and better efforts and services; focusing on psycho-social services, culture and leisure activities and so-called support-contacts in relation to leisure-activities, increase of personnel: a) 4500 new recruitments in total (both adults, children and adolescents), of these 184 new psychologists and 800 professionals at the maternal and child health centres, and in particular public health nurses with postgraduate studies in mental health.

³⁰ A programme directed at nurses, physiotherapists, ergonomists, social educators and social workers

³¹ For example the College in Telemark county offer a so-called "Multicultural preventative care with children and adolescents, presented in English at: <http://www.hit.no/nxceng/content/view/full/12067>

³² Source at: <http://www.regjeringen.no/upload/kilde/hod/red/2005/0011/ddd/pdfv/233840-mentalhealthweb.pdf>

The total increase of new recruitments covers the plan. However, looking at recruitment by area, there are still too few psychologists, and the increase in numbers of public health nurses or other high quality staff (800) within health maternal and child health centres has not yet been reached.

The funds from the Escalation Plan are used both for preventative measures and for treatment/follow-up within the municipalities²⁸. The objective is to uncover any previous non-optimal development, and be able to implement curative and preventative measures at an early stage. Pilot programs initiated at family assistance centres have been evaluated, proving this to be a suitable co-ordination plan for different municipal services directed at children, adolescents, and their families.

The Child Health Clinics, as well as school health services, have low threshold services for pregnant women, children, and adolescents as a central role of their services. An evaluation of these low threshold services shows that they represent an important supplement to specialist mental health services. They do not, and are not supposed to replace investigation and treatment performed by specialists. Furthermore, the evaluation has confirmed the existence of other studies and evaluations in this field which show initiatives being taken within the municipalities, and also that in a great deal of these initiatives the public health nurses are a part of the service.

A study of public health nurses' competence show that they have a lot of experience and that many of them have postgraduate education in addition to their training as a public health nurse²⁹. At the same time a considerable uncovered demand for more competence among nurses was found by this study, and especially in order to meet demands related to children ,adolescents' and also parents mental health. The findings show that the public health nurses perceive their role as important and central to community mental health work.

6. Research and dissemination

6.1. Key research projects on CAMH

There are many research projects going on within the field of CAMH; in the universities, colleges, research institutes as well as within the previously mentioned Regional Centre for Child and Adolescent Mental Health (RBUP). The research projects presented below are being conducted within several sub-fields; CAMH mental health and psychiatric disorders, care related issues, and prevention of mental disorders and promotion of mental health.

Child and adolescent psychiatric disorders

*"Children in Bergen" (Barn i Bergen)*³⁵

The project is a collaboration between the Bergen municipality and the Regional Centre for Child and Adolescent Mental Health (RBUP), department of western Norway. This project combines screening in a community sample with clinical assessment of cases and controls drawn from this population-based sample. In this way the project estimates the prevalence of mental health problems in children, and defines the characteristics of the different disorders in terms of co morbidity, risk factors and development, from both a categorical and dimensional perspective. Another important objective for the project involves the development of screening procedures for early identification of children at risk.

*"Early safe in Trondheim" (Tidlig Trygg i Trondheim)*³⁶

This is a collaboration between Trondheim municipality and The Norwegian University of Science and Technology looking at preschool children's development and mental health. 4000 four-year-olds will be evaluated by their parents in a short questionnaire about strengths and weaknesses in their development. 1000 of these will be selected for further studies and observation at home and at the university. The goal of the project is to map the prevalence of social and emotional difficulties with 4-year-old in order to develop an effective and sufficiently early follow up protocol.

The ADHD study³⁷

The ADHD-study, performed by researchers at the Norwegian Institute of Public Health, will study factors to identify pre-school children with ADHD, in order to diagnose those suffering from ADHD as early as possible. The overall goal with the study is to improve the knowledge available to develop preventive measures. The study is the first in the world to have access to biological material and information from the fetal stage and early infant-life of the participating children.

Care related issues

The SAMDATA project

The so-called SAMHDATA project is a yearly monitor of all specialist mental health services in Norway. Over the last 15 years, SINTEF Health research has, in cooperation with Statistics Norway, produced and developed this data. The purpose of this project has been to develop performance indicators that can monitor the development and functioning of services according to central governmental policy guidelines.

Thanks to the availability of these statistics, it was possible to describe the status of services in quite specific and quantifiable form, enabling concrete targets to be set for the development of services through the national Escalation Plan.

SAMDATA is presented in annual reports for the mental health services, as well as on the web, making it possible

³⁵ Presented in English at: <http://www.unifobhelse.no/index.php?Gruppe=3&Lang=eng&counter=11&ID=Prosjektsider>

³⁶ <http://www.trondheim.kommune.no/content.ap?thisId=1117619721>

³⁷ Presentation in Norwegian at: http://www.fhi.no/eway/default.aspx?pid=233&trg=MainLeft_5565&MainArea_5661=5565:0:15,4428:1:0:0::0:0&MainLeft_5565=5544:67265:1:5569:1::0:0

for policy-makers on all levels (as well as the public in general) to evaluate the development of services, and adjust policy in accordance with these evaluations. The development of statistics by an independent health research organisation has facilitated close collaboration between research and public policy, as well as close collaboration between Statistics Norway, decision-makers on all levels, and services and health professions.

Prevention of mental disorders and promotion of mental health

Both the projects "Early safe in Trondheim" and "Children in Bergen", presented above, fall under the category of prevention of mental disorders. Within the category of prevention/ promotion, a highly relevant example of ongoing research is "Mental health in School", also mentioned in chapter 3.1.1 as an example of a large-scale ongoing programme within CAMH.

6.1. Main bodies involved in information dissemination to keep health care professionals informed

The principal body involved in the dissemination of information about children's and adolescents' mental health care (services provision, but also promotion and prevention) to health care professionals is the Norwegian Directorate for Health³³. Besides the Directorate, the Regional Centre for Child and Adolescent Mental Health (RBUP)³⁴, is a central body. The Centre has a comprehensive package of post-graduate- and post-qualifying education, and has a special responsibility for education directed towards personnel within CAMH.

7. Challenges, opportunities and advances in the field⁴⁰

7.1. Key recent advances, barriers or issues in CAMH care

The key recent advances in care of children and adolescent's mental disorders are related to the goals of the national Escalation Plan (see also presentation in chapter 5):

- More accessible services; the amount of children in treatment increased from 2 to 4,5 % (with some regions having reached the goal of 5 %).
- More professional services; reached the national Escalation Plan's (1999-2008) goal of increasing the number of professionals within day-care by 400 persons.
- More effective services; reached the goal of increasing productivity in clinics by 50 %.

The most important barriers or issues that impede action on CAMH care are:

- Lack of implementation of good methods for coherent services.
- Responsibility for action is not clearly defined. For example the municipalities are given more responsibility and resources. However, it still is a problem that the responsibility for mental health care within the municipal services as well as the division of responsibility between primary and secondary care are not clearly defined.
- Responsibility for policy is spread over several ministries as well as two administrative levels (municipal and regional).

In order to increase action to improve child/adolescent mental health services, the municipalities should have a specified responsibility for the treatment of children/ adolescents in addition to a responsibility for prevention. Hence, the municipalities need more clinicians, in particular psychologists. Furthermore, there is a need for increased competence among GPs. There should be a greater focus on psychosocial problems within mental health services, for example more low threshold services. In many places there is also a need for an increased number of specialists in specialist care. Finally, the services should be supported by effective systems for collaboration between service levels (primary-secondary).

7.2. The key recent advances, barriers or issues within CAMH prevention and promotion

The most important recent advances affecting action on children and adolescents' mental health promotion or mental disorder prevention in Norway are:

- The increased role of municipal-level services in enhancing mental health of children and adolescents, with the establishment of low threshold services, family centres and an increase in the number of public health nurses.
- Big research projects on prevention/promotion in Bergen ("Children in Bergen") and Trondheim ("Early safe in Trondheim") and a large-scale ongoing school programme on prevention/promotion ("Mental health in School").

The most important barriers within the field of CAMH promotion and prevention are:

- Despite resources from the national Escalation Plan which have increased action in mental health promotion and mental disorder prevention, the field is still not sufficiently on the agenda, and there is a lack of coherence between primary and secondary care on these issues.
- Responsibility for mental health promotion and mental disorder prevention in the municipal services are not clearly enough defined. The

⁴⁰ These questions are answered by a group of 4 researchers at SINTEF Health Services who do research/evaluations within the area of CAMH.

lack of superior policy, and additional lack of evidence-based research (hence, knowledge) are important reasons for this problem.

The Government's strategy plan (2003-2008) with 100 measures that is being implemented at different levels and arenas of mental health in Norway will have finished by autumn 2008. The evaluation of this plan will tell us more about the status of this field. In order to develop the services further in the direction of more promotion and prevention, greater knowledge is needed.

7.3. Difficulties and further development

There is no doubt that both services and perspectives related to children and adolescent's mental health have come a long way during the plan-period of the National Escalation within mental health. However, barriers and issues still exist. The programme aims at improving availability, accessibility, quality and organisation of mental health services and treatment at all levels. It is, however, still a major challenge to develop a smoother collaboration and cooperation between primary health- and social services (at the municipal level) and specialised health services, but also within primary health services. This is confirmed by Johansen (2006), who states that the most important current challenge in the ongoing mental health reform that demands full attention during the next years is to implement cooperation and collaboration systems between the different service levels and entities.

The Government's policy for the future

The Government's policy⁴¹ after the escalation plan comes to an end in 2009, is to continue to give high priority to the area of mental health, and with the same goals and values as emphasised in the Plan; adaptation for an independent life, coping with ones own life, a clear user perspective, decentralisation, closeness to the services, work-related measures and preventive work will be central elements in the further development of the services. As a main principal, the Governmental directions will be given through yearly directions for the health and social services in the municipalities and the 5 Regional Health Authorities. Furthermore, the development of a measure- and indicator system will lay the foundation for a better follow up of the development within the sector. In order to meet the challenges within public health, continue placing a strong emphasis on municipal mental health services, low threshold services, preventive psycho-social work for children and adolescents, in order to strengthen mental health and identify needs as early as possible. The state budget for 2009 also signals a new strategy for municipal mental health work for children and adolescents. In order to succeed the efforts in the municipalities, the Government also sees the necessity of continue the work with skills upgrading, including knowledge about

mental illnesses and effective measures for prevention and treatment. A continued management of the several established competence centers in the country is seen as an important part of this. The accessibility of specialist services will also improve with shorter waiting times for treatment. The Government also sees the necessity of increasing the competence in the field of mental health and "broadness" of the problems and suffering connected to this. An emphasis is put on information and attitudes within school, working life and towards service users. The same emphasis applies to work and mental health.

8. Summary and conclusions

In Norway much has been achieved in the field of mental health during the 10 years of the national Escalation Plan which finishes at the end of 2008. Services related to children and adolescents' mental health have improved, due in part to more accessible and effective services, more professionals, better training in children and adolescent mental health, and opportunities such as special scholarships for training in this field funded through the Escalation Plan.

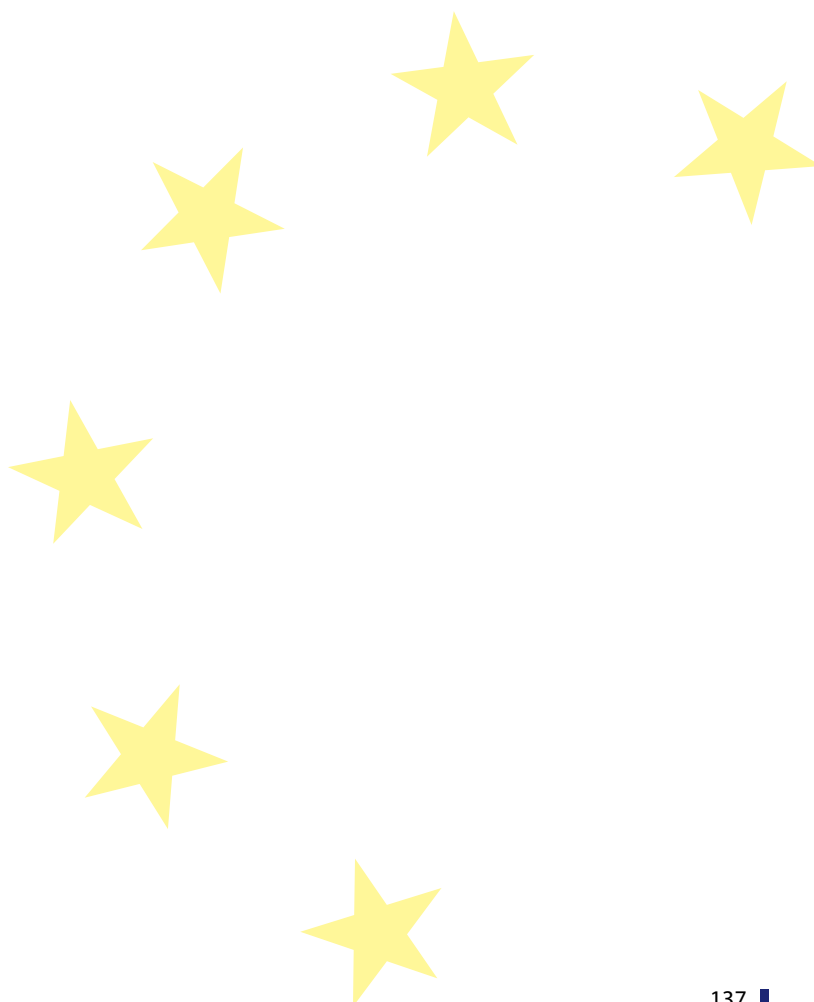
At the municipal level psycho-social services has been established, child health centres and school health services have been strengthened with personnel, and culture- and leisure activities supported with money. Within specialised mental health services, the number of personnel has increased by 71 percent since 1998; out-patient with 101 % and in-patient with 47 %. Furthermore, the number of treatment-measures per year has increased by 80 %. Currently, 4,5 percent of children and adolescents up to 18 years receive specialist services. The increase in beds has been low (11 %) during the period due to a conscious development towards more ambulant and outreaching methods, something that in many cases represents an alternative to hospitalisation.

In Norway there is the understanding that children constitute a vulnerable group in society. Within the framework of the national Escalation Plan, programs at prevention of mental disorders and promotion of mental health in children and adolescents have also been developed. For example, two large scale programs exist: promoting mental health at school, and for the prevention of disorders in children of parents with mental health and alcohol/drug problems. Other general policies, such as those related to social inclusion, day-care provision, reforms in the policy family or in the education system also point to this vision. The Norwegian Directorate for Health is the most important body ensuring that approved policies are implemented. Part of its mission is the initiation and implementation of programs and dissemination within the field of mental health promotion and prevention for children and adolescents.

⁴¹According to the government budget (2008) - in Norwegian at: <http://www.regjeringen.no/nb/dep/hod/pressesenter/pressemeldinger/2007/Statsbudsjettet-2008--HOD.html?id=481786>

There are still major challenges to accomplish, such as giving increasing role to the municipalities in both treatment and prevention action, developing smoother collaboration and cooperation between primary health and social health services, and defining more clearly the

responsibility for action. The Government's policy after the escalation plan comes to an end in 2009 is to continue to give high priority to the area of mental health, and with the same goals and values as emphasised in the plan.



POLAND

Prepared by Grażyna Herczyńska and Czesław Czabała

1. Introduction

1.1. Policy at a glance

The political and economic system in Poland has changed deeply in the last 18 years, after almost 45 years of the communist rule. It was necessary to introduce new legislation, including constitution (1997), to adapt strategies and programmes to the European standards, to the new challenges and demands of democratic society. The main task, broadly speaking, was to involve all citizens into the procedures of decision making, through enhancement of the role of local governments, rebuilding the social infrastructure, stimulating and supporting activities of NGOs. The rate of changes increased substantially before and after the accession of Poland to the European Union in 2004.

In Poland, the wide, long term governmental strategies related to children and adolescents were formulated in the National Action Plan for Children for the years 2004 – 2012, and the State Strategy for Adolescents for the years 2003-2012. An overall objective of both documents is to provide youngster's equal opportunities, independent of their social and geographical background. These strategies aim to promote well-being through education, support young generation's own activities in order to adapt them to the challenges of life.

Public policy, which have impact on mental health of children and adolescents, are formulated in many regulations and articles of general legislation and programmes concerning education, social welfare, employment, health care, counteracting delinquency, alcohol and drugs abuse etc. In the area of health, the Strategy on Health Development and its inherent part, the National Health Programme, are of special importance. The Strategy states, that the health promotion/prevention should be considered as equally important as the medical treatment in order to health improvement of the Polish society. It stresses also on the problem of decreasing inequalities in access to health services. The Programme covers, among others, prevention of mental disorders, reducing consumption of alcohol and psychoactive substances. Two documents Act on Mental Health and the National Mental Health Programme deal specifically with mental health problems. The Act stresses

that the mental health is a fundamental human value and the protection of this right is an obligation of the state. The Programme underlines the development of the new trends in this field, such as community psychiatry, focuses on outpatient and intermediate forms of care, at the expense of treatment in large specialized psychiatric hospitals. Problems of children and adolescents are widely treated in the Programme.

1.2. Process to prepare the country story

This report was written by Grażyna Herczyńska, from the Institute of Psychiatry and Neurology, Warsaw, with information from the following sources, institutions and persons:

- Policy and legislation-documents from the data base of the Polish Parliament, Ministry of National Education, Ministry of Labour and Social Welfare, Ministry of Health, Ministry of Justice, Bureau for the Ombudsman of the Rights of the Child.
- Published research
- Central Statistical Office.
- Irena Namysłowska, M.D., child and adolescent psychiatrist, professor at the Institute of Psychiatry and Neurology (IPN) in Warsaw, researcher, the national consultant on CAMH.
- Jarosław Rola, Ph.D. clinical psychologist, professor at the Academy of Special Education in Warsaw, his research focuses on mental disorders of child with intellectual disability.
- Joanna Mazur, M.D. medical biologist, senior researcher at the Mother and Child Institute, Warsaw, co-ordinator of the Polish part of the project: Health Behaviour in School-aged Children. A WHO Collaborative Cross-national Study.
- Ludmiła Boguszewska, sociologist, collects and analyses epidemiological data on mental health, the Institute of Psychiatry and Neurology, Warsaw.
- Wanda Langiewicz, economist, specialist in mental health policy and legislation, the Institute of Psychiatry and Neurology.

The group collecting information consists of:

- Dorota Danielewicz, Ph.D. psychologist, senior researcher in the Chair of Clinical Psychology of the Academy of Special Education, Warsaw. Her research focuses on children with developmental disorders, especially autism.
- Lidia Zabłocka-Żytka, psychologist, researcher at the Institute of Applied Psychology of the Academy of Special Education, Warsaw.
- Michał Szulawski, psychologist, researcher on child aggression at the Academy of Special Education, Warsaw.
- Joanna Wojda, child and adolescent psychologist, the Academy of Special Education.
- Małgorzata Gawron, educator, worker of the NGO: J. Korczak Polish Association; Łódź, trainer of children and adolescents (7-18 year old) in creativity skills.
- Grażyna Herczyńska – historian, responsible for technical assistance of collaboration between the Institute of Psychiatry and Neurology and WHO. She has participated in many WHO projects, carried out by the IPN.

Czesław Czabała, clinical psychologist, professor at the Academy of Special Education and at the Institute of Psychiatry and Neurology; expert in mental health promotion programmes in schools, coordinated the process of collecting and analysing information and provided technical assistance.

The final version of the Report was checked by Prof. I.Namysłowska and Prof. Cz. Czabała.

2. What we know about children and adolescents in our country and their mental health

2.1. Prevalence of mental disorders in children and adolescents in Poland

According to the estimations available, of almost 8,400,000 children and adolescents under 18, approximately 10% need psychiatric/psychological care and support. However, in 2006 approximately 120,000 children and adolescents received treatment in outpatient care facilities, and 10000 were hospitalized. Epidemiological studies carried out in different regions indicate that the prevalence of different mental health problems significantly exceeded the extent of cases registered in services.¹

Information on the prevalence of mental disorders among children and adolescents is available at the national and regional level. The main sources of data are the national reporting programme on psychiatric inpatient facilities and aggregated reports from outpatient facilities. The other sources are general statistics and epidemiological studies, carried out by the research institutions.

Data on prevalence rates for different childhood- and adolescent mental disorders gathered from the psychiatric services.

Table 2.1.1. Prevalence rates of some mental disorders per 100000 of child- and adolescent population treated in inpatient mental health facilities (according to ICD-10)²

Disorder	Prevalence rate	Age range	Reference period	Data-collection
Anxiety disorders [F93, F93.0-93.3, 93.8-9, F.40, F.41, F.41.0-F41.1, F.42, F.43.1]	11.1	3-18	Year	2006
Depression [F.32, F.33, F34.1]	3.6	3-18	Year	2006
Bipolar disorder [F.31, F.34.0]	1.0	3-18	Year	2006
Attention-Deficit/ Hyperactivity Disorder (ADHD) [F.90, F.90.0-1, F.90.8-F.90.9]	10.7	3-18	Year	2006
Learning disorders	Not collected			
Conduct disorder [F.91, F.91.0-3, F.91.8-9]	11.7	3-18	Year	2006
Eating disorders [F.50, F.98.2-3]	5.5	3-18	Year	2006
Autism and pervasive developmental disorders	Not collected	3-18	Year	2006
Schizophrenia [F.20]	5.4	3-18	Year	2006
Mental and behavioural disorders due to substance use other than alcohol [F.11-F.19]	24.4	3-18	Year	2006
Mental retardation [F.70-F.79]	7.5	3-18		

¹For example prevalence of depression and anxiety symptoms among children at the age of 10-17 was 25–28%, eating disorders among girls at the age of 13-17 was 12%. National Mental Health Programme. Draft. 2006, p.7.

²Data base on psychiatric inpatient facilities, Institute of Psychiatry and Neurology

Table 2.1.2 Prevalence rates of mental disorders per 100000 of child- and adolescent population treated in outpatient mental health facilities (according to ICD-10)³

Disorder	Prevalence rate	Age range	Reference period	Data-collection
Behavioural and emotional disorders [F.90-98]	573.0	0-18	Year	2006
Neurotic, stress related and somatoform disorders F.40-48]	218.1	0-18	Year	2006
Mental retardation [F.70-79]	184.0	0-18	Year	2006
Mental and behaviours disorders due to drug & tobacco use [F.11-19]	66.5	0-18	Year	2006
Behavioural syndromes associated with psychological disturbances and physical factors, incl. eating disorders [F.50-59]	46.5	0-18	Year	2006
Manic & depressive episodes [F.30 & F.32]	26.3	0-18	Year	2006
Organic incl. symptomatic, mental disorders [F.00-09]	25.6	0-18	Year	2006
Schizophrenia [F.20]	23.7	0-18	Year	2006
Mood (affective) disorders [F.34, F.38-39]	16.6	0-18	Year	2006
Bipolar affective & recurrent depressive disorders [F.31&F.33]	15.4	0-18	Year	2006

Epidemiological studies

The latest national epidemiological research on emotional and behavioural disorders among children and adolescents was carried out in the school year 1999/2000. The Child Behaviour Check List, Youth Self Report and Teacher's Report Form were used. The average prevalence of emotional and behavioural disorders (including being withdrawn, somatic complaints, anxiety and depression, social problems, thought and attention problems, delinquent behaviour, aggressive behaviour) from the three scales mentioned above was 9% for the age range 7-19 years⁴.

Findings of the research carried out by the Central Statistical Office in 2004 using KIDSCREEN Short Version Questionnaire indicate that about 1.0% of children at the age of 5-14 suffered from chronic (more than 6 months) anxiety, depression and behaviour disorders, about 2.2% of adolescents at the age of 15-19 from neurosis or depression (anxiety, mood disorders).⁵

The research on depression (symptoms: emotional, anxiety, learning, activities disorders, self-destructive behaviours and somatic symptoms) was carried out

on the representative groups of school students aged 10-12, 13-15, 17-19 from large towns in the years 2001-2003 and 2006, using the Krakow Depression Inventory Instrument. The findings were respectively 28.3%, 25.2% and 27.1%. Similar results were received in Gdansk and Lodz. The prevalence of depression among children and adolescents has been relatively stable during the last five years⁶.

Suicide

The data on prevalence of childhood/adolescent self-harm and suicide is provided by different sources. According to medical statement prevalence rate of suicide per 100000 of children and adolescent population aged 10-19 was 5.6 in 2005⁷. Childhood/adolescent suicide attempted and committed, registered by the police in the same year was 7.5, but slightly lowered in 2006 to 7.3.⁸

Prevalence of self-harm in the Łódź region among teenagers aged 12-18 in 2006 was 15.6%.⁹

2.2. Vulnerable child population

Children living in poverty

In 2001 in Poland, the poverty rate among children

³Boguszewska L., Moskalewicz J., Słupczyńska-Kossobudzka E., Milewska D., Sowińska M., Bartnik A., Głazowski C., Gomułka J., Welbel M., Skiba K. (ed.) (2007) Zakłady psychiatrycznej oraz neurologicznej opieki zdrowotnej. Rocznik Statystyczny 2006 [Mental health care and neurological care facilities. Statistical Yearbook 2006] Instytut Psychiatrii i Neurologii, Warszawa

⁴Wolańczyk T. (2002) Zaburzenia emocjonalne i behawioralne u dzieci i młodzieży szkolnej w Polsce [Emotional and behavioural disorders among children and adolescents in Poland]. Warszawa

⁵GUS (2006) Stan zdrowia ludności Polski w 2004 r. [Health state of the Polish population in 2004], Warszawa, p.103, 119.

⁶Bomba J. Modrzejewska R. (2006) Prospective studies on dynamics of depression from preadolescence to early adolescence. *Psychiatr. Pol.*, 40, 3, 481-490

Bomba J. Modrzejewska R. (2006) Prospective study on dynamics of depression in mid-adolescence. *Psychiatr. Pol.*, 40, 4, 683-693

Bomba J. Modrzejewska R. (2006) Prospective study on dynamics of depression in late adolescence. *Psychiatr. Pol.*, 40, 4, 695-706

The results of research concerning the year 2006 are prepared for publication. Information – Renata Modrzejewska, Children and Youth's Psychiatric Department, Chair of Psychiatry, Collegium Medicum, Jagiellonian University, Krakow

⁷Rocznik Demograficzny 2007 [Demographic Yearbook of Poland 2007]. GUS [Central Statistical Office], Warszawa 2007

⁸Rocznik Statystyczny 2007 [Statistical Yearbook 2007]. GUS [Central Statistical Office] Warszawa 2007

⁹Lewandowska A., Gmitrowicz A. (2007) Samouszkodzenia u młodzieży szkolnej [Self-harm among adolescents], *Psychiatr. Pol.* 41, suppl., p. 88.

aged 0-17 was 29.5% compared with the poverty rate in general population – 16.2%.¹⁰ The similar rate but measured by different tools was recorded in 2004 (29%), and was the highest in EU. The next year, when the social-economical situation improved (unemployment rate decreased, salaries grew, social benefit policy widened) and level of life raised, this rate decreased to 26%. Since than poverty rate among children has been lowered, but still is on a high level.¹¹ Poverty rate among children is related to the family type: the highest is in two parent families with three children, the lowest in two parent families with one child. Especially difficult is the situation of children living in single-parent family.

Children experiencing violence and bullying

Data concerning children experience violence are obtained from the Polish National Police.¹² Data on children, victims of bullying at schools come from the research carried out at the beginning of 2006 in the frame of the project Health Behaviour in school-aged children: A WHO Collaborative Cross-national study (HBSC) by the Institute of Mother and Child¹³. The table below shows findings from these two sources.

Table 2.2.1

Children populations	% of child population (total number)	Age-range	Reference period	Data-collection
Children experiencing domestic violence according to "Blue card" procedure ¹⁴	0.6 (31001) 0.4 (14963)	0-12 13-18	year	2007 Polish National Police
Children experiencing bullying at schools	30.9 [11.2 twice or more]	11 & 13	Recent two months	2006 HBSC
	19.4 [6.7 twice or more]	15	Recent few months [month]	
	14.7 [3.8 twice or more]	16 & 18		

With the aim of learning the extent of aggression and violence at school, the Ministry of National Education financed three editions of research, in 1997, 2000 and 2003/2004. Research was conducted on representative sample of pupils of all types of schools in Poland. The findings show that 40.3% of children offended and abused other pupils, 25.3% beat colleagues, 11.3% forced others to do what they do not, 1.4-2.9% behaved in the way, which indicate the breach of the law (from threatening, using gun to provoke sexual behaviours). The greatest numbers of cases of aggression and bullying take place in the first grade of schools (gymnasia) and vocational schools.¹⁵

Asylum seeker children

Asylum seeker children in Poland have not been sufficiently studied. There are no statistical data

concerning children without parental care transiting through Poland. Although there are some discrepancies in the data on the number of children without parental care applying for the refugee status, nevertheless the scale of the phenomenon can be estimated. In 2005, 335 persons received refugee status, 25% of them were children younger than 4. More than a half of the recognized refugees were below 18. Twelve children separated from their parents received asylum in Poland. Six of those children were under 4. One hundred and thirty one children and adolescents applied for refugee status without parents or guardians in 2005, 69 of them received asylum permanent or temporary. A large number of asylum seekers (incl. children and adolescents) came to Poland from the Russian Federation, mainly Chechnya. People from Chechnya constituted over 90% of a total number of asylum seekers in Poland in 2005.¹⁶

¹⁰The poverty rate is a percentage of the population living in "relative" poverty defined as all members of households, which are entitled to and received social help in the terms of the Act of Social Support. Warzywoda - Kruszyńska W. (2002) Zjawisko biedy dzieci a zagrożenie wykluczeniem społecznym w przyszłości [Poverty of children and threat of social exclusion in the future], in <http://www.brpd.gov.pl/detail.php?recid=56>

¹¹The poverty limit was counted using 60% of median income. The National Programme "Social Security and Social Integration for the years 2008-2010", p.17. <http://www.mps.gov.pl/index.php?gid=1139>

¹²Polish National Police, www.policja.pl including: Raport o działaniach policji w zakresie zapobiegania przestępczości oraz zjawiskom patologii społecznej w 2007 [Report on police activities in prevention of crime and social pathology in 2007]. Komenda Główna Policji, Warszawa 2008 http://www.policja.pl/portal/pol/296/22999/Raport_o_dzialaniach_Policji_w_zakresie_zapobiegania_przestepczosci_oraz_zjawisk.html

¹³Mazur J., Woynarowska B., Kołło H. (2007) Zdrowie subiektywne, styl życia i środowisko psychospołeczne młodzieży szkolnej w Polsce. Raport techniczny z badań HBSC 2006. [Subjective health, life style and psycho-social environment of school adolescent in Poland. Technical report from the HBSC 2006]. Instytut Matki i Dziecka, Warszawa, p.199-202.

Oblacińska A., Woynarowska B. (eds) (2006) Zdrowie subiektywne, zadowolenie z życia i zachowania zdrowotne uczniów szkół ponadgimnazjalnych w Polsce w kontekście czynników psychospołecznych i ekonomicznych [Subjective health, life satisfaction and pro-health behaviours of high school students in Poland in the psycho-social and economic context], Instytut Matki i Dziecka, Warszawa, p.83-89.

¹⁴Forms of violence include sexual acts with minors (experienced by 0.03% of children under the age of 15), presenting pornographic content to minors, profiting from prostitution, infanticide or abandonment (in total registered in a dozen cases).

¹⁵Programme "Zero tolerance", pp. 5-8. In the HBSC study the percent of pupils bullied others in the recent two months ranged between 27.0 and 34.0. Oblacińska, op. cit.p.89, Mazur, op. cit.,p.202

¹⁶The Office of the UN High Commissioner for Refugees (Poland) www.unhcr.pl

Children experiencing the migration of parents
In 2006, between 25.9% and 29.3% of pupils at the age of 9-18 experienced migration (seasonal, short term from 2 to 6 month, long term for over a year) of at least

one parent. Children, whose parents migrated, were left with family or friends.¹⁷

The table below presents available data on the percent of other specific child populations in Poland.

Table 2.2.2 Percent of specific child populations in Poland

Vulnerable child populations	% of child population (total number)	Age-range	Reference period	Data-collection
Homeless children	Data not collected			
Early school leavers	0.28 0.19	7-13 14-16	School year	GUS ¹⁸ 2006/2007
Youth unemployment	19	18-24	year	LMS ¹⁹ 2007
Children in care ²⁰ Care and Education Centres for Children and Young People	0,3 (20663)	0-17	year	GUS ²¹ 2006
Residential centres Residential social welfare facilities	0.05 (3609)			
Traveller children	Data not collected			
Juvenile offenders, to whom educational measures were validly adjudicated for: - demoralization - punishable acts as e.g. homicide, damage to health, participation in violence, rape, against property	0.2 [73% of boys] 1.3 [86% of boys]	0-17 13-16	year	2006 GUS ²²

2.3. Positive child and adolescent mental health

Information on child and adolescents' positive mental health was collected in Poland since 1990 in the frame of HBSC. The table below shows findings of some aspects

of positive mental health as: self-rated health, self-rated mental health and life satisfaction.²³

Table 2.3.1 Child and adolescents' positive mental health - HBSC

Positive child and adolescent mental health	%	Age-range	Reference period	Instrument	Year of data collection
Self-rated health (good/ very good)	39.7/48.8 42.9/43.2 50.8/32.8 80.5	11 13 15 16 & 18	Last six month	HBSC questionnaire	2006
Self-rated mental health (normal)	82.4	11 & 13 & 15	last six month	SDQ*	2006
Life satisfaction (high / high and satisfactory)	43.6/ 85.8 29.6/81.2 19.4/ 78.9 68.7 85.0	11 13 15 16 & 18 16 & 18	Now	Cantril ladder SLSS** (Huebner scale)	2006

* Strength and Difficulties Questionnaire by R. Goodman (1994)

** Student's Life Satisfaction Scale

¹⁷Survey, using self administrated questionnaire was carried out in February - March and 21 May - 6 June 2008. Walczak B. (2007) Społeczne, edukacyjne i wychowawcze konsekwencje migracji rodziców i opiekunów prawnych uczniów szkół podstawowych, gimnazjalnych i ponad gimnazjalnych [Social and educational consequences of migration of parents and legal guardians of primary, lower secondary and secondary school students]. Warszawa 2008

http://www.brpd.gov.pl/eurosieroctwo/raport_eurmigracje.pdf

¹⁸Oświata i Wychowanie w roku szkolnym 2006/2007 [Education in the school year 2006/2007] GUS, Warszawa 2007

http://www.stat.gov.pl/cps/rde/xbcr/gus/PUBL_oswiata_wychowanie_2006-2007.pdf

¹⁹Statystyki rynku pracy [Labour market statistics] www.psz.praca.gov.pl

²⁰Living in any residential places other than families.

²¹Mały Rocznik Statystyczny 2007 [Concise Statistical Yearbook 2007] GUS, Warszawa 2007; part: Health Care and Social Welfare http://www.stat.gov.pl/gus/opracowania_zbiorcze_PLK_HTML.htm

²²Rocznik Statystyczny 2007 [Statistical Yearbook 2007]. GUS [Central Statistical Office] Warszawa 2007, p.173-174

²³Mazur, op. cit. p. 112-113, 116-117, 119-120, 135; Oblacińska, op. cit. p. 18, 23-27

In 2003 and 2005 research was carried out on some aspects of positive mental health, using different than HBSC indicators, on pupils of high schools in Warsaw

(sample close to representative, approx. 900 and 600 pupils)²⁴. Findings of the study are presented below.

Table 2.3.2. Child and adolescents' positive mental health

Positive child and adolescent mental health	%	Age-range	Reference period	Instrument	Year of data collection
High subjective well-being (general)	21.7 26.1	16-17 17-18	now	5 point ranking scale	2003 2005
High eudaimonia	43.2 50.8	16-17 17-18	now	analogous to Keyes*	2003 2005
High hedonia	44.5 48.9	16-17 17-18	now	analogous to Keyes	2003 2005
High self-esteem	54.3 56.9	16-17 17-18	now	BQSW/Y**	2003 2005
Life satisfaction	86.4 86.0	16-17 17-18	now	Jessor et al.***	2003 2005

* Keyes C.L.M. (2006) Mental Health in Adolescence: is American's Youth Flourishing. *American Journal of Orthopsychiatry*, 76, 3, 395-402. Method adapted by I.Jelonkiewicz, K.Kosińska-Dec, M. Zwoliński

** Berne Questionnaire of Subjective Well-Being, Youth Form. A.Grob (1995), adapted by A.Kwiatkowska and modified by B.Mroziak, by I.Jelonkiewicz, K.Kosińska-Dec, M. Zwoliński

*** Questionnaire by R.Jessor, J.E.Donovan, F.M.Costa, adapted by A. Frączek, E.Stępień

3.Actions for promotion and prevention in mental health

3.1. Policies and programmes for CAMH

Specific policies and large-scale programmes for CAMH

As was noted already in the introduction, solutions to problems concerning CAMH are dispersed in different strategies, legislation acts, policy statements and programmes.

Strategies concerning children and adolescents

National Action Plan for Children 2004-2012. Poland for children²⁵

The strategy was prepared by the Ministry of National Education in collaboration with other ministries, NGO, Polish Committee of UNICEF and the Office of Ombudsmen of the Right of the Child. The strategy was accepted by the Polish government, and started in January 2005, financed by national and local governmental agendas, coordinated by the Ministry of National Education. The main aims of the National Action Plan for Children are: 1) providing equal opportunities for each child; 2) assuring the appropriate conditions for children's life as well as the adequate quality of education and equal access to it for all children; 3) promoting and carrying out comprehensive health education and healthy life style among children and parents; 4) supporting comprehensive system of family assistance, preventing poverty of the family, disseminating and popularizing knowledge on physical and mental development of a child; 5) protecting children against violence and abuse;

6) increasing the quality of teaching; 7) facilitating cooperation between teachers, parents and pupils in the area of education. The strategy postulates agreement between different political parties in common work on children well-being.

State Strategy for Adolescents for the years 2003-2012²⁶
The inspiration and a base for the strategy was the White Book of Youth published by the European Commission in 2001. Experts, in consultation with youth and governmental administration, developed the main priorities of the Strategy. It concerns the social group at the age of 15-25. The aims of the Strategy are: 1) creation and equalization of developmental chances, self-realization of the young generation, 2) providing opportunities for development of their own activity, 3) counteracting social exclusion of youngsters, e.g. unemployment, poverty, 4) encouraging international youth co-operation, 5) development of a youth information system, 6) education and professional training for adults working with youth. Methods of "open co-ordination" is used in implementation of the Strategy.

Legislation and programmes in the area of health

National Health Programme (NHP)²⁷

The first edition of the National Health Programme was implemented during the years 1996-2005. After evaluation and updating, it is continued in the years 2007-2015. The main aim of NHP is to improve health and the quality of life of the whole society. This goal should be achieved through promoting healthy life style, developing friendly environment of life, work

²⁵<http://www.men.gov.pl/oswiata/istotne/npd.php>

²⁶http://www.yforum.pl/strategia/strategia_ml.php

²⁷http://www.mz.gov.pl/wwwfiles/ma_struktura/docs/zal_urm_npz_90_15052007p.pdf

and education as well as supporting local government and NGO in their activities for health. The targets directly related to child and adolescents' health are: 1) improvement of health care of mother, infant and toddlers, 2) supporting physical and psycho-social well-being as well as prevention of health and social problems of children and adolescents.

The strategic objectives, concerning reducing alcohol and psychoactive substances consumption as well as prevention of mental disorders through preventive and promotional activities are also focused on children and adolescents.

Mental Health Act (MHA)²⁸

The main judicial enactment concerning mental health in Poland is the Mental Health Act, passed by the parliament in 1994. The Act defines legal protection of rights of people with mental disorders and legal principles concerning relations between patients and a staff of hospitals. It aims at the promotion of mental health, prevention of mental disorders, development of appropriate social attitudes towards persons with mental health problems, especially counteracting discrimination of such persons, providing mental health care within the primary health care as well as in specialised psychiatric services. A number of articles concern the dignity of patients, hospitalisation, the procedures of Guardianship Courts.

Few articles exclusively address children and adolescents. Children and adolescents are among the vulnerable groups on which prevention measures are targeted first and foremost. These measures include adherence to mental health principles in schools, educational and child care institutions, providing prevention services, and especially child psychological counselling as well as early intervention centres diagnosing the needs of children with psychomotor development disorders. Mentally disabled children and youth should be provided with education and rehabilitation in nursery schools, schools, rehabilitation centres, nursing homes, health care facilities.

Since 1994 the Act was amended a few times. In 2005 a special amendment appointed an ombudsman of patient rights in psychiatric hospitals.

National Mental Health Programme (MHP)²⁹

The first draft of the Mental Health Programme was developed in collaboration with WHO in 1992 and was accepted by the Ministry of Health in 1995. Since then MHP has been updated a number of times (the latest in 2006) and implemented partially without proper funding. Finally, long lasting efforts to include articles on the MHP in the Mental Health Act were accepted by the both houses of the Parliament in 2008. This amendment was the starting point for implementation of the National Mental Health Programme as a governmental policy for the years 2009-2013.

MHP defines directions for changes in mental health. Its main aims are to promote mental health (especially in

schools and the workplace), to prevent mental disorders (especially depression), suicides, violence in families and schools, disorders related to use of psychoactive substances. It also defines the necessary support for persons with mental disorders (adults and minors) by broad, multilevel health care and other kinds of assistance, which are essential for their life in the society. It underlines the need of carrying out research and developing adequate information systems in the area of mental health. The Programme aims at improving availability, accessibility, quality and organisation of mental health services and treatment at all levels.

It is emphasised in the MHP that the programme should be implemented by the health sectors in partnership with other governmental departments: employment, housing, educational etc. A strong stress is placed on the development of community based psychiatry, which requires organising special Mental Health Centres. The necessity of coordination between mental health care and social help is underlined. MHP focuses on guaranteeing social and occupational rehabilitation as well as employment for people with mental health problems.

The mental health of children and adolescents were described widely in the Programme, especially in the part concerning promotion and prevention. In addition to activities mentioned above it requires: (i) support for parents in their educational tasks during the first years of children life; (ii) providing parents with necessary knowledge and skills to develop correct psychosocial development of their children; (iii) limiting risk factors and strengthening protect factors of children and adolescents; (iv) organising early intervention concerning developmental disorders among children; (v) setting up regional and local centres of counselling and psychological support in kindergartens, schools and other institutions for children and adolescents as well as for families, to ensure early diagnose of mental disorders among toddlers and youths, especially by the family doctors/GPs and paediatricians. It is proposed to introduce these goals and tasks to the National Mental Health Programme for the years 2009-2013, which is currently under development.

Examples of other programmes

The National Programme for Prevention of Social Maladjustment and Crime among Children and Adolescents³⁰

The increasing extends of crimes, committed by minors and the low and inadequate effectiveness of dispersed programmes triggered the necessity to coordinate existing efforts. The Programme developed by the inter-sector governmental committee in 2003 is implemented during 10 years. The Programme's modules aim at developing: 1) guidelines on conduct of teachers in the situation of alcohol and drug abuse, prostitution among

²⁸<http://isip.sejm.gov.pl/servlet/Search?todo=file&id=WDU19941110535&type=3&name=D19940535Lj.pdf>

²⁹<http://www.ipin.edu.pl/>

³⁰<http://www.mswia.gov.pl/portal/pl/199/4203/>

children and adolescents, 2) methods of cooperation between schools, police and NGO, 3) the methodological system of assistance for people who work with young children at risk of maladjustment, particularly in the area of crisis intervention, 4) recommended prevention programmes, including various strategies, such as engaging children and adolescents in social activities. In 2007 local government received 2.1mln PLN for implementation of 110 projects focused on children and youth. Supporting families endangered by social pathology and supporting children day-care forms were among the main tasks.

National Programme on Counteracting Violence in the Family³¹

In 2005, the Act on Counteracting Violence in Family was adopted by the Polish Parliament and, in the following year - the Programme under the same name started to be implemented. It was the first attempt to coordinate activities in this area. The Programme's aims are to reduce violence in a family, increase safety of victims of violence and accessibility of assistance. The Programme focuses particularly on women, children and adolescents, elderly and disabled people, who are most often victims of violence. In the framework of the Programme, 33 support centres were set up and special educational programmes for persons using violence were implemented. A social campaign against violence was organised and research was carried out.

The National Programme for Prevention of Alcohol Related Problems³²

Problems experienced by children and adolescents living in families with alcohol abuse demanded action in Poland. Alarming were figures showing trends of lowering age of drinking initiation among pupils, an increasing number of youngsters drinking alcohol³³ and alcohol related harm in 10-15% of the population aged 15-18. For the first time the National Programme was developed by the State Agency for Prevention Alcohol Related Problems in 1994. Since then it was modified and updated four times, the latest for the years 2006-2010. The Programme describes the level of alcohol consumption and harms associated with it and defines the main strategies for action. The main aims of the Programme are to: 1) decrease alcohol consumption and change the structure of alcoholic beverage consumption, 2) decrease alcohol consumption among adolescents and young people, 3) reduce alcohol related harm in families, 4) increase awareness of health and social harms associated with alcohol, 5) foster knowledge in the society about the consequences of alcohol abuse and methods of prevention, 6) promote healthy life styles, sobriety and abstinence, 7) promote local alcohol prevention programmes in schools, 8) train professionals in the areas of health care, education,

social help and judiciary.

Besides increasing quality and access to alcohol therapeutic and rehabilitation services, it is also planned to increase psychological assistance for children living in families with alcohol related problems and children with Foetal Alcohol Syndrome.

National Programme for Counteracting Drug Addiction³⁴

The National Programme for Counteracting Drug Addiction has been developed, implemented and coordinated by the National Bureau for Drug Addiction since 1993. The latest edition of the Programme is for years 2006-2010. The government task is to support local policies in counteracting psychoactive substance use. The goals of the Programme are to: 1) improve knowledge within the society of illicit substances and problems associated with their use, 2) reduce drug demand among children and adolescents through school educational programmes, programmes for parents and for youth from high risk groups, through organising free-time for minors 3) engage local communities in prevention of drug use, 4) increase the number of competent professionals of prevention programmes, 5) increase the number and diversity of available drug prevention programmes, 6) disseminate knowledge concerning the standards and strategies of prevention programmes, 7) improve quality of services of treatment and rehabilitation.

Regional Suicide Prevention Programme among Youth³⁵

This Programme, the first of its kind in Poland, was developed for the Lodz region in 2007. The main aim of the Programme is to prevent suicidal behaviours among youths (self-harm, suicidal ideation, attempts and completed suicides). The Programme has been implemented on different levels: first - to educate teachers and guardians about epidemiology and identification of self-harming behaviours among youth. The second concerns the continuous education of all pupils on mental health and risk factors, training social skills and providing information on psychiatric and psychological help in the region. The third step - identification of pupils at increased risk of suicide. This involves meetings with local authorities regarding the threats to mental health for children and adolescents, training medical students, physicians and paediatricians.

Other general policies related to CAMH

Poverty, social inclusion and social welfare

The first National Programme Social Security and Social Integration³⁶ was implemented in the years 2004-2006. It was extended for the next four years, up to 2010. The Programme was prepared by the Ministry of Labour and Social Security in consultation with local governments,

³¹<http://www.mps.gov.pl/indextxt.php?gid=990>

³²http://parpa.pl/download/Narodowy_Program_2006-2010.pdf

³³92% of 17 age old adolescents drunk alcohol during 12 recent month before the study of 2007.

³⁴English version of the Programme in the home page of the Bureau in English <http://www.kbnp.gov.pl/>

³⁵Rosa K, Gmitrowicz A (2007) Regional Suicide Prevention Programme among Youth. *Suicidologia*, v.III, pp. 18-28

scientists and NGOs. The priority of the Programme is counteracting poverty and social exclusion among children. Other areas of action are: integration through social and professional activities of persons threatened by social exclusion, development of high quality social services, improvement of the retirement and pensioning system, as well as health care and long-term care provision.

As the best way of combating poverty and social exclusion among children is to support families and eliminate educational differences, financial benefits for families are provided within the framework of the Programme. In 2007, the number of children whose family's received benefits, reached 4,200,000 (52% of children population age 0-18). Also, 117 new socio-therapeutic community centres for children from dysfunctional families were organised, pupils of all stage of schools received supplements of food, social grants, and primary school pupils from poor families received school books free of charge. The Programme focuses especially on children living in rural areas.

A complementary programme to that described above is called Active forms of counteracting social exclusion. It provides activities, which help with the integration of groups at risk of social exclusion with the local community by increasing number of employed (workforce members) and staffing in all available workplaces. The programme Social support for persons with mental disorders has similar tasks but focuses on a particular group.

The Act on family financial assistance describes the scope of financial assistance for families, especially benefiting children, teenagers, and disabled children. It describes types, amount and rules for providing the provisions.

Child care/ protection

The Constitution of the Republic of Poland ensures protection of the rights of the child (art.72). Public authorities have an obligation to defend children against violence, cruelty, exploitation. Special care and assistance should also be provided by authorities to children and adolescents deprived of parental care.

The Convention on the Rights of the Child, was ratified by the Polish President on 30 April 1991, with subsequent changes in 1999. The Convention sets standards in health care, education, legal, civil and social services. Two reservations were introduced in Poland: the first regards the confidentiality of the child's origin, the second concerns the age of call-up to the military service. The Convention declares also that the rights defined in articles 12, 16 and 24 should be exercised in accordance with the Polish tradition.

If the basic needs and rights of the child are threatened,

the welfare system takes over the role of parents for a short or longer period. Different kinds of assistance are provided by local self-governments, such as family guidance, and therapy (psychological, sociological activities, which aim at regaining a family's capacity to function), social work, day-care institutions and education. Institutions of care and education ensure 24-hour continuous or temporary care and education of children as well as satisfying their basic living and development needs, including emotional, social and religious. The payment required for a stay in such institution depends on the family's financial situation, and the payment may be waived – fully or partially.

The Programme of support local governments in developing local system on child and family care³⁷ was developed by the Ministry of Labour and Social Welfare in 2006. The main aim of the Programme is to develop local child and family care systems. Other goals are to: 1) improve the situation of families threatened by pathology through prevention programmes, 2) support child day-care institutions to avoid referring children, completely or partially deprived of parental care, to residential child-care institutions, 3) increase number of professional foster families not related to the child, 4) adapt child-care institutions in order to ensure an appropriate course of the development of children, 5) prevent social exclusion of youth brought up in residential child-care institutions and in foster families.

Education and school programmes

The Constitution of the Republic of Poland states, that everyone has a right to education. The education to 18 years of age is compulsory (art.70). The tasks of the education system, its finances, rights and duties of teachers and pupils are defined in 115 articles of the Act on Education System adopted by the Polish Parliament in 1991 (with the latest changes in 2008).³⁸ The Act states that school should ensure each pupil benefits from the conditions necessary for his/her development and be prepared to fulfilling public and family duties. The Strategy on Education Development for the years 2007-2013³⁹ describes the task of a school, which is not limited only to the provision of necessary knowledge, but also to educate in an integral way, to develop social, cultural and ethical skills and enable pupils to take responsibility for their own lives. The Strategy proposes the participation of pupils in different special lessons after school-day, engaging them during free time and supporting their interests.

The Strategy also stresses the need to integrate disabled children and adolescents into education which is appropriate for their development. Disabled youths, especially those with mild intellectual disability, as well as children with behaviour disorders have to find a place in mainstream of education. The Strategy proposes organising a network of centres supporting the re-

³⁷<http://www.mps.gov.pl/indextxt.php?gid=980>

³⁸<http://isip.sejm.gov.pl/servlet/Search?todo=file&id=WDU19910950425&type=3&name=D19910425Lj.pdf>

³⁹http://www.nauka.gov.pl/mn/index.jsp?layout=2&news_cat_id=924&place=Menu06

socialisation of children and adolescent who are not socially adapted. Psychological counselling should be expanded.

Day care legislation/policy for pre-school children

In Poland preschool day-care and education applies to children aged 3-6 years old. Starting from the year 2004/2005, compulsory preschool education for 6 year old children was introduced⁴⁰. The local authorities are obliged to ensure free transport to a kindergarten and care for disabled children aged 6. The low level of participation by children of 3-5 year old in pre-schooling (only 30%) is perceived as a disadvantage. In 2007, no kindergarten existed in 21.8% of communities, the lowest rate in the European Union⁴¹. Access to the preschool education system is severely poor in rural areas due to the shortage of the day-care institutions. To resolve the problem the Strategy on Education Development for the years 2007-2013 proposes the introduction of a new alternative form of day care centres as small preschool groups and individual lessons. One important aspect of this proposal is to engage parents in the education process, which facilitates the work of kindergartens and improves their effectiveness. The year 2008/2009 was proclaimed as a year of the preschool child by the Ministry of National Education,⁴² with the aim of promoting pre-school education. The well organised pre-school education and care, focused on individual development of a child, is considered as a priority.

Family friendly workplace policy

The Act on Labour of 1991⁴³ (with the latest changes in 2008) defines rights and duties of workers and employers. Special Articles provide regulations on the working time for pregnant women and child-caring parent employees, define maternity and post-maternity leaves, parenthood-related employee rights, as well as the employment of minors, including children under the age of 16. During pregnancy, women have the right to sick leave with full pay. Work during the night, overtime and in harmful conditions is forbidden for women during pregnancy and breast feeding. An employer may not terminate an employees contract during the time of pregnancy or maternity leave. During maternity leave, which lasts 18-28 weeks and depends on the number of consecutive children, women receive financial benefits. Leave can be taken by both parents, but only 2% of fathers avail themselves of this privilege. Starting from 2010, a father of a newborn child is obliged to take care leave for a week (rising to two weeks in 2011), otherwise he forfeits the benefits. Mothers have the right to care-leave for a child up to 4 years old with employers not permitted to terminate the contract during this period. On returning to work the employer is obliged to give her the same position as before and during the care-leave

mothers can work part-time.

There are arrangements intended to help parents in combining work with taking care of children e.g. the right to paid time off when children are ill, both parents can be at home on paid leave for 2 days per a year (fully paid) and 60 days at 80% of their salary, up to the child age of 14.

The maternity benefits are supposed to substitute lack of income for parents bringing up a handicapped child and therefore unable to earn a living.

Adoption, fostering policies

The basic principles are that adoption must be in the best interest of a child and is the irreversible inclusion of a child into a family. According to Polish law⁴⁴ the aim of adoption is to create a substitute family environment for children deprived of their own families. Only married couples can adopt children. Biological parents can consent to adoption after 6 weeks of their child being born. The procedure of adoption is very restricted, and in some cases even humiliating for the future adoptive parents, given the detailed personal information requested and the amount of bureaucratic effort and time required to adopt.

If the child is totally or partly deprived of parental care or in cases where parents neglect their parental duties, the guardianship court can ordain to place a child in a foster family.

The Polish Parliament proclaims the year 2009, as the year of fostering care. This move is aimed at the promotion and development of fostering care as the most effective and desirable type of help and protection of children, without a natural and normally functioning family. The special Act on fostering care was prepared. It formulates in details principles, forms, duties of fostering parents and authorities.

Divorce and custody policies

In principle, if children of a married couple will suffer, divorce is not admissible. In cases of divorce the court grants parental power to one of the couple and decides the amount of financial provision to be paid by the other one.⁴⁵

Urbanisation policies and housing

The problem of housing is especially difficult in Poland. The deficit of the available apartment's number is high and the price of rather modest apartment exceeds the financial resources of a considerable part of population, especially of the youngsters. For families living in poverty it is difficult to even maintain their flats due to the rising costs of services.

A wide action to support building houses for poor families is considered as a priority task of the government.

⁴³<http://isip.sejm.gov.pl/servlet/Search?todo=file&id=WDU19740240141&type=3&name=D19740141Lj.pdf>

⁴⁴Kodeks rodzinny i opiekuńczy [Family and guardianship code of 25 February 1964 with changes, the latest in 2004] <http://isip.sejm.gov.pl/servlet/Search?todo=file&id=WDU19640090059&type=3&name=D19640059Lj.pdf>

⁴⁵Family and guardianship code, ibidem

Anti discrimination policies⁴⁶

The Constitution of 1997 and other legislation as the Labour Code, Act on Education, Act on Social Support, Act on Religion, Act on National and Ethnic Minorities and Regional Languages forbid discrimination in any aspects of life. In 2003, to fulfil obligations of UNO documents of 2001, the Ministry of Interior and Administration developed the National Programme of Combating Racial Discrimination, Xenophobia, and Intolerance for the years 2004-2009. It promotes the right of every human being to equal treatment in all areas of social life, regardless of race, nationality, religion, language or gender. The strategic aims of the Programme are to develop methods of counteracting discrimination, to undertake activities, especially educational, to raise awareness of problems of discrimination and rights and duties of citizens. Anti-discrimination activities of the Programme concern different life spheres, such as the labour market and health (e.g. equal access for woman, facilities for disabled persons), education and culture, mass media. The education of public officers, teachers and children in open minded attitudes toward others is an important part of the Programme. Despite principle of access to education for all, there are some groups, which needed the special attention e.g. pupils from ethnic minorities, migrant children. A special school programme for Roma children has been implemented, children from Belarus, Lithuanian, Ukrainian or German families can be educated in schools in their native languages (618 schools in 2002/2003), anti-racism education is introduced through sport and via the internet and a Council for monitoring racism and xenophobia was set up.

Ombudsman for children and adolescents⁴⁷

Suggestions to appoint an ombudsman for children and adolescent came from NGOs and activist groups on children rights, in the mid-90s, during discussions concerning changes in the Polish constitution. The Act on Ombudsman of the Rights of the Child, adopted by the Parliament in 2000, defines tasks of the Ombudsman and principle of its appointment. According to the Act the Ombudsman is an independent, non-partisan, politically neutral (responsible only before the Lower House of the Parliament) and an active participant, complying with the UN Convention on the Rights of the Child.

According to the Act, the child is defined as an each individual from conception up to coming of age. The task of the Ombudsman is to protect the rights of a child in four areas: the right to life and health; the right to grow up and participate fully in a family; the right to adequate social conditions and to education. The Ombudsman is obliged to protect minors, including disabled children, against violence, harmful influences, abuse and exploitation. The Ombudsman does not replace specialised institutions, organisations or services and reacts only in situations, when applied procedures prove to be not effective or are relinquished. She/he

has the power to control, advise and initiate matters important for improving the rights of children and youth, e.g. financial support for treatment, violence of teachers or peers.

The Ombudsman's Office advises children, parents, professionals and organisations, as well as collecting information concerning children.

3.2. Availability of programmes for CAMH promotion and mental disorder prevention

Studies to quantify the availability of programmes for CAMH promotion and mental disorder prevention are not carried out in Poland. Hence, the account given below should be considered as the first approximation.⁴⁸

Home-based programmes for promotion/prevention are widely available for families needed support: financial, psychological, and pedagogical. Also as part of public health services mainly in towns, community nurses visit families with newborn babies, undertake a medical examination of a child, check physical status of a mother and life condition of a family.

Parenting programmes are quite common. Since 1995, the Centre of Psychological and Pedagogical Assistance has run the programme School for parents and tutors. Its goal is to support parents in coping with everyday contact with youth and children. It also aims at developing dialogue and more profound relationships between the generations of parents and their children. The Programme How to cope with difficult behaviours among children for parents, develops their skills to intervene on problems of young children. The programme is also focussed on autistic children and those with behaviour disorders. The Government's action also contains several activities directed towards parents: a) information action about youth and alcohol and drugs, b) a national telephone-help-line for parents, c) better collaboration between home and schools.

School mental health promotion is widely available through the school health services and also through different local, regional or large-scale national programmes. The Health promoting school system is currently being implemented in many Polish schools (initiated and supported by the Ministry of National Education). Activities of the Programme have been developed on the base of the WHO idea of school promoting health and have been implemented in collaboration with the European network "Schools for Health". The Programme is expected to: provide health education to pupils, teachers and other school employees, and strive to increase its effectiveness, create a social climate promoting participation and co-operation between members of the school community,

⁴⁶Information from the Ministry of Interior and Administration: <http://www.mswia.gov.pl/portal/pl/100/208/Dokumenty.html> and <http://www.mswia.gov.pl/portal/pl/99/204/Dzialalnosc.html>

⁴⁷Source: <http://www.brpd.gov.pl>

⁴⁸Estimation on the base of reports on implementation of the programmes done by J.Wojda

parents, and local community members; create a physical environment promoting health, safety, and well-being of pupils and school employees.

Since 2005, in kindergarten and primary schools has been implemented the international programme Zippy's friends. It promotes emotional health of young children (6-7 years old), develops psychosocial skills, teaches coping with stress, rejection and changes in life etc.

Mental health issues are included into the school curricula in the framework of the project, The inter-subject path of pro-health education. Programmes developed by schools in collaboration with local health sectors publish educational material for teachers in the special bulletin "Edukacja zdrowotna i promocja zdrowia psychicznego" [Health education and promotion of mental health].

School targeted preventive programmes directed at smoking, drinking alcohol, using drugs, problematic behaviour, social competence etc. are widely available in the Polish schools.⁴⁹ National Programme for Safety Improvement in Schools and Educational Institutions, "Zero tolerance" aimed at increasing safety in schools and preventing social pathology, such as aggression and peer violence. Starting from the end of 2008, "Zero tolerance" was replaced by the Safe and friendly school Programme.⁵⁰ Emphasis is put non on restrictions but on mutual respects and dialogue between children, parents and teachers. Actions comprise health promotion, including mental health, crisis intervention, therapy, reducing aggression and violence.

The aim of the programme Preventive health care provision to children and adolescents in educational environment is to ensure health care to all pupils in all types of schools (also children at the age of six) and to increase the quality of care. The Programme describes tasks of health professionals working at schools.

Promotion/prevention programmes at hospitals/clinics are common in Poland, mainly through informative actions, such as leaflets, brochures, information on special boards. Volunteers support children psychologically, read books to them, play, organise cultural events. Often children and youth, whose experienced illness, also engage in such actions.

Promotion/prevention actions in churches, clubs, and recreation centres are not widely available for children and adolescents in Poland. The main catholic NGO "Foundation for Helping Dependent Persons and Children" is involved in many projects. Worth mentioning are Promotion of Healthy Thinking with the goals of promoting healthy and ecological lifestyles, taking into account human needs; Student's compendium - everything you should know about dependence and prevention - during workshops students are taught about various types of addiction, as from psychoactive

substances, internet, gambling etc. as well as developing effective prevention actions; Schools for Youth Leaders "Fair Play" - workshops concern enhancement of pro-social skills among children and adolescents, and on the other hand, development of leadership skills necessary for conducting prevention activities among peers; The Stop Violence Programme aimed at: preventing and eliminating social maladjustment, including aggression and violence among children and adolescents, - broadening awareness of professionals who work with children and adolescents on the importance of training pro-social skills for the child's general development, - preventing drug and alcohol abuse, - involving school staff, parents, local community members, nationwide and regional mass media, as well as artists in activities of this Programme.

In 2006, the National Bureau for Drug Prevention implemented 12 prevention programmes for drug endangered children and youth in recreational settings aimed at preventing drug initiation and reducing risks related to occasional drug use. Under these programmes the following interventions were undertaken: education on drug-related risk, motivation to change attitudes and behaviours, providing information on drug outreach centres and distributing information materials.

Promotion/prevention action via Internet is very common, via web pages of governmental agencies and NGOs. Actions are focused on a knowledge-base for alcohol, drug and tobacco prevention as well as health promotion. Information about measures directed towards children, youth, teachers and parents are given. The "Nobody's Children Foundation" runs the programme Child on the web, which aims to educate children, adolescents, parents and professionals on safety on the web. Within the framework of the programme campaigns, trainings, help-lines etc. have been organised. The programme goals include 1) acquainting parents and carers with possibilities and risks involved in Web use, 2) teaching children on potentially dangerous situations on the Web, 3) protecting youth against harmful content on the internet and internet dependence.

Custodial settings (detention centres). According to the Act on proceeding in the case of minors,⁵¹ juveniles between 13-21, who break the law or exhibit anti-social behaviour are detained in four different kinds of institution: from the most severe correctional centre, through hospices for minors, youth educational centres, and youth centres for socio-therapy. In such detention centres the main principle is to undertake activities which enable minors to return to normal life. The educational measures focus on the universal development of the personality of the minor, his or her abilities to cope with difficulties and responsibility. Centres ensure general and occupational education, cultural and social activities

⁴⁹For recommended prevention programmes at schools see: <http://www.cmppp.edu.pl/node/13718>

⁵⁰Bezpieczna i przyjazna szkoła. Rządowy program na lata 2008-2013. http://bip.men.gov.pl/akty_prawne/uchwala_20080819_zalacznik.pdf

⁵¹Ustawa o postępowaniu w sprawach nieletnich [Act on proceeding in the case of minors of 1982 with the latest changes in 2008] <http://isip.sejm.gov.pl/servlet/Search?todo=file&id=WDU19820350228&type=3&name=D19820228Lj.pdf>

and sports. In principle, the most important promotion measure inside detention centres is a tutor whose role is supporting, motivating, and, if needed, discussing future-plans and activities. Unfortunately, in this case, practice is far away from theory.

Community settings. Organised leisure time activities for children and youths is widely available and is the most important measure of mental health promotion.

Telephone counselling. Many help-lines either for children and adolescents or for parents have been established in recent years, most importantly the Polish Nationwide Emergency Service for Victims of Domestic Violence or "Blue Line". The "Blue Line" is for people suffering family violence, especially children and youth, to perpetrators of violence in the family, and witnesses of family violence. The tasks of the "Blue Line" include: psychological support for callers, legal counselling, education concerning violence and alcoholism, encouraging people to take actions against family violence and interventions in formal institutions.

4. Organisation and resources for implementation

4.1. Implementation of programmes

The main bodies for carrying out the policy, initiating

and implementing programmes within the field of mental health promotion and prevention for children and adolescents are: the Ministry of National Education (Department of General Education, Department of Strategy), Ministry of Labour and Welfare (Department of Women, Family and Counteracting Discrimination, Department of Family Benefits, Department of Social Assistance and Integration) and Ministry of Health (Public Health Department and Health Policy Department).⁵²

4.2. Services

In Poland children and adolescents suffering from mental health problems receive the first help from paediatricians responsible for referral to specialist services. Teachers and school health services are important in the identification of problems at an early stage. Psychological services also provide active support. In 2006/2007 there were 559 public psycho-pedagogical clinics.⁵³

Children and adolescents with mental disorders receive treatment in:⁵⁴

- outpatient psychiatric clinics for children and adolescents (in 2006 - 162 clinics),
- psychiatric and addiction day treatment units for children and adolescents (2006 - 22 units with 644 places). Minors are also treated in units for adults,
- psychiatric and addiction treatment wards for children and adolescents in psychiatric hospitals (in 2006 - 29 wards),

Table. 4.2.2 Availability of services in 2008

	0%	1-25%	26-50%	51-75%	76-100%
Child psychiatrist counselling sessions		x			
Psychologist counselling sessions		x			
Social service interventions			x		
Family therapy/ counselling	x				
Infant-specific services	x				
Adolescent-specific services/outpatient centres		x			
Group therapy	x				
School counselling		x			
Pharmacological treatment			x		
Psychological rehabilitation centres for adolescents	x				
In-patient beds on child psychiatric wards in general hospitals					x
In-patient beds on child wards in psychiatric hospitals					x
Telephone consultations		x			
Individual psychotherapy	x				

⁵²<http://www.men.gov.pl/> English version: <http://www.mpips.gov.pl/index.php?lang=2>, <http://www.mzios.gov.pl/>

⁵³Organizacja poradnictwa w Polsce – dane statystyczne za rok szkolny 2006/2007 [Organization of counselling services in Poland – statistical data for the school year 2006/2007] <http://www.cmppp.edu.pl/node/19524>

⁵⁴Source of data: Boguszewska L., Moskalewicz J., Słupczyńska-Kossobudzka E., Milewska D., Sowińska M., Bartnik A., Głazowski C., Gomułka J., Welbel M., Skiba K. (ed.) (2007), op. cit.

- psychiatric and dependence treatment wards for children and adolescents in general hospitals (in 2006 - 16 wards).

Availability of services

The table below presents only an approximate indication of access to mental health services. As data on access to specific types of services is not available, approximate indication is given, based on information received from Prof. I. Namysłowska, the national consultant on CAMH. Child psychiatrist and psychologist counselling. In general, the availability of out-patient services related to children and adolescents' mental health is relatively good. In 2006, the rate of psychiatric counselling sessions for children aged 0-18 was 506.0 per 100000 of the general population, the rate of psychologist counselling sessions – 552.1 in outpatient psychiatric facilities. In the school year 2006/2007, in public psycho-pedagogical clinics, 12.8% of children and adolescents aged 0-19 received help (including psychological diagnosis). Social services are available widely. The rate of intervention of social staff in 2006 was 1.3 per 100000 of the general population. Family therapy and group therapy are inadequately available. In 2006 the rate was 29.6 per 100000 of the general population. Adolescent-specific services (outpatient) provided counselling on alcohol and drug problems. School-counselling is available in the half of all schools. Pharmacological treatment is accessed mainly through

out and in patient services or GPs.

Psychological rehabilitation for adolescents is not available in specific centres, but is an integrated part of main stream of health services.

In-patient mental health services for children and adolescents are widely available. In 2006, a bed ratio at child psychiatric wards in general hospitals was 0.9 per 100000 of general population, and at child wards in psychiatric hospitals – 2.0.

Other services are available, but inadequately. In 2006 the rate of telephone consultation was 29.4 per 100000 of the general population, individual psychotherapy – 55.7.

Access to specially designated mental health services and promotion/prevention actions

In Poland there are not specially designated services for specific subgroups of children and adolescents. All of them have access to all public mental health facilities and are treated in accordance with their needs. Promotion/prevention programmes, which are focused on children and adolescents in general also provide assistance for the special groups as those living in poverty, minorities, migrants etc.

The following table presents specific subgroups of children and adolescents whose have access to specially designated and tailored mental health promotion/preventive actions. As data for the most of these groups is not available, an approximate indication is given, based on the estimation made by J.Wojda.

Table 4.3.2. Access to specially designated mental health promotion/prevention actions

Group	0%	1-25%	26-50%	51-75%	76-100%
Minority groups					
Migrant population					
Orphans					
Children living in poverty					x
Runaways/homeless					
Refugees/disaster-affected population					
Seriously emotionally disturbed					x
Victims of violence in families/ bullying					x
Early school leavers					
Unemployed youth					

4.3. Funding

In the past 5 years (2003-2007), resources allocated to CAMH in general, as well as to specific areas of child and adolescents' mental health, increased modestly, especially in treatment and care in inpatient facilities. Funds dedicated to CAMH are not clearly specified in the national budget. Promotion and prevention programmes are financed by the Ministry of National Education, alcohol and drug prevention programmes by

the Ministry of Health, treatment and care mainly by the National Health Fund.

The sources of funding of NGOs activities come from the state budget, regional/municipal budgets and international organisations.

4.4. Training of the professional workforce

Training in child and adolescent mental health is a part of the undergraduate education national curriculum.

At this level CAMH is included into general courses of psychiatry and psychology. Specific courses for teachers and social workers an exception. However, for medical doctors specialising in psychiatry and for psychologist taking a master level and postgraduates, CAMH is recognised as an independent field. In the year 2005 the specialization in child and adolescents psychiatry was introduced. In September 2008, the total number of psychiatrists specialised in this field reached 228, 48 persons had participated in the specialised procedure. For primary care doctors/GPs specialised in family medicine, paediatricians, neurologists specialised in child neurology special courses on child and adolescent mental health are organised, but do not take place each year. Primary care nurses and nurses specialised in psychiatry, as well as public health professionals are also trained in this field.

CAMH training for undergraduate and master level students is provided in 11 medical universities, the Academy of Special Education, as well as other universities. The Medical Centre for Postgraduate Education organises courses for physicians specialised in psychiatry, neurology, paediatrics etc.

5. Monitoring and evaluation of action for promotion and prevention in mental health

5.1. Mental health service and care policies evaluated

Care services

Since 1992, after a detailed evaluation of the situation, the Mental Health Programme set up standards for mental health care services. Despite the lack of full financial support from government, these recommendations were partially implemented. The Programme emphasised that accessibility and differentiation of psychiatric health services for children and adolescents should be improved. It suggests an increase of capacity for out-patient care, as well as consultation and family support. In 1998 the Programme recommended the following accessibility of facilities for children and adolescents – (1) at least one clinic per 250000 of population (since 2000 – 150000), open daily with a staff consisting of at least one child psychiatrist, 2 psychologists, a nurse, a social worker and a psychotherapist; (2) specialist clinic for family support, at least one in a province; (3) 1 place open daily per 10000 of urban population in a day treatment unit, (4) mobile community teams with 1-3 visits per week. For inpatient care the Programme proposed the provision of equally accessible hospital care at a rate of 0.3-0.4 bed

per 10000 inhabitants, and the establishment of cross-regional psychiatric care facilities as forensic psychiatry wards and rehabilitation centres for youth dependent on alcohol and drug.

During the years 1998-2006 care of children and adolescent changed substantially, but did not reach proposed standards. The number of outpatient psychiatric clinics increased by about 80% (but is still short by 36%), the number of day treatment units rose by 70% (still needed: 83% and in the half of all provinces). The number of beds in psychiatric departments of general hospitals was on the rise at the expense of beds in psychiatric hospitals (where 10% are still lacking). The forensic psychiatric ward for adolescents was organised. Mobile community teams still do not exist.

Professionals: the number and qualifications

Desirable numbers of staff employed in child and adolescent care services have still not been reached. Out of 400 children and adolescents psychiatrists proposed by the Mental Health Programme there were only 228 in 2008 (a rise of 34% since 2000). The professional qualifications of personnel in the children and adolescent specialist services are generally high. All children and adolescent psychiatrists are specialists in psychiatry. Psychologists and other medical doctors have a university degree. The number of certified clinical psychologists and therapists has risen significantly since 1998.

5.2. Mental health promotion and mental disorder prevention policies evaluated

The implementation of the National Health Programme (NHP) for the years 1996-2005, was monitored and evaluated.⁵⁵

Summary of monitoring and evaluation of the alcohol target

The prevalence of drinking and drunkenness among school children tended to level-off after reaching a relatively high level in the first years the new millenium. In contrast, average alcohol consumption in the adult population reached the same level as that of the post-war peak.

Summary of monitoring of the drug target

Similarly to alcohol use, after more than a decade of continuous growth, school surveys suggested a levelling off in drug use among the teenage population that may indicate a declining demand. On the other hand, accessibility of drugs and their affordability are on the rise.

⁵⁵Goryński P., Wojtyniak B., Kuszewski K. (eds.) (2004) Monitoring oczekiwanych efektów realizacji Narodowego Programu Zdrowia, PZH, Warszawa, 59-76, 85-93.

Goryński P., Wojtyniak B., Kuszewski K. (eds.) (2005) Monitoring oczekiwanych efektów realizacji Narodowego Programu Zdrowia 1996-2005, MZ, PZH, Warszawa, 77-104, 116-135.

National Health Programme 2007-2015, p.64-66.

Summary of monitoring of the health education target

Health education was introduced to all types of schools, but despite efforts, healthy behaviours among children and adolescents are still far from satisfactory.

Summary of monitoring of the mental health target

Despite the continuous growth in numbers of persons with mental health problems, including children and adolescents, being treated in inpatient and outpatient care facilities, the financial resources for prevention of mental disorders and mental health promotion were unsatisfactory. Resources for developing new community psychiatric centres were inadequate. Mental health promotion activities were not coordinated, nor evaluated.

Evaluation of preventive programmes

Programmes counteracting alcohol and drug consumption among children and adolescents implemented by the local communities were evaluated. For example, in the years 2004 and 2005, evaluation of the two year alcohol prevention programme for 10-12 year olds consisting of the Slick Tracy Home Team Programme and its continuation Amazing Alternatives was carried out. The aim was to assess the stability over time of preventive intervention effects. The outcomes of the evaluation showed changes in alcohol attitudes, increases in knowledge about the consequences of drinking. Analyses also indicated that participation in this preventive programme resulted in lowering the number of cases of drunkenness and drinking of alcohol among peers.

6. Research and dissemination

6.1. Key research projects on CAMH

There are many research projects going on within the field of CAMH in university departments (mainly in institutes of psychology and pedagogy), medical universities (in dept. of child and adolescent psychiatry in Kraków, Poznań, Łódź, Warsaw), and research institutes (such as the Institute of Psychiatry and Neurology, the Institute of Mother and Child). Problems of eating disorders, first episode of schizophrenia, depression, obsessive compulsive disorders, ADHD and autism in early childhood are widely studied from the point of view of biological determinants, clinical picture, co-morbidity, methods of treatment (including family therapy), clinical

psychology, and epidemiology.⁵⁶ Presented below are research projects chosen as examples from several sub-fields among the many conducted.

Child and adolescent mental disorders

Research on schizophrenia

Research on the first episode of schizophrenia is carried out by the Department of Child and Adolescent Psychiatry, IPN. The research describes characteristics of psychopathology and the course of early onset of schizophrenia in comparison with that of adult patients. The adolescent schizophrenic patients develop depression symptoms more often than the adult. Research on thinking processes in schizophrenia is conducted by the Department of Child and Adolescent Psychiatry, Chair of Psychiatry, Poznań University of Medical Sciences

Treatment and care related issues

Study on resources of mental health care in Poland

Since 1968, yearly, detailed data concerning personal, material and organisational resources of the psychiatric care system in Poland has been collected and analysed by IPN. At first, only data on child and adolescents inpatient services was collected, but since 2005 information concerning child and adolescents outpatients facilities has been included.

The data is presented in the yearbook *Zakłady psychiatrycznej oraz neurologicznej opieki zdrowotnej. Rocznik Statystyczny [Mental health care and neurological care facilities. Statistical Yearbook]*. About one thousand copies of this book are disseminated through libraries, psychiatric departments of medical universities, among policy makers, mental health professionals, etc. The statistics allow the development of recommendations on allocation of mental health services in order to improve their accessibility.

Prevention of mental disorders

Assessing major risk and preventive factors in drug and alcohol use among children and adolescents

Research is carried out by the Institute of Psychiatry and Neurology. Since 1984, prevalence and patterns of substance use among adolescents as well as risk and protective factors associated with behavioural problems has been monitored in three districts of Warsaw. The seventh cluster of the study was broadened to include violence, tattooing and body piercing, youth delinquency

⁵⁶Research on different subgroups of anorexia nervosa and their genetic and neurophysiological correlates are carried out by the Child and Adolescent Psychiatry, IPN and the Depart. of Adolescent Psychiatry, Medical University, Warsaw; on genes in ADHD with chosen cognitive function and clinical factors are performed by the researchers at the Depart. of Child and Adolescent Psychiatry, Chair of Psychiatry, Poznań University of Medical Sciences.

Research on family therapy is carried out by the Children and Youth's Psychiatric Clinic, Chair of Psychiatry, Collegium Medicum, Jagiellonian University, Kraków and the Depart. of Child and Adolescent Psychiatry, IPN. The role of the family in treatment of emotional disorders in children and adolescents is studied. Research on treatment of eating disorders is a subject of the Children and Youth's Psychiatric Clinic, Chair of Psychiatry, Collegium Medicum, Jagiellonian University, Kraków and Depart. of Child and Adolescent Psychiatry, IPN, 2nd Depart. of Psychiatry of Medical University in Łódź. The great number of various problems presented during the National conferences of child and adolescents psychiatrists, held yearly (23rd in 2008), illustrates the wide range of conducted research. Abstracts of these presentations are published in *Psychiatria i Psychologia Kliniczna*.

and mental health indicators such as anxiety or depressive symptoms. The study findings are gathered in a database on substance use among adolescents (since 1988). Evidence-based preventive programmes for schools and local government are prepared. Reports from research are available for governmental agencies, institutions, organisations and persons dealing with drug and alcohol abuse, as well as special trainings of health professionals and teachers are organised.

School-based intervention for adolescents using drugs

Despite a well developed primary prevention network and various treatment opportunities for drug addicts, there is a lack of programmes for drug users with less serious problems. One of barriers is related to the difficulties in accurate diagnose. This finding prompted IPN and the National Bureau for Drug Prevention to undertake studies aimed at development of an effective screening test for adolescent with problematic drug use. The idea behind it was to enhance the effectiveness of intervention and treatment services by providing professionals with an easy-to use, quick and effective diagnostic tool.

Research on *Prevention programme of eating disorders* were carried out by the Department of Child and Adolescent Psychiatry, IPN, aiming at establishing the efficacy of the eating disorders prevention programme for girls from the secondary schools.

Research on a *Suicide prevention programme*, carried out by the Department of Affective Disorders and Psychiatry of Adolescents, Chair of Psychiatry, Medical University, Łódź, concerns social and clinical risk factors of suicidal behaviours among youths. Results of the study were helpful in the development of the regional suicide prevention programme.

Promotion of mental health

Evaluation of mental health promotion programmes - the case of Mazovian Province The aim of the project carried out by the Institute of Psychiatry and Neurology is to analyze activities concerning mental health promotion, to identify the most urgent needs in this area and future tasks. Special attention is paid to promotion programmes focused on children and adolescents.

Studies in the framework of the EC project "Screening for and Promotion of Health Related Quality of Life in Children and Adolescents - a European Health Perspectives, KIDSCREEN" The project, sponsored by the European Commission, has been carried out by the Institute of Mother and Child, Warsaw since 2000. The main objective was to develop a standardised screening instrument for measuring children's quality of life. Children at risk, in terms of their subjective health, were identified and appropriate early intervention suggested.

Epidemiology

Epidemiology of depression in developmental age

The project is carried out by the Children and Youth's Psychiatric Department, Chair of Psychiatry, Collegium Medicum, Jagiellonian University, Kraków. The aim of the study was to evaluate changes in prevalence and dynamics of depression among pupils age 10 – 19 from the large towns in the subsequent years 2001, 2002, 2003 and also 2006.

European School Survey project on Alcohol and Drugs

The project, coordinated by the Swedish Council for Information on Alcohol and other Drugs and supported by the Pompidou Group, has been carried out by the IPN every four years, the latest in 2007. Research aimed at collecting data on alcohol, tobacco and drug use among 15-16 year old students.

6.2. Main bodies involved in information dissemination to keep health care professionals informed

The main bodies involved in the dissemination of information about all aspect of children's and adolescents' mental health to health care professionals are IPN and Institute of Mother and Child. Besides these two, in the area of promotion and prevention, dissemination of information is also the duty of the governmental agencies e.g. the National Bureau for Drug Prevention, the State Agency for Prevention of Alcohol Related Problems and Methodical Centre for Psycho-pedagogical Assistance.

Three departments of the Institute of Psychiatry and Neurology: Department of Child and Adolescent Psychiatry, Department of Clinical Psychology and Mental Health Promotion, Department of Studies on Alcoholism and Drug Dependence carry out research on mental health of children and adolescents. The staff of these departments disseminate the results of research by publishing handbooks, articles in scientific journals, by participation in meetings and conferences, workshops, by organising training for postgraduates and psychiatrists, clinical psychologists and psychotherapists. The special training concerns child psychiatry. The Institute publishes its own quarterlies: *Postępy Psychiatrii i Neurologii* [Advances in Psychiatry and Neurology], *Farmakoterapia w Psychiatrii i Neurologii* [Pharmacotherapy in Psychiatry and Neurology] and *Alkoholizm i Narkomania* [Alcoholism and Drug Abuse], as well as the Statistical yearbook on mental health care facilities. Each year, the Report on the Institute's clinical, research and teaching activities is put on the home page. Problems of children and adolescents are always included.

Three departments of the Institute of Mother and Child: Department of Care and Promotion of Child and Adolescent Health, Department of Epidemiology, Department of Early Psychological Intervention carry out research on mental health of children and adolescents. To disseminate the results of research, the staff of the departments publish handbooks and articles in scientific journals, participate in meetings and

conferences and organise training and workshops. The Institute publishes its own quarterly: *Medycyna Wieku Rozwojowego* [Developmental Medicine]. The results of research activities, reports and articles are available on the Institute's home page.

The main task of the National Bureau for Drug Prevention is to implement drug prevention policy. The Bureau shapes the policy of drug addiction rehabilitation, of preventing drug use among children and adolescents as well as of training system. It systematically monitors and assesses epidemiological drug use situation in Poland, initiates research. It publishes reports, guidelines, brochures, etc. on different aspects of drug problems. It organises scientific conferences and workshops. The Bureau uses its website to disseminate comprehensive information on all aspects of drugs, namely on drug abuse and dependence, reports on epidemiology of drug abuse in Poland, on legislation, and provides data base on all kinds of drug services in the country. Additionally, on its website one can find a short description of journals, books and educational materials for specialists, parents and young people.

The areas of expertise of the State Agency for Prevention of Alcohol related Problems span from legislation and strategic planning to prevention and treatment. The Agency's work covers education of professionals in the area of alcohol addiction, counselling, research and the publication of education and information materials. It organises scientific conferences and workshops. The Agency also disseminates information through its website, which contains a comprehensive set of alcohol-related data. It features, among others sections, such problems as health consequences of alcohol and dependence, violence in family and the role of alcohol in young peoples' lives. Reports on research are also presented. Short information about books, journals and educational materials published by Agency are also available.

The Methodical Centre for Psycho-pedagogical Assistance was founded by the Ministry of National Education. Its mission is to support educational policy of the state, to initiate strategies on child and adolescent development in the education system. It offers different forms of support for human resources, disseminates results of research carried out in the Centre's departments, publishes books, handbooks, guidelines. The Centre develops and disseminates informational and educational material on programmes for schools, and standards and tools for the evaluation of these programmes. It organises trainings, conferences, workshops.

7. Challenges, opportunities and advances in the field⁵⁷

7.1. Key recent advances, barriers or issues in CAMH

The key recent advances in care of children and adolescent's mental health are:

- Child and adolescent psychiatry was established as the separate medical speciality
- Amendments to the Mental Health Act were adopted by Parliament; the amended Act allows full implementation and financing the National Mental Health Programme
- The role of psychotherapy (especially family therapy) in the treatment of children and adolescents has increased
- Scientific conferences on children and adolescents mental health have been held regularly

The most important barriers that impede action on CAMH care are:

- The insufficient number of child and adolescents psychiatrists (only 228 per more than 8 million of child and adolescents population)
- Inadequate funding, especially for out-patient and community services by the National Health Fund
- Low availability of psychotherapy and sociotherapy for children and adolescents in the national health service system, especially outside larger towns
- Lack of inter-institutional cooperation between the Ministries of Labour, Education and Health

The key recent advances within CAMH prevention and promotion

- Introduction into the school curricula hours devoted to healthy physical and psychological life-style
- Prevention programmes on family violence were implemented by the State Agency for Prevention of Alcohol-Related Problems
- The programme "Safe and friendly school" accepted by the government in October 2008
- Two national conferences on mental health promotion were held in 2005 and 2007. The third one is planned for 2009.

⁵⁷These questions are answered by two researchers at the Institute of Psychiatry and Neurology, who are involved in research and treatment within the area of CAMH.

The most important barriers within the field of CAMH promotion and prevention are:

- In general
- Lack of a long-term CAMH national strategy and policy (e.g. lack of the separate National Programme on Promoting Mental Health among Children and Adolescents)
- Lack of CAMH promotion and prevention programmes on the local level
- Insufficient numbers of all kinds of professionals in the field of CAMH
- Lack of tradition in positive thinking about mental health

In particular

- Insufficient numbers of programmes related to early intervention (e.g. for autistic children)
- Highly insufficient number of centres to help dysfunctional families and families in crises
- Lack of interest among policy makers in organising leisure time activities for youth in villages and small towns
- Little interest among school staff in the promotion of mental health and prevention of mental problems
- Insufficient number of programmes on mental health promotion implemented as regular activities in schools

Examples of success in CAMH intersectoral work

- In 2007, the Ministry of National Education provided special subvention for disabled children, which is 9.5% higher than for an average child. This subvention is especially important for treatment and care of autistic children.
- Close cooperation between the Institute of Psychiatry and Neurology, the Ministry of National Education, the State Agency for Prevention Alcohol Related Problems and the National Bureau for Drug Prevention in developing evidence-based mental health promotion programmes, adapting them to Polish contexts and implementing in as many schools as possible.

7.2. Youth involvement

Methods of including children and adolescents in the process of decision making and implementation of various actions concerning their mental health, especially in the area of drug and alcohol abuse were described in the National Action Plan for Children and the National Programme for Prevention of Social Maladjustment and Crime among Adolescents and Children, the National Programme of Prevention Alcohol Related Problems and the National Programme of Counteracting Drug Addiction. Proposals concerning activities in organising

and implementing different kind of social activities aimed at making young people responsible for their own life were also included. Children and adolescents take part in the development of the CAMH policies mainly through participation in formulating and evaluation of programmes⁵⁸.

In 2006, the Children and Adolescents Council was brought into being at the Ministry of National Education. The tasks of the Council are to give opinions on the Ministry's initiatives related to children and adolescents and offer its own proposals. The Council consists of 48 pupils, each for two year term. Also, since the beginning of 1990s, the so called Parliament of Children and Adolescents has gathered once a year to discuss problems suggested by the Ministry of National Education.⁵⁹

To increase participation of children and adolescents in developing policies and programmes on mental health, the following actions are needed:

- training of peer-leaders,
- widening cooperation between children, adolescents and the institutions responsible for developing CAMH programmes and their implementation,
- increasing awareness and knowledge on threats to mental health among children and adolescents,
- taking the views of children into consideration more often than at present in developing and implementing promotion and prevention programmes.

7.3. Proposals for further development

The interest of policymakers in problems of mental health of children and adolescents is rather inadequate due to unwillingness to take up such "marginal" problems as mental health. The opposition to introducing mental health promotion to school curricula serves as an example. The attitude of professionals is quite the opposite and it is due to the pressure they have placed on policymakers that a number of actions have been accepted. Also thanks to their efforts, problems of mental health of children and adolescents are often mentioned in the mass-media, aimed, first of all, at overcoming negative attitudes towards people with mental health problems throughout Polish society. Further actions of such kind are badly needed.

In order to increase actions to improve child/adolescent mental health services, an adequate financial system must first be established. Emphasis should be put on the out-patient and community services for children and adolescents. In many places more clinicians are necessary, in particular psychologists of children and adolescents. Furthermore, there is a need for increased competence on mental problems among paediatricians and GPs. A greater stress on psychosocial problems within mental

⁵⁸The document published by K. Wojcieszek and J. Szymańska describes the necessary basic rules of developing prevention programmes and the standards of their implementation and evaluation in educational institutions, <http://www.cmppp.edu.pl/node/16973>.

⁵⁹<http://www.rdim.org/>

health services is necessary. The services should be supported by effective systems of collaboration between service levels (primary-secondary-social services and specialised health services). More financial support for research is needed. In the area of child/adolescent mental health promotion and prevention of mental health problems/disorders, the education of the general public, policy makers, physicians, teachers should be increased. Improvement of family relationships should be taken into account in developing mental health promotion programmes.⁶⁰

8. Summary and conclusions

The first period of political and economic transformation, lasting 10 or 12 years, caused an increased burden and permanent stress to all families, and created, without a doubt, a threat for the mental health of the whole Polish population. The number of one-parent family has grown, the number of divorces increased, violence and harm to children, including sexual abuse, increased sharply, the number of hours spent at work increased and the threat of unemployment touched every household. The system of values was diminishing. All these factors influenced mental health, especially that of children and adolescents. The last three years have brought some stabilisation to this situation.

Recent years witnessed undisputable achievements in the field of mental health. Services related to children and adolescents' mental health have improved, due to more accessible and effective services, more professionals with better training were prepared to meet mental health problems of children and adolescents.

However, the present system has still many deficiencies. The distribution of mental health care services for children and adolescents is uneven. The system

concentrates on hospitals, while the community and out-patient facilities are poorly developed. Accessibility of early diagnosis and intervention is inadequate. Child and adolescent psychiatry obtains less money from the National Health Fund, than other medical services. Many facilities, especially community and outpatient ones, have had to be closed down due to lack of financial resources. Psychotherapy is provided mainly by private clinics. The relative number of children and adolescent psychiatrists is the smallest in Europe.

The understanding that children and adolescent constitute a vulnerable group in society has become more and more widespread among policy makers and professionals. Two large scale strategies concerning children and adolescents have been implemented in which mental health at school, healthy families, prevention of alcohol/drug abuse are an important part. Prevention of mental disorders and promotion of mental health among children and adolescents is included in the National Mental Health Programme. Other general policies, such as those related to social inclusion, day-care provision, family friendly work places and education system also point to this vision.

There are still major challenges to overcome, such as developing smoother collaboration and cooperation between primary health and social services, as well as early diagnosis, intensive treatment and psychological help for families.

The developed strategies and programmes are of high quality but this is at odds with their implementation. There is a common opinion that implementation of these programmes by the existing systems of health care and education is inadequate. The shape of the expected changes is still under discussion, but there is a little doubt that both systems should be overhauled during the coming years.

⁶⁰ Tabak I., Mazur J. Współczesna rodzina a zdrowie psychiczne i zadowolenia z życia polskich nastolatków [Contemporary family in relation to mental health and life satisfaction of Polish adolescents] in: K. Okulicz-Kozaryn, K. Ostaszewski (ed) Promocja zdrowia psychicznego: badania i działania w Polsce [Mental health promotion: research and action in Poland]. IPN, Warszawa 2008, p. 101-117.

ROMANIA

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Introduction

1.1. Policy at a glance

Discussions of the child and adolescence mental health in Romania must be made in the framework of the significant changes that have occurred in the country over the last 19 years, since the Revolution of December '89. Today, many things have changed dramatically when compared with that moment, many changes are still in process and, unfortunately, there are still some aspects that need our efforts to change for the better. An equally important moment for Romania, from a child and adolescent mental health perspective, is joining the European Union in 2007.

In 2005, The Action Plan for Implementing The Mental Health Strategy of the Ministry of Health¹ proposed a significant change of the mental health services in Romania.

The evaluation of the situation of mental health services for children and adolescents in Romania showed, in concordance with the situation for adult mental health, the need for many essential changes. This evaluation revealed that the organisation of mental health services for children and adolescents has many and significant gaps.

The proposed objectives of The Action Plan for Implementing The Mental Health Strategy of the Ministry of Health were: Developing community services for mental health; Improvement of service quality in psychiatric institutions; Promotion of the rights of persons with mental health problems; Promotion of mental health and prevention of mental disorders; Intersectoral collaboration and communication with civil society; and, Coordinating the implementation of a mental health strategy.

1.2. Process to prepare the country story

This report was compiled with information from the following sources, institutions and persons:

- Policy-documents from Ministry of Public Health
- Policy-documents from Ministry of Education and Research
- Policy-documents from Labour and Social Protection Ministry
- Published research
- Centre for Medical Statistics of Ministry of Public Health
- "Carol Davila" University of Medicine and Pharmacy, Bucharest
- Domnica Petrovai and Eugen Hriscu from National Centre for Mental Health
- Bogdana Tudorache and Raluca Nica from Romanian Leagues for Mental Health
- Save the children Organisation
- UNICEF Romania

2. What we know about children and adolescents in our country and their mental health

2.1. Prevalence of mental disorders in children and adolescents in Romania

The most recent epidemiological study on the prevalence of mental disorders among children and young people in Romania was performed between 1981-1984. Unfortunately, the study results were only published in 1999. The study, performed by the Institute of Psychiatry and Neurology from Bucharest (which has since ceased to exist), was carried out with help from the Centre for Medical Statistics of the Ministry of Health and under the supervision of the Romanian Academy of Medical Sciences. Information was collected on prevalence rates of childhood mental disorders at the national level from

¹Phare programme RO 2003/005.551.0303 Twinning light RO03/IB/OT 09 TL

a nationally representative sample, composed of 15.360 subjects. The instrument used was a semi-structured interview based on DSM III and ICD 9 criteria. Since then only small local, academic studies have been performed.

The table below presents the prevalence rates for different childhood- and adolescent mental disorders according to that study:

Table 2.1 Prevalence rates for different child- and adolescent mental disorders

Disorder	Prevalence (%)	Age range	Data-collection
Anxiety disorders	0.05-1,62	0-16	1981-1984
Depression (moderate to severe diagnosis)	0.03-0.49 Dysthymia	0-16	1981-1984
Bipolar disorder (Manic-depressive)	0.05	0-16	1981-1984
Attention-Deficit/ Hyperactivity Disorder (ADHD)	0.31-4.91	0-16	1981-1984
Learning disorders	0.10-1.23	0-16	1981-1984
Conduct disorder (act out their feelings or impulses in destructive ways)	0.03-1.64	0-16	1981-1984
Eating disorders	AN 0.10	0-16	1981-1984
Autism and pervasive developmental disorders	0.03-0.05	0-16	1981-1984
Schizophrenia	0	0-16	1981-1984

Referrals to specialist mental health services:

The most common reasons for referral of children and adolescents to a specialist service in Romania are hyperactivity and concentration-problems, autism spectrum disorder problems, behavioural problems, depression and anxiety, learning problems. In the period 2004-2008, the greatest increase has been in referrals for hyperactivity and concentration-problems and autism spectrum disorder problems.

2.2. Vulnerable child population

The table below presents available data about the prevalence of specific vulnerable child populations in Romania.

Table 2.2. Prevalence of specific vulnerable child populations in Romania

Vulnerable child populations	% of child population (total number)	Age range	Reference period	Data-collection
Children living in poverty	29,9% 31,9% Roma ethnic group 80%	Under 15 15-24	May- June 2004	Bucuresti, Iasi, Timis, Botosani
Homeless children	70000 persons	around 11	2004	
Early school leavers	23,2% Roma ethnic group 17,3% No school attendance 11,6 Early leavers	18-24 7- 16	ICCV, 1998	
Children experiencing bullying ¹	3 from 5 82% urban 71%, rural		Dec 2005- dec 2006 Nov 2006	Bucharest UNICEF, Ministry of Education, Institute for Education Sciences
Youth unemployment	6,4%	15-24	2007	National Institute for Statistic (INS).
Children in care (living in any residential places other than families)	13553 1,60%	14-17		2003 2007
Asylum seeker children	Not collected			
Traveller children	Not collected			
Juvenile offenders (cautioned or prosecuted)	425 (living in detention centres)		2008	National Agency of Detention (ANP),
Children abandoned due to parental migration for employment	350.000 persons		2007	The Gallup Organization Romania, UNICEF Romanian Alternative Social Iasi
Other Vulnerable populations: Working on the street children Roma ethnic group children	70000	around 11	2004	INS

2.3. Positive child and adolescent mental health

Scientific research evaluating the prevalence rates for aspects of positive mental health; self-esteem and quality of life has not yet been carried out in Romania on an epidemiological scale.

3. Actions for promotion and prevention in mental health

3.1. Policies and programmes for CAMH

Specific policies and large-scale programmes for CAMH

The Action Plan for Implementing The Mental Health Strategy of Ministry of Health (2006-2015) has the following aims:

- Developing the community services for mental health (Developing community centres for mental health, Creating centres of psychiatric care, Developing multidisciplinary therapeutic teams, Developing functional liaisons with primary health care)
- Improvement of the service quality in psychiatric institutions (Modernisation of infrastructure, Developing therapeutic programmes, Efficient management of mental health services)
- Promotion of the rights of persons with mental health problems (Anti-stigma campaigns, updating the legal framework, improvement of conditions and safety measures in psychiatric hospitals, Helping in the development of clients' associations and users' groups)
- Promotion of mental health and prevention of mental disorder (Education of the public about mental health problems, Promoting mental health in schools, Promoting mental health in

the workplace, Violence prevention, Substance abuse prevention)

- Intersectoral collaboration and communication with civil society (Social inclusion of people with mental health problems, Partnerships with Non governmental organisations, up-to-date training programmes for professionals in mental health)
- Coordinating the implementation of the mental health strategy (Adequate funding of system of mental health services, Monitoring the reforming process of mental health services, International cooperation)

In order to implement this policy, the activity of the Ministry of Public Health started in 2006 with several legislative actions: the Parliament adopted the Norms for applications of the Mental Health Law (Law 487/2002), The National Centre for Mental Health was created and other actions were carried out (e.g., creating the speciality of psychiatric nursing).

The reform of the psychiatric care sector started with the creation of the first Centres for Mental Health (the total number planned by 2014 is 140).

In 2007, the budget of the Ministry of Public Health funded the development of specific services for treatment of autism spectrum disorder and ADHD as part of the National Programme of Mental Health – Sub programme of prophylaxis in psychiatric and psychosocial pathology.

The Government offers funds (awarded through competition) via several programmes, coordinated by different ministries: the Ministry of Public Health (AVIASAN), Ministry of Education and Research (CEEX, CNCISIS), Ministry of Labour and Social protection and Ministry of Finance for development of research and services in the field of children and adolescents' mental health.

Examples of large scale programmes

The National Programme "Education for Health into Romanian Schools" is a school-based national intervention initiative started in 2002 with the aim of developing health information for children and adolescents in schools. It offers general information about health and has only a limited part referring to sexual development, violence and substance use. The programme is financed by Ministry of Education and Research.

Several campaigns against violence on children have been run by national level NGOs ("Save the Children") and through an official initiative, during period 2002-2007.

Until now, it is not possible to report any national, government-funded programme in the field of violence, depression and anxiety, prevention of suicide and self-

harm/mutilation or prevention of mental disorders in children associated with parental mental health problems or parental alcohol and drug problems.

Other general policies related to CAMH

Poverty, social inclusion and social welfare

The overall objective of the Government's policy on children and adolescents⁴ is to give equal opportunities, services and developmental opportunities, independent of social background and geographical location.

The Government policy gives special funds to the children and families in poor financial situations to covering daily living, access to the health system and access to education.

Child care/protection

The institution responsible for child protection and the promotion of children's rights is the National Agency for protection of children rights, which follows the rules of Law 272/ 2004 on the protection and promotion of children's rights.

In the most recent period, the development of the National Agency for protection of children's rights can be evaluated in terms of the dimension and diversity of teams, the level of qualifications of personnel and number and quality of interventions. The principle of "best for the child" is always fundamental to its process of working and decisions.

Education and school programmes

Education Law⁵ states the right of everyone to attend school in concordance with his intellectual abilities. Primary and high school education is free of charge for all children. Children from very low income families with good academic results receive funding support for school attendance.

Day care legislation/policy for pre-school children

The social differences in access to the education system have been reduced by providing more day-care institutions (as well as introducing ten years of compulsory schooling for everyone and the right to upper secondary education). A shortage of day-care places, the families' financial situations and particularities of Romanian society (close relationships between the nuclear family and grandparents) are the principal reasons why some children do not attend a day-care institution. The rules of the Ministry of Education and Research⁶ require that children attend kindergarten in the preschool year.

Family friendly workplace policy

Romania has several arrangements intended to help parents combine work and taking care of children; paid parental leave (when the child is between 0-2), cash benefits for children younger than 2 if the parent is returning to work, subsidised day-care and kindergarten and the right to paid time off when the children are ill are

⁶Law 84/1995- Education Law

among these. The arrangements are gender neutral, and can be used by both parents. However, absence from work due to children is still very skewed, with mothers still taking the majority of parental-leave, more often working part-time and representing the majority of the cash benefit-receivers.

Adoption, fostering policies

The general adoption and fostering policy⁷ is that adoptive and foster parents and children shall have the same rights as biological parents and children.

Divorce and custody policies

Romanian policy relating to divorce and custody⁸ expresses two important principles related child support payment: 1) the child's need for provision is to be shared between parents according to economic ability and as fairly as possible, 2) the regulations shall encourage care from both parents.

Housing

Those with low incomes and some categories of persons with mental disabilities are housed by the local administrative authorities around the country.

Ombudsman for children and adolescents

At present in Romania there is no functioning Ombudsman for children and adolescents' rights. The institution which has this function is the "Child Advocate", part of "Peoples' Advocate". At each county level, children's rights are the responsibility of the Director General for Social Assistance and Child Protection.

4.2. Availability of programmes for CAMH promotion and mental disorder prevention

It is a difficult task to evaluate the availability of programmes for child and adolescents' mental health promotion and mental disorder prevention in Romania. Hence, this account must be considered an approximate measure.

Home-based programmes for promotion/prevention are not common as part of public health services in Romania, except for family doctors and nurses visiting families with newborn babies. Some NGO initiatives are offering support to families with children with disabilities or families with very limited incomes.

Parenting programmes. In 2007, the Ministry of Public Health funded the elaboration of 2 informative materials for parents of children with ADHD and Autism Spectrum Disorders. As part of the preparation of foster parents, The Child Protection services are offering parenting training. The majority of programmes for parenting around the country are carried out by NGOs (Save the Children, UNICEF Romania, etc). Again, it must be mentioned that

the particularities of Romanian society, are, to a certain extent, compensating for the lack of official parenting programmes through naturally-occurring "social, group parenting support".

School mental health promotion is done around the country by school counsellors and psychologists, but is not yet at the desired level.

School targeted preventive programmes directed at drugs, drinking, smoking, problematic behaviour etc. are widely available in Romanian schools, and supported by public money.

Promotion/prevention programmes at hospitals/clinics are not very commonly among the measures offered there.

Churches, clubs, and recreation centres are of limited availability for children and adolescents in Romania.

Promotion/prevention action via the internet is quite common, for example via the web pages of NGOs; promotion in collaboration with different mental health professionals and directed towards parents, teachers and, although occasionally, at adolescents and young persons.

Custodial settings (detention centres). According to the National Agency of Detention (ANP), in 2008, 425 persons under 18 were living in detention centres.

Programmes in community settings are very present in Romania.

Telephone counselling. Several help-lines either for children and adolescents or for parents have been established in recent years.

4. Organisation and resources for implementation

4.1. Implementation of programmes

The most important body developing policy, initiating and implementing programmes within the field of mental health promotion and prevention for children and adolescents is the National Centre for Mental Health.

The National Centre for Mental Health is a specialist director and an administrative body under the Ministry of Public Health. Its objective is to improve the whole population's mental health through comprehensive and targeted efforts across services, sectors and administrative levels.

⁷Law 273/2004 Adoption Law, Law 272/ 2004 about protection and promotion of child rights

4.1.1. Availability of services

The table below presents only an approximate indication of access to therapeutic services. Data on access to specific types of therapy is not available, to the best of our knowledge.

Table 3. Availability of services

Services	0%	1-25%	26-50%	51-75%	76-100%
Child psychiatrist appointments				x	
Psychologist appointments		x			
Social service appointments/ child protection			x		
Family therapy/ counselling		x			
Adolescent-specific services/outpatient centres		x			
Group therapy		x			
School counselling			x		
Pharmacological treatment					x
Psychological rehabilitation centres for adolescents		x			
In-patient beds on child psychiatric ward				x	
In-patient beds on general psychiatric ward				x	
Infant-specific services/early intervention		x			

Child psychiatrist and psychologist appointments. The availability of services related to children and adolescents' mental health care and treatment in Romania differs across urban and rural area, with a better representation in urban areas.

Social services (e.g. child protection) are available in the urban area.

Adolescent-specific services (outpatient) are presented in a very limited number; they are situated only in the big cities of the country.

School-counselling is well presented in the town schools and in many rural area.

Pharmacological treatment is widely accessible through child and adolescent psychiatrists and family doctors.

Psychological rehabilitation for adolescents is not available at the time of writing.

Access to specially designated mental health services

There is in general an absence in Romania of specially designated and tailored mental health services or promotion/preventive action for specific subgroups of children and adolescents.

4.3. Funding

Resource allocation to CAMH in general, as well as to specific areas of child and adolescents' mental health, has increased slightly in recent years as a consequence of the Action Plan for Implementing The Mental Health Strategy of Ministry of Health. In the 2007 national budget, funds specifically allocated to CAMH were around 100000 Euro.

The main source of funding for NGOs in the field is private contributions.

4.4. Training of the professional workforce

Training in child and adolescent psychiatry is recognised as an independent field from general psychiatry for medical doctors. This is not the case for psychologists. The total number of child or adolescent psychiatrists is 250.

The child and adolescent psychiatry training capacity within university hospitals has increased during recent years. At present, 8 centres offer postgraduate studies in child and adolescent psychiatry, and around 5 centres offer training in other specialities as part of multidisciplinary teams.

5. Monitoring and evaluation of action for promotion and prevention in mental health

At present, monitoring and evaluation of action for promotion and prevention in mental health does not occur in Romania.

6. Research and dissemination

6.1. Key research projects on CAMH

Many small research projects are going on within the field of CAMH in the universities, hospital departments, outpatient departments, schools, kindergarten. However, none of them can be cited in the category of key research project.

6.2. Main bodies involved in information dissemination to keep health care professionals informed

The main bodies involved in the dissemination of information about children's and adolescents' mental health care (services provision, but also promotion and prevention) to health care professionals are university departments of child and adolescent psychiatry and psychology, the Romanian Association for Child and Adolescent Mental Health, Scholar central department, the Romanian League for Mental Health, UNICEF and Save the Children organisation.

7. Challenges, opportunities and advances in the field

7.1. Key recent advances, barriers or issues in CAMH care, prevention and promotion

The key recent advances in care of children and adolescent's mental disorders are:

- A higher level of information for professionals and the general population on topics of mental health of children and adolescents
- The services are more accessible and more professionalized.

In this moment in Romania, there are many important issues that impede action on CAMH care. Some of them are:

- Lack of proper funding
- Lack of adequate level of training of the professionals

7.2. Youth involvement

In Romania, children and adolescents are not included in the process of policy decision-making/ programme planning, design and implementation/development of CAMH policies.

8. Summary and conclusions

In Romania, changes in the field of mental health started a short period of time ago.

A few things have started to change, slowly and with small changes. Many changes are still needed in the field of services for children and adolescents' mental health, such as more accessible and effective services, more professionals and better training in children and adolescent mental health. On the positive side, recent reforms have included promotion and prevention services in policy development at a sustained level, which means the future looks brighter for child and adolescent mental health if these changes come to fruition.



SLOVENIA

Prepared by Ana Petrovic

1. Introduction

Policy at a glance

Analysis of the mental health of children and adolescents in Slovenia indicates the need for special attention and additional prevention – promotion programmes. Care for mental health in the child and adolescent population is scattered between sectors, the integration is weak and there is also a lack of common vision or strategy. A national action plan in mental health for adults and children is currently in preparation. Until now this area has been covered by various policies, linked to the general health of adolescents (originating in health or related fields like social security, education etc.). In general there are many good programmes in the country, but they are not all connected or firmly integrated into the system. The key challenges that emerge are ensuring the integration of good practice and building a supportive policy framework for mental health of children and adolescents in Slovenia.

One of the most important national documents, focusing on the population of children and adolescents, is the Programme for Children and Adolescents 2006 – 2016 of the Ministry for Labour¹, Family and Social Affairs. Among other issues it contains directions for development in mental health and preventing the most frequent causes of death in children and adolescents. Priority goals are related to directing national preventive activities for mental health protection, including preventing suicide, ensuring possibilities for healthy psychosocial development, strengthening of mental health and reducing suicide rates among youngsters.

In June 2008 the Law on Mental Health² was accepted after long endeavours. With that, Slovenia got the first national document in the mental health field. On this basis the fundamentals for developing a national programme for mental health protection (in preparation until June 2009) have been set. The national action plan should harmonize the activities and actions at different levels and point out the common goals in the field of mental health in general and also specifically in the field of CAMH.

1.2 Process of preparing the country story

This report was compiled by Ana Petrovic, researcher at PINT, University of Primorska, with information from cooperation with following persons:

- Mojca Zvezdana Dernovsek; The Head of research group at the educational-research institute "Ozara" and employed at the Psychiatric Hospital Ljubljana
- Nusa Konec Juricic; Head of Department for Social Medicine and Health Promotion at the Regional Institute for Health Care Celje
- Nadja Cobal; Secretary of Ministry of Health (Mental health field), Ministry of Health; Sector for population risk groups
- Aco Prosnik; Former Director of the Counselling Centre for Children, Adolescents and Parents
- Dejan Kozel; Researcher at Countrywide Integrated Non-communicable Diseases Intervention – "CINDI"
- The Working group at The Institute of Public Health of the Republic of Slovenia (Health Promotion Department) which prepared the document³ about mental health in Slovenia, as a background for the national programme for mental health

The Country Profiles Questionnaire was distributed among people working in the field of CAMH. They were asked to complete the questionnaire and were invited to discuss it. The response rate was relatively small.

A smaller group of people gathered with the common interest of aligning opinions regarding the questionnaire and debating discrepancies, linked to that. Consensus on the answers on the questions was quite difficult to reach since the experts came from various fields and subfields. There was also a profound lack of essential information, data at the national level and absence of national programmes in this area. After the meeting there was additional missing data collection by communication and careful examination of additional material. This country story has been prepared on the basis of the

¹Programme For Children and Youth 2006-2016

²<http://www.uradni-list.si/1/objava.jsp?urlid=200877&stevilka=3448>

gathered answers, information from other resources and following discussions.

2. What we know about the children and adolescents in our country and their mental health

2.1 Prevalence of mental disorders in children and adolescents

HBSC study

Data from international HBSC study (2006)⁴ show that ¼ of Slovenian girls in the sample thought that they were overweight. Almost half of the youngsters in the sample experience symptoms of irritability, restlessness, insomnia, feeling down, headache, stomach-ache and back pain at least once a month. The fact that around 10% of adolescents experience such symptoms more than once a week is disturbing, as is the fact that girls report more symptoms than boys. Similarly and even more distressing are data gathered from research conducted by M. Tomori (1998)⁵ which show a state of clinical depression in 20% of boys and 40,5% of girls in Slovenian schools. 44% of high school adolescents have apparently considered suicide, 11% report a suicide attempt. The number of completed suicides in the age range from 15 to 20 years was 12, 09 per 100000 in 2006⁶.

Data from Institute of Public Health of the Republic of Slovenia

Analysis of the mental health of all age groups, conducted by Institute of Public Health of the Republic of Slovenia, includes also children and adolescents. It is based on the data documented in initial visits in primary and secondary level health care received for mental disorders as well as hospital examinations carried out due to mental problems. Despite the fact that this data basically points towards the most frequent causes of help-seeking for mental problems rather than representing accurate, prevalence data, it affords at least a partial insight into the situation regarding mental disorders among adolescents in Slovenia.

In the youngest age group (0 – 6 years) the most frequent causes of primary health care visits are Mental (psychological) development disorders (F80 – F89). Others are behavioural and emotional disorders that usually start in childhood (F98), tics (F95) and hyperkinetic disorders (F90). Analysing boys and girls separately we can see that behavioural disorders are among the 5 most frequent causes of visits to health

care institutions among boys, whereas girls often suffer from reactions to severe stress and adaptation disorders (F43). The most frequent disorders in general are found more often in the male population.

In the age group 7 – 14 years, some disorders from the younger age group are still among the most frequent causes of primary health visits. Other behavioural and emotional disorders that predominantly begin in childhood (F80 – F89), also Tics (F95) and Hyperkinetic disorders (F90) are found among boys. Among girls, again, there are mostly reactions to severe stress and adaptation disorders (F43).

For adolescents between 15 and 19 years of age the most frequent cause for visits, irrespective of sex, are mental and behavioural disorders due to alcohol drinking (F10). Depression (F32 + 33), anxiety disorders (F40+41) and reactions to severe stress and adaptation disorders (F43) also receive high ratings. The abovementioned are all more frequent among girls than boys. In the female population, eating disorders (F50) also rank among the top five reasons for visits; girls more frequently seek help for mental and behavioural disorders than boys.

In the youngest age group (0-6 years), among the most frequent causes for visits for secondary health care (in specialist clinics) are other behavioural and emotional disorders which usually start in childhood (F98), mental (psychological) development disorders (F89 – 98), mental retardation (F70-79), hyperkinetic disorders (F98) and emotional disorders that begin in childhood (F93). These are more common among boys than girls.

In the age group 7-14 the most frequent causes of visits are still developmental and behavioural disorders, as mentioned previously. Eating disorders (F50) are the first cause of visits among Slovenian girls in this age group.

In adolescence (15-19) treatment rates are higher in girls than in boys. Regardless of sex the most frequent causes of first visits to specialist clinics are reaction to severe stress and adaptation disorders (F43), depression (F32+33) and anxiety disorders (F40+41). Among girls we also find eating disorders (F50), whereas boys display schizophrenic, schizotypal and delusional disorders (F20-29).

In 2006, preschool children (0-6 years) of both sexes were most frequently hospitalized because of mental development disorders (F80-89), Other behavioural and emotional disorders that usually begin in childhood and adolescence (F98) and mental retardation (F70-79).

Listed as the cause of the highest hospitalization rate in school children (7-14 years) among boys and girls alike are mental and behavioural disorders due to alcohol drinking (F10) and other behavioural and emotional disorders that usually begin in childhood and adolescence (F98). Among boys there are also mixed behavioural and emotional disorders (F92), mental

³Jericek Klanscek, H., Zorko, M., Bajt, M., Roskar, S. (2009) Mental Health in Slovenia. Ljubljana: Institute for Public Health of the Republic of Slovenia

⁴http://www.ivz.si/javne_datoteke/datoteke/1461-HBSC_POROCILO_271107_zascitena.pdf

⁵Tomori, M., Stergar, E., Pinter, B., Rus-Makovec, M., Stikovič S. (1998) Risk factors in the population of Slovenian high-school students. Ljubljana: Littera picta

⁶<http://www.ciesin.org/IC/who/MortalityDatabase.html>

development disorders (F80-89) and hyperkinetic (F90); female population includes eating disorders (F50), somatophormic disorders (F45) and intentional self-harm (X60-84, Y 87.0).

In high school children the number one cause for hospitalization among boys is schizophrenic, schizotypal and delusional disorders (F20-29). Second place in both sexes are mental and behavioural disorders due to alcohol drinking (F10) and the third is intentional self-harm (X60-84, Y87.0). Among girls the first place goes to eating disorders (F50). Among five most frequent causes there are also mental and behavioural disorders due to use of other psychoactive substances (F11+12+14+15+16+18+19) and mixed behavioural and emotional disorders (F92) – in male population, whereas in female there are somatoformic disorders (F45) and depression (F32+33).

2.2 Vulnerable child population

The data on specific vulnerable child population on national level are limited to various fields, offices or are integrated into general population data (children, adults, old people etc.)

Lots of expansive research define the percentage of children experiencing bullying. According to the research of Pusnik⁷, which includes 1553 children of 3rd and 6th grade of primary school and 1st and 3rd grade of high school at least 21,5% of primary school children and 8% of high school children experienced bullying. The research of the Pedagogic faculty in Ljubljana⁸, including 1382 primary school pupils in Ljubljana, has shown that at least 45% of children report bullying, at least 20% experienced that more than once or twice, whereas approximately 5% experience bullying on a daily basis. The results of HBSC study in 2006 show us that at least 24,5% of adolescents reported being bullied at least once, 9,2% of that reported being bullied at least twice or thrice. There were statistically more boys (27,2%) than girls (21,8%). Statistical importance is also displayed in age differences: among 15 year olds there were less statistically important answers that indicated being bullied (15,9%) than among 11 year olds (28,9%) and 13 year olds (28,6%).

According to the data of the Employment Service of Slovenia⁹ there were supposedly 15,5% unemployed youngsters in category up to 26 years of age in December 2008. Children that live in poverty are defined only through the data on the families living in poverty.

Statistical data of the Ministry of Labour, Family and Social Affairs¹⁰ provide us numerous definitions of children living in foster homes. The number of such children is estimated at 1156 in December 2008.

In the year 2007 according to police data¹¹ 9 % of

youngsters aged between 14 and 17 were cautioned.

2.3 Positive child and adolescent mental health

Positive child and adolescent mental health was profoundly researched in Slovenia through the international study HBSC.

The majority of Slovenian adolescents in the sample estimate their health as good or excellent. However, the girls are more critical towards their own health since only 38,8% estimate it as excellent, whereas that percentage is much higher among boys (53,1%). With the years the estimation of one's own health decreases statistically significantly.

The absence or rarity of psychosomatic symptoms can also be an indicator of positive mental health. The estimates linked to the last 6 months before the research show that children and adolescents rarely or never experience irritability (40,2%), followed by nervousness (45,4%), insomnia (50,7%), feeling down (62,2%), stomach-ache (66,9%), pain in the back (70,2%) and dizziness (79,9%). The order of the symptoms that show at least once a week is different: in first place is nervousness, followed by insomnia, irritability, headache, feeling down, back pain, stomach-ache and dizziness. There are statistically important differences in all listed symptoms between sexes; the number of psychosomatic symptoms increases on a weekly basis – 11 year olds have much less of them than 15 year olds.

The results regarding satisfaction with life as an indicator of mental wellbeing or positive mental health show that Slovenian girls are less satisfied with their lives than Slovenian boys (84% in comparison to 88%). Satisfaction with life decreases with age in female population, the differences are statistically important. There are no statistically important differences in male population.

3. Actions for promotion and prevention of mental health

3.1 Policies and programmes for CAMH

Specific policies and large-scale programmes for CAMH

Mental health promotion and mental disorder prevention (in general and in the area of CAMH) in Slovenia still has not got its own national programme that would integrate and organize all policy areas around mental health issues.

The old National Programme for Public Health Prevention was operative until 2004, but did not specifically include

⁸Dekleva, B. (1996). Nasilje med vrstniki v šoli in v zvezi s šolo, V: Šelih, A. (Ur.). Otrokove pravice, šolska pravila in nasilje v šoli, Ljubljana: Inštitut za kriminologijo pri Pravni fakulteti, 113-181

⁹<http://www.ess.gov.si/eng/Introduction/Introduction.htm>

¹⁰<http://www.mddsz.gov.si/en/>

¹¹http://www.policija.si/portal_en/

mental health priorities and prevention and promotion actions. The new National Programme for Public health Prevention 2008-2013¹² includes among others also mental health priorities, especially in the field of mental health strengthening, suicide and drug use prevention/reduction.

Consistent with WHO directions, commitments to promotion and prevention are increasing in our public health policy. Commitment was clearly evidenced already with the establishment of the old National Programme for Public health prevention until 2004, and the allocation of significant funding to public health communication interventions for improving and increasing the health of the Slovenian population. Mental health did not receive any attention among those interventions, but the range of programmes related to mental health can be identified across different settings in our country.

When speaking about promotion and prevention in the mental health field there is a frequent link between the mental health of the adult population and CAMH. Children and adolescents also do not have their own ombudsman.

More specific direction regarding prevention in the CAMH field have up to now mainly been included in wider national programmes. For example, within the National Programme for Children and Adolescents 2006-2016 key fields of CAMH are defined.

As mentioned already, in 2008 we witnessed the acceptance of Law on Mental Health which presents the first document at the national level in the field of mental health. Currently there is a national programme of mental health protection in preparation, which should also define specific CAMH policies.

Due to a lack of appropriate statutory bases and also still strong stigmatization of mental health, mental health promotion / prevention is rather under-represented in Slovenia as a public issue. As a consequence there is a lack of appropriate general programmes, their dissemination to specific relevant fields, activities of certain NGO's or inclusion of MHP/MDP with programmes for health in general.

Prevention in the earliest stage of human life is inevitably linked to preventive general health. According to the Health Care Act and Health Insurance Act¹³ and the Health Services Act¹⁴, children and adolescents in Slovenia have the right to preventive health care such as systematic checkups. The right to preventive health care applies to all children and adolescents as family members of an insured person until the completion of their regular education period (students are also included).

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

- preventive well-child visits for preschool children at 1, 3, 6, 9, 12 and 18 months and 3 and 5 years; and
- preventive well-child visits for schoolchildren before school entry, in the first, third, fifth and seventh grade of elementary school and first and third grade of secondary school. All three-year-old toddlers also have a psychological examination and all five-year-olds are assessed by a speech and language therapist (and optionally by a psychologist). (Instructions for the implementation of preventive health protection at the primary level¹⁵).

If necessary the children are directed into further forms of appropriate treatments, however, a detailed, systematic follow up is not defined.

One of the newest and widely recognised projects is the "THAT IS ME" project –promoting health among youth. It was launched in 2000 as an example of primary prevention aimed at adolescents in Celje region in Slovenia. According to its first stage epidemiological study, the web site "That is me" (www.tosemjaz.net) has been developed. It has two main aims: firstly, to provide adolescents with information regarding their health and well-being in general and to influence their views and values about their health and well-being and secondly, to prevent risk behaviour and to help adolescents to solve their problems by getting advice from counsellors and peers. The website is intended for adolescents (primary target group), their parents, teachers, school psychologists and others working with adolescents. It is also intended for use in the teaching curriculum during class periods. A team of 30 experts is continuously available to answer adolescents' questions.

Other general policies related to CAMH

Poverty and social exclusion

The National Report on Strategies for Social Protection and Social Inclusion 2008¹⁶

This report was prepared within the framework of the new cycle of the European Union's open method of coordination (OMC). The report is based on two aspects or concepts, namely: the reporting aspect, aimed at presenting information about the situation in the area

⁸Dekleva, B. (1996). Nasilje med vrstniki v šoli in v zvezi s šolo, V: Šelih, A. (Ur.): Otrokove pravice, šolska pravila in nasilje v šoli, Ljubljana: Inštitut za kriminologijo pri Pravni fakulteti, 113-181

⁹<http://www.ess.gov.si/eng/Introduction/Introduction.htm>

¹⁰<http://www.mddsz.gov.si/en/>

¹¹http://www.policija.si/portal_en/

¹²<http://www.uradni-list.si/1/objava.jsp?urlid=200872&stevilka=3163>

¹³http://www2.gov.si/zak/zak_vel.nsf/zakposop/1992-01-0459?OpenDocument

¹⁴http://www2.gov.si/zak/zak_vel.nsf/zakposop/1992-01-0460?OpenDocument

¹⁵<http://www.uradni-list.si/1/objava.jsp?urlid=199819&stevilka=807>

¹⁶National Report on Strategies for Social Protection and Social Inclusion 2008–2010

of social protection; and the planning aspect, aimed at shaping development directions in particular areas.

The structure of the report complies with the agreement and common guidelines adopted by the Social Protection Council. The report consists of four chapters. The first chapter offers an overview and assessment of the social situation. The second, third and fourth chapters address the following subject areas: social inclusion, pensions, and health and long-term care; they also define the priorities for the 2008–2010 period, most of which are based on national and EU guidelines. Children (whose physical, mental/emotional and social development is threatened by poverty or social exclusion) are pointed out as one of the vulnerable groups of the population facing a higher degree of risk of social exclusion and/or poverty.

In the National Action Plan for Social Inclusion priority number 1 is to provide adequate income support to vulnerable groups in order to prevent social exclusion: for the child population that means child benefits, subsidies for kindergartens, subsidised school meals and scholarships. Priority number 2 is to realise the potential of an inclusive labour market in the fight against poverty and social exclusion by way of better integration of vulnerable groups (including youth) into the labour market and the priority number 3 is to provide access to social services of general significance in order to prevent social exclusion.

In the part focused on health, health and long term care in general is defined (area of children and adolescents: Preventive examinations of newborns, pre-school and school children, youth and students, participation of health care users, promotion and preventive of health in general...).

*Social Security Act (Act Nr. 54/1992) and Resolution on national programme of social security for the period from 2006 to 2010 (ReNPSV06-10) which became operational in 31 of March 2006.*¹⁷

This act defines activities of social assistance in general - they shall include preventing and solving social problems of individual persons, families and population groups. It includes policies in the areas of social security services; choice of a family attendant; financial social assistance; implementation of social welfare activities: public social welfare institutions, other public social welfare institutions, common provisions, charity organisations, self-care organisations and disability organisations, private work, communities of social welfare institutions, workers performing social welfare; social chamber; social welfare services provided outside of social welfare activities; procedures; financing; supervision; data bases; penal provisions and transitional and final provisions.

Social welfare

Act Concerning Social Care of Mentally and Physically Handicapped Persons (Act Nr. 41/1983)¹⁸

With this act the forms of social care for moderately and severely mentally handicapped and severely physically handicapped persons who can not be trained for autonomous life and work are defined. The handicap must have begun before the age of 18 or in the process of education but not longer than until the age of 26. The forms of social care are following:

1. social care in general or special social institutions
 2. social care in another family
 3. financial payment for handicap
 4. financial payment for other peoples' care and help.
- The rights of handicapped children and adolescents are included in rights of adult population.

*Action Programme for persons with disabilities 2007-2013*¹⁹

General principles and obligations of the Action Programme for Persons with Disabilities 2007-2013 based on international and national acts may be summarised up as follows:

- respect for difference and acceptance of disability as part of human diversity and assurance of equal opportunities: the principle ensures positive measures for ensuring equal opportunities in all areas necessary for enjoying full citizenship;
- non-discrimination: the principle of non-discrimination shall ensure that persons with disabilities are not treated as different, excluded or restricted in enjoying the rights that are guaranteed to all other members of the community;
- on the level of society, ensure full and effective participation and inclusion in society: persons with disabilities shall have the same opportunities as other citizens for effective participation in the development of the community they live in on the local, regional and state levels and to take responsibilities for its development;
- at the level of an individual ensure respect for human rights - dignity and autonomy of persons including freedom of their own choice and independence;
- individualized approach to the provision and performance of services and programmes intended for persons with disabilities, and
- accessibility as a prerequisite for exercising rights and social inclusion.

Social Security Act (Act Nr. 54/1992)
See above.

¹⁶Social Security Act (official consolidated text) (ZSV-UPB2)

¹⁷http://www.mddsz.gov.si/fileadmin/mddsz.gov.si/pageuploads/dokumenti__pdf/zdvtp.pdf

¹⁹Action Programme for persons with disabilities 2007-2013

National programme for children and adolescents 2006-2016

Objectives of the social policy of this programme are:

1. To achieve better efficiency in supporting and helping children and their families.
2. To ensure quality life and development for children within the framework of the primary social network.
3. To reduce poverty and social exclusion of children and families in which such children live; to create and ensure that effective measures are taken to find a suitable solution.
4. To ensure sufficient welfare benefits that will in the future be aimed at the most vulnerable groups of children.
5. To ensure measures for reducing the drop-out in secondary schools and to increase the number of available positions in all education programmes; to improve the inclusion of unemployed youth in vocational and education programmes.

Health Care and Health Insurance Act (Act Nr. 9/1992)

This is an act about the system of health care and health insurance; it defines the providers of societal care for health and their actions, health care in relation to work and the work environment, relationships between health insurance and health institutions and enforcement of rights from health insurance.

Health care by this act consists of a system of societal, group and individual activities, actions and services for health strengthening, disease prevention, early detection, timely treatment, care and rehabilitation of sick and injured people. Beside that health care includes the rights to health insurance, which ensure social security in the cases of disease, injury, childbirth or death.

*Child protection**Marriages and family relations act (Act Nr. 69/2004)²⁰*

By that law marriages, relations between parents and children and other relatives, adoptions, foster placement and protection of juvenile children and other people who are incapable of self-care, are determined. Parents have the right and duty to enable successful physical and mental development of their children with their direct care, their work and activities. Because of healthy growth, harmonious personal development and enabling for independent life the parents have the right and duty to take care of life, personal development, rights and benefits of their juvenile children. Bodies that influence or execute that law: Courts of Justice in cooperation with centres for social work with physical and legal entities, which include institutions, concessionaires in the field of social security, schooling, health, local communities, enterprises, organizations, establishments, judicial and other state bodies, police, other expert services and humanitarian aid or other non-state organizations.

Programme for Children and Youth 2006-2016

In this programme child and adolescent protection is defined in different areas of life: health, family, education, social and special social care, protection from neglect violence and abuse, and illegal drugs abuse. Free time activities policy, urban planning and culture policy are also included.

Act on prevention of use of illegal drugs and treatment of illegal drug users (Act Nr. 98/1999) and National Programme in the Field of Drugs 2004-2009²¹

This act determines steps for prevention of use of illegal drugs and treatment of users of illegal drugs. Steps paragraph including informative, health, educational and consulting activities, treatment, social-security services and programmes for solving social problematics, connected to the use of illegal drugs and observing the use of illegal drugs, are executed by competent ministries. In order to realise the tasks from the previous paragraph the National Assembly of the Republic of Slovenia accepted the national programme on prevention and decreasing the use of illegal drugs as proposed by the Slovenian Government which determines the strategy for prevention, treatment and solving social problems linked to the use of illegal drugs.

Steps in the field of health and social security include programmes of health and social security services, especially prevention services, treatments and programmes on solving social problems, linked to the use of illegal drugs. Executors: Social security centres, centres for treatment of addictions, various other non-state organizations, competent ministries... and others)

Family violence Prevention Act (Act Nr. 16/2008)²²

This Act defines the notion of violence in families, the role and tasks of state authorities, holders of public authority, public service contractors, authorities of self-governing local communities (hereinafter: authorities and organisations), as well as nongovernmental organisations taking part in consideration of family violence, and determines the actions for protecting the victims of family violence. To prevent violence in families and to protect as well as provide aid to victims there are other actions that shall be taken as defined by other acts and regulations besides the actions, which are defined by this Act.

Special protection and care is provided for children. The child is defined as victim of violence, even if they are only present when violence is exerted against other family members, or if they live in an environment where violence is exerted.

As proposed by the government the National Assembly also accepted National programme for family violence prevention for a 5 year period.

Resolution on the grounds for the formation of family policy²³

²⁰Zakon o zakonski zvezi in družinskih razmerjih (Uradni list RS, št. 69/2004)

²¹http://zakonodaja.gov.si/rpsi/r05/predpis_ZAKO1375.html <http://www.uradzadroge.gov.si/zakoni/ReNPPD.pdf>

²²Family violence Prevention Act

On the basis of this resolution, grounds for the formation of family policy are defined and child protection is formulated through the frame of family and its protective role. Namely, one of the principles of family policy is the protection of children rights in the family and society and prioritising quality of life of children.

Education and school programmes

Elementary School Act (Act Nr. 12/1996)²⁴

This act is a collection of rules in education, forms of education and conditions in educational process. The rights of school children and their duties in general are defined.

Resolution on the grounds for the formation of family policy

See above

Actions for realisation of family policy in the frame of the school system:

- introduction of greater choice of educational programmes that will allow development of the potential of every child and will provide different educational possibilities in relation to child needs,
- development of possibilities for fast child development and provision of alternative educational possibilities and additional education,
- development of different forms of help for children with intellectual or psychosocial problems,
- provision of equal school accessibility,
- organisation and partial financing of school meals,
- organisation of after school care for children,
- care for further education of children,
- development of different educational programmes related to humanisation of relationships, gender equality

Programme for Children and Youth 2006-2016

See above.

Objectives in the field of educational policies in this programme are:

1. To ensure equal possibilities for education and improve accessibility.
2. To ensure quality upbringing and education (stressing quality education in tolerance, reduction of inequalities in the society and respect for diversity and human rights).
3. To implement lifelong learning on all levels of education.

Day care legislation/policy for pre-school children

*Kindergarten Act (Act Nr. 12/1996)*²⁵

Formulates rules, principles, organisation and financing of day care in kindergartens. The main task of kindergartens is defined as helping parents in integrated care for children, improving quality of life of families and children and creation of the conditions for child physical and mental development.

Resolution on the grounds for the formation of family policy

In the Resolution the relationship between family and society in the field of day care is defined – family is mainly responsible for education and care of pre-school children and society provides conditions for coordination between family and professional obligations of parents and gives possibility of socialisation outside the family and develops kindergartens and other forms of education and care. Further activities in this field should be focused on the development of specific programmes and services for children with special needs, development of counselling and educational programmes for parents and children, financing of different forms of pre-school care...

Family friendly workplace policies

Project for Certificate Family friendly workplace²⁶

The goals of the project for certificate "Family Friendly Enterprise" can be summarized into following:

to sensitize businesses about negative business impact of discriminating against (potential) parents in the workplace as well as in the labour market,
to provide businesses with tools for implementation of HR policies that enable better balancing of work and family for their employees,
to publicly recognize those business with a positive attitude to providing options of balancing work and family of their employees

Adoption fostering policies

Provision of foster care Act (Act Nr. 110/2002)²⁷

This Act governs the conditions to be fulfilled by a person who wishes to provide foster care, procedures for obtaining a licence to provide foster care, the manner of providing foster care and its funding, as well as other issues related to the provision of foster care.

Marriages and family relations act (Act Nr. 69/2004)

See above.

Among other directions, this act also governs specific conditions in cases of adoption and fostering.

²⁴<http://www.uradni-list.si/1/objava.jsp?urlid=199612&stevilka=570>

²⁵<http://www.uradni-list.si/1/objava.jsp?urlid=199612&stevilka=569>

²⁶<http://www.certifikatdpp.si/english/>

²⁷Provision of foster care Act

Divorce and custody policies

Marriages and family relations act (Act Nr. 69/2004)

See above.

Conditions needed for divorce and conditions and directions for custody of children (in their best interest) are specified in this act.

Urbanisation policies

Urban Planning Act (Act Nr. 110/2002)²⁸

This act defined planning and actions for the implementation of urban projects. The need to consider the community, environment and peoples' needs is emphasised.

Housing

*Housing Act (Act Nr. 69/2003)*²⁹

This act defines types of housing construction, conditions for housing maintenance, conditions for planning apartments, property-law relationships and management in multi-apartment buildings, rent-related issues, building and sale of new apartments, help for getting and using an apartment, powers and obligations of the country in the field of housing, powers and obligations of municipalities in the field of housing, obligations of other organisations that are active in the field of housing, and registers.

Resolution on the grounds of the formation of family policy

This resolution defines some aims in the field of housing:

- financial support to young families, families with many children and economically disadvantaged families through provision of housing
- suitable housing areas for families with children and economically disadvantaged family members,
- suitable housing conditions for handicapped persons,
- promoting the work of non-profit housing organisations,
- provision of a network of services for helping families.

The National Report on Strategies for Social Protection and Social Inclusion 2008

The Act Amending the Act on the National Housing Savings Scheme and Subsidies to Address the Problems of Young Families Obtaining Their First Home adopted in July 2007 should be mentioned with respect to accommodation. The act upgrades the existing solutions in housing schemes, especially concerning affordability of housing, which has a significant impact on social

status. The main goal of the proposed amendments was to provide subsidies to the broadest possible group of young families.

Anti discrimination

*Constitution of the Republic of Slovenia: Human Rights and Fundamental Freedoms – in general, especially Article 56 (Rights of Children)*³⁰

By the Constitution children shall enjoy special protection and care. Children shall enjoy human rights and fundamental freedoms consistent with their age and maturity. Children shall be guaranteed special protection from economic, social, physical, mental or other exploitation and abuse. Such protection shall be regulated by law. Children and minors who are not cared for by their parents, who have no parents or who are without proper family care shall enjoy the special protection of the state. Their position shall be regulated by law.

The National Report on Strategies for Social Protection and Social Inclusion 2008

Gives a broad perspective about the fight against discrimination (in general, gender related) and integration of migrants in our society.

Action Programme for persons with disabilities 2007-2013
Objectives of this action programme include antidiscrimination goals:

- Raising awareness about persons with disabilities regarding their contribution to the development of society, and to foster respect for their rights, dignity and needs.
- All persons with disabilities have the right to decide, on an equal basis with others and without discrimination, where they wish to live and have the right to fully participate in community living.
- Ensuring an inclusive education system at all levels and life long learning without discrimination and on equal basis.
- Ensuring persons with disabilities access to work and employment without discrimination in a work environment that is open, inclusive and accessible.
- Ensuring persons with disabilities an adequate standard of living, financial assistance and social security.
- Ensuring equal health care, inclusion in culture activities, sport, prevention of violence and discrimination against persons with disabilities.

Programme for Children and Youth 2006-2016

In its general goals this programme touches antidiscrimination: All children are born free and equal

²⁸<http://www.uradni-list.si/1/objava.jsp?urlid=2002110&stevilka=5386>

²⁹<http://www.uradni-list.si/1/objava.jsp?urlid=200369&stevilka=3312>

³⁰<http://www.varuh-rs.si/index.php?id=113&L=6#c874>

regarding their dignity and rights. Every child is entitled to all rights and freedoms, as stated in the Universal Declaration on Human Rights and the Convention on the Rights of the Child as well as to equal opportunities, regardless of race, colour, sex, language, national, social or economic background, birth or other individual circumstances. Slovenia will place special care on children with special needs (physically and mentally disabled), children in difficult social conditions, children with behaviour problems, children of the Roma community, children in single-parent families and children without caregivers.

3.2 Availability of programmes for CAMH promotion and mental disorder prevention

Availability of CAMH prevention and promotion programmes is quite difficult to define, since we do not have detailed national level data. Programmes are also not integrated within the frame of the same policies. Below are only approximate estimations of the availability of CAMH programmes.

Parenting programmes for the general population are quite widely accessible. Free health education is provided for future parents in health care centres and maternity hospitals. Education for healthy parenting represents one of the basic elements of health education. Childbirth classes are aimed at all pregnant women and future fathers or companions of pregnant women. Health education covers:

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

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

Accessibility of school mental health promotion increased in the last few years, but the choice is still dependant on school policies, activities and awareness of school workers and variety of providers (eg. NGOs). One programme of the Institute of Public Health of the Republic of Slovenia is promotion of mental health in schools³¹.

The programmes priorities are still linked to health promotion in general. The Slovenian Network of Health Promoting Schools³² (SNHPS) has existed since 1993, when it was launched in 12 institutions. By 1998, the network had extended to 130 schools out of approximately 600. In 2008 the gradual inclusion of other schools started. It is coordinated by the regional institutes of public health.

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

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

School targeted preventive programmes focused on bullying or violence and drug and alcohol abuse prevention are also increasing, mostly because of alarming data on violence in schools. These programmes are also promoting awareness through the media of critical events of violence and high levels of alcohol and drugs abuse among adolescents. In the field of drugs and related violence there is a quite active Society - autonomous preventive programme for the prevention and decrease of drug use and related violence in Slovenian schools³³. Violence is also the subject of government programmes like the Programme for school violence prevention, Institute of Education (Pusnik, 2003) as well as the NGO Society for Non-violent Communication³⁴.

In churches, clubs, recreation centres, protective services, custodial settings and community settings programmes for promotion and prevention are accessible but availability varies according to the specifics of the organisation and also the local community.

The most available programmes are promotion programmes on the internet (51-75%) and telephone consultation services (76-100%). The most used among internet programmes is "That is Me"³⁵, telephone consulting is quite diverse – from general lines like TOM – Children and Youth Telephone³⁶, to more focused ones like the line for eating disorders³⁷.

³¹<http://www.ivz.si/index.php?akcija=novica&n=558>

³²<http://www.ivz.si/index.php?akcija=novica&n=558>

³³<http://www.projektclovek.si>

³⁴<http://www.drustvo-dnk.si/>

³⁵www.tosemjaz.net

³⁶http://en.zpms.si/index.php?menu_item=item_1638

³⁷<http://www.svetovalnica-pu.org/>

4. Organisation and resources for implementation

4.1 Institutions and organisations

Active organisations at the governmental level are:

- The Ministry of Health
- Council for Mental Health of the Government of Republic of Slovenia (acts as an advisory body, consists of 28 members including representatives from non-governmental organizations, users and carers)

Other active organisations and institutions:

- The Institute of Public Health of the Republic of Slovenia - Department of Health Promotion
- Regional Institutes for Public Health Prevention - In particular the Regional Institute for Public Health Prevention in the region Celje and the project "That is me"
- Institution of Psychiatry
- NGOs
- Associations for volunteers
- Groups with a specific focus (e.g., violence, drugs)

4.2 Services

Services at the Primary level include:

- Clinics of general and family medicine
- Clinics for health security of children and adolescents
- Mental health clinics (rarely)
- Centres for prevention and treatment of drug addiction.

Services at the Secondary level:

- Specialist, psychiatric, psychotherapeutic and psychological clinics for children and adolescents
- Psychiatric hospitals and psychiatric clinics Ljubljana (Department for Children and Adolescents³⁸)
- The Counselling Centre for Children, Adolescents and Parents in Ljubljana and Maribor (state institution with focus in child and adolescent mental health; helping children, adolescents and parents in cases of learning problems,

emotional, behavioural, psychosocial and psychiatric disorders and difficulties)³⁹

Availability:

Services	Estimated availability
Child psychiatric appointments	26-50%
Psychologist appointments	26-50%
Social service appointments for children (e.g. child protection)	26-50%
Family therapy/counselling appointments	26-50%
Infant-specific services (e.g. early intervention services)	1-25%
Adolescent-specific services (e.g. outpatient centres)	1-25%
Group therapy	1-25%
School counselling	26-50%
Pharmacological treatment	51-75%
Psychosocial rehabilitation centres for adolescents	1-25%
In-patient beds on general psychiatric ward	0%
In-patient beds on child psychiatric ward	1-25%

* Available: statistical data on out-patient specialist consultations in general and for children and adults together

There is no specific data about the subgroups of children and adolescents that would have access to specially designated mental health services or promotion / preventive action, tailored to the subgroup's unique needs.

However, it is important to point out the programmes for school drop-outs. Several national and regional programmes and services are provided for school drop-outs in a variety of settings.

The National and Regional Employment Service offers occupational counselling for young people who discontinue compulsory education and are aged between 15 and 19 years. There are also information and occupational counselling centres offering individual counselling in three Slovenian cities. An especially successful project of the employment services and information and occupational counselling centres was "Counselling and social skills and knowledge for reinclusion in education"; while workshop based, a part of the project also involved street work with adolescents. In addition, there are other programmes in Slovenia that address social inequalities with interdisciplinary actions. These include the "Production school" and "Learning for young adults" projects⁴⁰. They target social skills training of school dropouts to increase their capacities for social inclusion.

³⁸<http://www.psih-klinika.si/index.php?id=121>

³⁹www.scoms-lj.si

⁴⁰<http://www.ess.gov.si/slo/Dejavnost/KnjigelnZlozenke/Zlozenke/ESSPUM.htm>

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

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

4.3 Funding

In the past 5 years there has been no or little change in resource allocation to child and adolescent mental health in general. Small increases in resources were detected in the field of evidence-based and community-oriented / family-focused services and evidence-based MH promotion activities. In the treatment and care in residential institutions a small decrease in resources was evidenced.

The funds dedicated to child and adolescent mental health are not clearly identifiable in the most recent national budget. They are clearly identifiable in the budgets of non-governmental institutions. The main donors of funds to NGOs are State budgets and regional/ municipal budgets.

4.4 Training of the professional workforce

In our country training in child mental health / psychiatry is a recognised independent field from general mental health / psychiatry. The number of child or adolescent psychologists is 15, with 9 in private practice. The number of child or adolescent psychiatrists is also 15, with 2 in private practice.

Higher education specifically in child and adolescent mental health promotion and / or mental disorder prevention is not available in any of the institutions of higher education.

Certain experts are educated in CAMH within various different subjects. Psychologists acquire CAMH knowledge from developmental and clinical psychology, psychopathology etc. Doctors during graduate studying acquire knowledge in the field of psychiatry which includes CAMH. Paediatricians acquire that title with specialist training which includes education in this area. Mental health of adolescents is also one of the fields in the psychiatry specialisation. As for other, non-health related professions, education on CAMH is available mostly for social workers and special educators.

5. Monitoring and evaluation of actions for the mental health promotion and mental disorder prevention

There are no policies for children and adolescents evaluated and reported in the areas of mental health service and care policies, mental health promotion policies and mental disorder prevention. Evaluation can be seen only with some projects, primarily at the local level. They use a broad range of tools to collect qualitative and quantitative data, primarily self-completion questionnaires pre- and post- group work, counselling and befriending initiatives.

6. Research and dissemination

Child and adolescent mental health and psychiatric disorders:

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

Findings according to gender revealed:

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

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

The main findings of the “Risk factors among Slovenian high-school children” study relating to mental health were consistent with some of the findings from the HBSC survey.

The HBSC survey is a WHO collaborative cross-national study. It presents the key findings on patterns of health among young people aged 11, 13 and 15 years in 41 countries and regions across the WHO European Region

and North America in 2005/2006. Its theme is health inequalities: quantifying the gender, age, geographic and socioeconomic dimensions of health differentials. Its aim is to highlight where these inequalities exist, to inform and influence policy and practice and to help improve health for all young people.

In Slovenia, the HBSC research was conducted in the spring of 2006 for the second time. It included 5130 children aged 11, 13 and 15.

The main results from Slovenian HBSC study were presented in previous chapters of this report.

Prevention of mental disorders and promotion of mental health:

The project "That is me" was launched in 2000 as an example of primary prevention aimed at adolescents in the Celje region in Slovenia. In the first phase of the project an epidemiological study was conducted among 1000 adolescents aged between 13 and 17 years. Results showed that adolescents' biggest problems are lack of self-confidence and optimism, no self-esteem, fear of failure and the feeling that life is meaningless. In relation to communication channels the research showed that 90 % of adolescents in the Celje region preferred using the internet as a communication tool to learn and to discuss the mentioned problems. Accordingly, the web site "That is me" has been developed – to provide adolescents with information regarding their health and well-being in general and consequently to influence their views, values about their health and well-being in general and to prevent risk behaviour and to help adolescents solve their problems by getting advice from counsellors and peers.⁴¹

Main bodies involved in information dissemination to keep health care professionals informed

Information sharing on CAMH is quite scattered, divided predominantly between the Institute of Public Health of the Republic of Slovenia, Regional Institutes for Public Health Prevention, Institution of Psychiatry – University Clinic and Ministry of Health.

7. Challenges, opportunities and advances in the field

7.1 Key recent advances

There are no recent apparent changes in mental health care. Worth mentioning is the establishment of the Department for Eating Disorders in Ljubljana, expansion of activities of the consulting centres for children, adolescents and parents and also establishment of "That is me" web portal which also has a consulting function. "That is me" represents the biggest achievement in mental

health promotion and mental disorder prevention. Programmes that stand out are also the programmes of Institute of Public health and related programmes linked to health promotion in general (healthy schools), prevention of alcohol and drug abuse in adolescents, programmes related to violent behaviour.

In recent years there have been many activities of various NGO's, but they lack common coordination and vision.

Future advances in this field are in forming activities, based on the accepted Law for Children and Adolescents 2006 – 2016 (chapter on directions on mental health of adolescents), stronger representations of mental health in promotion programmes and the acceptance of National Programme for Mental Health Protection.

7.2 Youth involvement

In Slovenia young people are predominantly not included in the process of policy decision-making / programme planning, design and implementation / development of CAMH policies (with the exception of a few programmes / projects). One of the indirect forms of expressing opinions on current topics is the Children's Parliament⁴². These are held on class, school, community and national level. The topics are different each year and are chosen by children themselves. Some topics include mental health issues. This project has been going on for ten years and is becoming an essential part of communication among students, teachers and representatives of the state.

Youth should be included in choosing target fields for CAMH activity programmes since it is a way to discover their needs. An important step forward will also be the creation of a special ombudsman for children.

7.3 Difficulties and proposals for further development

Difficulties:

- CAMH, and mental health in general has still got low priority in Slovenia, mental disorders are still stigmatized
- We do not have a reviewed influence of public policies on mental health and vice versa
- A national programme on mental health is still in preparation.
- There is too little interdisciplinary cooperation.
- Research in this field is not developed enough – there is a lack of epidemiological studies and research on socio-economic factors.
- Funds for mental health protection are insufficient.
- There is also an inadequate information system for registration and observation of mental disorders.
- Coordination of psychosocial programmes of various non-governmental organisations is unsatisfactory, we also do not have a register of

⁴¹Research about preventive/ promotional programme »That is me«: Erzen, I., Lekic, K., Konec Juricic, N. (2006). Celje: Social security institute

⁴²http://en.zpms.si/index.php?menu_item=item_1826

non-governmental organisations and there is no appropriate programme evaluation.

- There is insufficient cooperation between governmental and non-governmental organisations and associations in this field.
- Health care workers in primary care do not have sufficient knowledge and competencies in psychiatry and the mental health protection field; because of this there is less probability of recognising mental disorders and greater risk of wrong diagnoses.
- Health care worker education is not fully in accordance with the needs of current CAMH protection, principles of prevention and improvement of CAMH.
- There is a need for interdisciplinary and multidisciplinary teams, fully trained for an integrated approach.

Proposals for further development:

We need to:

- develop programmes, interventions and forms of help which will be included in the educational system from kindergarten to university and encourage the inclusion of education in social and emotional competencies in activities within and outside of the curricula in kindergartens, schools and universities.
- implement programmes for prevention of abuse, bullying, violence among youth and social exclusion. Special care and education programmes need to be focused on parents and parents-to-be.
- encourage education on CAMH for experts in the field of health, education, youth work and other relevant sectors.
- form teams of experts for children and adolescents and also increase the preventive and therapeutic potential of primary health care.

8. Summary and conclusions

Children in Slovenia are recognised as vulnerable group, but CAMH, and mental health in general, have are still given relatively low priority and mental disorders are stigmatised.

The area of mental health and well-being is complex and wide. That is why it is difficult to define which sectors are responsible for establishing the conditions and circumstances that affect mental well-being. The question of accountability for this area is only one of the difficulties and obstacles for financing, re-establishing and implementing existing interventions, as well as new ones. Beside the problem of financing, there is a lack of studies on effectiveness for these kind of interventions and a lack of general studies in the field of CAMH on the national level. There are many good programmes and interventions but they are scattered between different sectors and not firmly integrated into the system. Coordination of psychosocial programmes of various non-governmental organisations is unsatisfactory; there is insufficient cooperation between governmental and non-governmental organisations and associations in this field. A more holistic approach and common vision is needed.

However, it seems that public and political awareness about CAMH issues is improving. Slovenia is trying to establish effective CAMH prevention and promotion with integration of the themes of a multidisciplinary approach, some high-risk group preventive programmes and active parental involvement. Still, there are many remaining challenges in this field.

CAMH related issues are now more included in different policies, for example in the Programme for Children and Youth 2006-2016 and in the National Programme for Public Health Prevention 2008-2013. The National Programme of Mental Health is in the process of preparation and will become operative this year. Hopefully, it will integrate and systemize activities and actions at different levels and point out common directions in the field of child and adolescent mental health.

SPAIN, CATALONIA

Prepared by Vanesa Carral, Andrea Gabilondo and Joan Colom

1. Introduction

Policy at a glance

Catalonia is one of the 17 autonomous communities of Spain. At the end of 2007 the total population was of 7.2 million inhabitants, from a total of 46.1 million Spaniards. The population profile of Catalonia in 2005 shows an ageing population. In the last years, however, the birth rate in Catalonia has seen renewed growth as in Spain in general, largely associated with migration.^{1,2} In 2007 children and adolescents of 18 years or less represented 17.11% of the Catalan population (1 234 096).³

The Catalan health system exhibits important differences with respect to the other autonomous communities and cannot be extrapolated to the rest of Spain. In the year 1986 the integration of psychiatric assistance into the National Health System, which had evolved differently in the various autonomous communities, was established with the approval of the General Law of Health 14/86 of the 25th April. From the mentioned law, in 1989, across the Departments of Health and Social Security, the Government of Catalonia pioneered the development of a network of care specifically for children and adolescents with mental health problems⁴. In 1992 the first mental health services specific to children and adolescents were created (child and adolescent mental health centres (CSMIJ - Centres de Salut Mental Infantil i Juvenil), hospital child psychiatry reference unit (URPI - Unitat de Referència Psiquiàtrica Infantil), adolescent crisis unit (UCA - Unitat de Crisi d'Adolescent) and outpatient clinics / day hospitals). Currently, more than 30 000 children and adolescents receive treatment every year in the child and adolescent mental health centres (CSMIJ). Before the creation of this assistance network there were teams that attended to children in some of the general hospitals and in services promoted by local non-profit organisations subsidised by town councils, which were the embryo of the public network that was constituted later on.

In December of 2007 the Plan for Mental Health and

Addictions (PDSMiAd) was published, and it joined for the first time the goals of the worktreball in the mental health and drug addictions fields. Included among the 12 main goals until the year 2010 of the PDSMiAd, is mental health promotion for all the population. In the 2007 health budget, the allocation of funds for mental disorders is the second largest, at 773171 euros (10.8% of the total).⁵

Process to prepare the country story⁶

The work to develop the country profile was coordinated by **Vanesa Carral, Andrea Gabilondo** and **Joan Colom**, from the "Department of Health - Program on Substance Abuse, Government of Catalonia". A wide consultation process was established among different experts and organisations who provided information for the creation of this report, and feedback to the report:

- Anna Maria Montes i Vallecillos, Head of "Infància Respón" and "Somnia - Servei d'Orientació i Mediació de la Infància i l'Adolescència" services, NGO.
- Blanca Prats Viedma, Program of Mother-Child Health, Department of Health - General Department of Public Health, Government of Catalonia.
- Diego José Palao Vidal, Parc Taulí - Health Corporation, Sabadell, Chief of Mental health care.
- Esther Jordá, General Direction of Planning and Evaluation- Department of Health. Government of Catalonia.
- Francisco Villegas, Catalan Association of Mental Health Professionals – AEN, NGO.
- Jordi Samsó, Criminal execution and juvenile justice, Department of Justice, Government of Catalonia.
- Jorge Tió Rodríguez, Sant Pere Claver - Hospital Foundation, Barcelona. Program coordinator - "Atenció al Menor" programme.

¹In Barcelona, in 2001 2.2% of children and adolescents up to 19 years of age were immigrants, while this proportion was 13,9% in 2005.

http://www.ciimu.org/uploads/20080904/Barcelona_Programa_Municipal_para_la_infancia_2007_2010.pdf

²Of the total of births in 2004, 21% had at least one foreign parent and this percentage has continued growing in the last years: <http://www.gencat.cat/salut/depsalut/pdf/mapa07anal.pdf>

³<http://www.idescat.cat/territ/BasicTerr?TC=8&V3=669&V4=1180&ALLINFO=TRUE&PARENT=1&V0=3&V1=0&CTX=B&VN=3&VOK=Confirmar>

⁴Master Plan on Mental Health and Addictions. Government of Catalonia. Department of Health. Barcelona, 2007. Edited by the General Direction of Planning and Evaluation, Government of Catalonia. <http://www.gencat.net/salut/depsalut/pdf/salutmental2006n.pdf>

⁵Health in figures. Government of Catalonia. Department of Health. Edited by the General Direction of Planning and Evaluation, Government of Catalonia. Barcelona, 2008 http://www.gencat.net/salut/depsalut/html/ca/xifres/salutxifres_2008.pdf

⁶The following report has been developed with the intention of involving the largest possible number of relevant persons in the area, although we are conscious that in the face of the great diversity of agencies and organisations involved in Catalonia, we have not been able to include the perspective of all of them.

- Jorge L. Tizón García, Mental Health Prevention, EAPPP- Early Detection and Prevention of Psychosis team.
- Josefina Castro Fornieles, Head of the Department of Child and Adolescent Psychiatry and Psychology - Hospital Clinic of Barcelona. CIBERSAM. Associated Professor at the Faculty of Medicine, Department of Psychiatry and Clinical Psychobiology, University of Barcelona.
- Josefina Castro Fornieles, Head of the "Psychology and Psychiatrist Service for Children and Adolescent - Hospital Clinic" – Barcelona, Professor at the Faculty of Medicine, Barcelona University.
- Lina Abellanas and Esther Gonell, Mensalus Foundation, NGO.
- Lluís Lalucat, Les Corts Mental Health Centre.
- Lluís Mauri, Sant Pere Claver - Hospital Foundation, Training and Research coordinator.
- Luis Rajmil, Catalan Agency for Health Technology, Assessment and Research.
- Margarita Coll, School and Health Program, Department of Health, Government of Catalonia.
- M. Claustre Jané Ballabriga, Unit of Research of Psychopathology of the Childhood and the Adolescence, Autonomous University of Barcelona.
- Maria Estrada Ocón, Program coordinator of Drug Addiction Prevention, Department of Health - Program on Substance Abuse, Government of Catalonia.
- Marta Voltas Fornt and Cristina Carretero, Image and self-stem Foundation, NGO.
- Montse Pàmias Massana, Mental Health Services of Parc Taulí - Health Corporation, Sabadell, Children Psychiatry Chief.
- Montserrat Güell Roca, Department of Social Welfare, Directorate-General for Care for Children and Adolescents, Government of Catalonia.
- Rosa Sales Guàrdia, General Direction of Community Education, Department of Education, Government of Catalonia.
- Xènia Pascual i Sunyer, Catalan Agency of Youth, Department of Youth, Government of Catalonia.

2. What do we know about the mental health of children and adolescents in our country?

2.1. Prevalence of mental disorders in children and adolescents

The Catalonia Health Survey (ESCA) is one of the main sources of information about mental health in Catalonia. In the last survey, carried out in 2006, a specific questionnaire on the mental health of children aged 4 to 14 years was included for the first time. On the national level, the National Institute of Statistics in collaboration with the Spanish Ministry of Health also picks up information about mental health in all the Spanish regions. Both the national and regional surveys use the Strengths and Difficulties Questionnaire (SDQ). There are also some research studies investigación investigación carried out by non-governmental institutions and universities. Moreover there is some data about the disorders attended to in the specialised mental health services through the system "CMBD". All the data provided has been included in Table 1.

Table 1. Mental disorders in Catalonia

Disorder	Prevalence (%)	Age range	Reference period	Instrument and version used to measure	Year of most recent data collection	Reference
Anxiety disorders	6.54%	3-6	Year	ECI-4	2002	(a)
Depression (moderate to severe)	1%	3-6	Month	ESDM:3-6	2002-3	(a)
	6,99%	15-16	6 Months	BDI	2007-8	(e)
Bipolar Disorder	0,3%	6-8	6 Months	CBCL	2007	(a)
Attention Deficit / Hyperactivity Disorder (ADHD)	1,2-2%	3-6	6 Months	ECI-4	2002	(a)
	0,3%* 0,7%*	0-17 Men 12-17	Year	CMBD	2007	(b)
Learning Disorders	0,2%*	0 - 17	Year	CMBD	2007	(b)
Conduct Disorders	4,7%-5,2%	3-6	6 Months	ECI-4	2002	(a)
	0,2%* 0,4%	0-17 Men 12-17	Year	CMBD	2007	(b)
	2.66%** 1.3%** 3.72%** 2.98%**	0-15 0-4 5-9 10-15	Year	Symptoms of SDQ (Spanish data)	2006	(c)
Eating disorders	4,8%	3-6	6 Months	ECI-4	2002	(a)
Autism and pervasive developmental disorders	0,2%-2,5%	3-6	6 Months	ECI-4	2002	(a)
	0,1%*	0-17	Year	CMBD	2007	(b)
Schizophrenia	0,0%*	0-18	Year	CMBD	2007	(b)
Self-mutilation or self harm	N/R					
Childhood/adolescence suicide attempt	3,32% (intentionality)	6-12	6 Months	CDI	1999	(a)
Childhood/adolescence suicide	0,32 x 100.000 1,64 x 100.000	5-14 15-24	Year	Record of Mortality	2006	(f)
Reactions of adaptation	0,8%*	12 a 17	Year	CMBD	2007	(b)
Somatization	20%	3-6	Year	Ad Hoc Questionnaire (1999)	2002	(a)
Likelihood of any disorder	6,8%	4-14				
	4,3%	4-7	6 Months	SDQ	2006	(d)
	9,6%	8-11				
	6,4%	12-14				

* Prevalence in those attending a mental health care service

** Data refers to all of Spain

(a) Data provided by the "Research Group in Psychopathology in Infancy and Adolescence". Autonomous University of Barcelona. <http://psicologiaclinica.uab.cat/ca/node/445>

(b) CMBD: Record of population that picks up information about the pathology in the specialized sanitary centres of Catalonia. The scale of measure (% with 1 decimal) converts the values of the most severe pathologies to 0.

(c) Survey of the National Institute of Statistics (NIS) <http://www.ine.es/jaxi/menu.do?type=pcaxis&path=%2Ft15/p419&file=inebase&L=0>

(d) ESCA survey of the Department of Health of the Government of Catalonia, the Agency of Public Health, the IMIM and the Agency of Evaluation of Technology and of Medical Research.

(e) Evaluation of the knowledge, attitudes and prevalence of depression in the juvenile population of Sabadell. Study of the European project EAAD.

(f) Data provided by the Department of Health.

According to the ESCA survey, mental pathology is strongly associated with social class, with a likelihood of mental disorder of 1.8% for the higher social classes and of 11.1% for the lower social classes.

2.2. Vulnerable child population

Table 2. Vulnerable child populations in Catalonia

Vulnerable child populations	% of child population (or total number)	Age range	Year of reference	Instrument and version used	Reference
Children living in poverty	5,4 20,6 in risk of poverty	0-16 0-16	2006 2005	Level of admissions Net annual admissions	(a) (b)
Homeless children	Data not found				
Early school leavers	31**	18-24	2007	European survey "Labour Force"	(g)
Children experiencing intimidation or "bullying"	23,7%	8-18	One week	KIDSCREEN 52	(c)
Youth unemployment	(49.481)	0-25	January 2009	Registered Unemployment	(d)
Children in care	471,1 x 100.000 7448	0-18 0-18	2005 2009	Protections Protections	(h) (i)
Asylum seeker children	Data not found				
Traveller children	Data not found				
Juvenile offenders (cautioned or prosecuted)	2,2%	14-18	2003	Direct interventions of Juvenile Justice	(e)
	1,59%	14-17	2003	In programmes of Juvenile Justice	(f)
Children abandoned due to parental migration for employment	Data not found				

** Data refers to all of Spain

(a) CIIMU (2006). Report of the Social Inclusion in Spain, 2008. La Caixa Foundation, Social Action, Barcelona.

(b) Statistics of personal distribution of the rent and of risk to <A[to]in> poverty 2005. Enlargement of results of the Survey of living conditions. Government of Catalonia, Institute of Statistics of Catalonia. The data refers to Barcelona. <http://www.idescat.cat/cat/societat/qualitat/edrirp05.pdf?20080229>

(c) Ravens-Sieberer, O. (2008). Mental Health of Children and Adolescents in 12 European Countries-Results from the European KIDSCREEN Study. Clin. Psychol. Psychother. 15, 154-163.

(d) Demands of employment. Registered Unemployment. Technical cabinet. Services of Studies and Statistics. Government of Catalonia. Department of Work. http://www.gencat.cat/treball/doc/doc_40564638_1.pdf

(e) Master Plan of Juvenile Justice, 2004-2007 http://www20.gencat.cat/docs/Justicia/Documents/ARXIUS/doc_93922505_1.pdf

(f) Report from the Department of Juvenile Justice 2007. Government of Catalonia. Department of Justice.

http://www20.gencat.cat/docs/Justicia/Documents/ARXIUS/memoria_dj_07.pdf

(g) EUROSTAT <http://epp.eurostat.ec.europa.eu>

(h) The childhood in figures (2). (2007) Ministry of Work and of Social Matters. The Institute of Child and Urban World, N.5. http://www.ciimu.org/uploads/20080417/la_infancia_en_cifras_2_MTAS.pdf

(i) The protection of children in situations of high social risk in Catalonia (2009). Extraordinary report. Ombudsman of Catalonia.

and consequently increased unemployment among young people. The percentage of young people from 18 to 24 years that leave school early (those whose maximum level is the lowest level of secondary education) in Spain is 31 %, this is high in comparison with 15.2% in Europe overall. Attention services are available for the 2.2% of young criminals.

According to a recent report on poverty⁷, in 2006, 19% of the population of Catalonia was under the state threshold for moderate poverty. Persons at higher risk of suffering poverty are those under 16 years (5.4%). The risk of moderate poverty for children and adolescents is much higher in homes where only one works (34%) than in the homes where both parents work (8.6%). 52% of children who live in a single-parent household where the mother does not work is poor. Around half of children and adolescents of immigrant origin live in a situation of moderate poverty (52%), this is 2.5 times higher than those of Spanish origin. Among immigrant children and adolescents rates of high and severe poverty are very high (32% and 28%; respectively). In Barcelona the percentage of immigrant children and adolescents (from 0 to 19 years) increased from 6.5% in 2001 to 13.9% in 2005.

There has been a large increase in unemployment in Spain,

⁷http://www.ciimu.org/uploads/20080904/Barcelona_Programa_Municipal_para_la_infancia_2007_2010.pdf

2.3. Positive child and adolescent mental health

Table 3. Positive mental health in children and adolescents in Catalonia

Positive mental health in children and adolescents	Prevalence (%)	Age Range	Period of reference	Instrument	Year of data collection	Reference
Quality of Life	Measure of effect of: 0,64 for Psychological Welfare 0,7 for state of mind and emotions	8-18	last week	KID-SCREEN-52	2003	(a)
Resilience	10% brings resilience down	12-19	4 weeks	CHIP-AE	2000	(b)
Self perceived health: Better possible health	45%	12-19	4 weeks	CHIP-AE	2000	(b)

(a) Ravens-Sieberer, O. (2008). Mental Health of Children Teenage and in 12 European Countries-Results from the European KIDSCREEN Study. *Clin. Psychol. Psychother.* 15, 154-163.

(b) Alonso, J et al (2008). Validity of the Health Profile-Types-Types of the Spanish Child Health and Illness Profile-Adolescent-Adolescent Edition (XIP-AE). *Value in Health*,11(3): 440- 449.

According to data from the National Institute of Statistics, in 2006 the quality of life related with the health of children from 8 to 15 years in Catalonia and Spain scores 58.21 and 61.81 respectively (the European standard averagemitjana is of 50 with a standard deviation of 15).

3. Actions for promotion and prevention in mental health

3.1.1. Specific large-scale policies and programs for CAMH

Organisation of public health (national/regional level)

In Spain public health activities are largely distributed among the autonomous, regional and local administrations, reducing the role of the central administration (state level) to very concrete areas like international health. As already explained, the territorial distribution of health services is different according to each Autonomous Community. In Catalonia, in 1986 the reform of the public health system distinguished two levels of organisation: the central (regional) level and the local. At central level the highest level of responsibility falls on the Directorate General of Public Health of the Department of Health. At the local level, the services organise themselves around regions or health sectors. In addition, large and medium town councils often have their own specific public health bodies.

On 10th June 2008 a new organisation of the Directorate General of Public Health of Catalonia was approved. A portfolio of actions in health protection, promotion

and prevention were specified for the first time. The law includes the creation of the Catalan Public Health Agency in one or two years, which will join the planning, coordination and implementation of the public health activities at all levels.

Legislation in promotion and prevention

At present mental health promotion and mental disorder prevention are not regulated under any specific legislation, but are included in other more general laws:

- Law 14/1986 of the 25th April includes prevention of illness and health promotion among the purposes of the national health system.
- The Catalan Health Care Planning Act (La Ley de Ordenación Sanitaria de Cataluña) 15/1990, of 9 July (LOSC) orders the integration of psychiatric assistance into the system of coverage of the Catalan health service.

In relation to children and adolescents, Decree 213/1999, of 3 August of the Department of Health and Social Security, defines the 10 different services that form the network, and differentiates adults, children and adolescents.

The current Master Plan for Health in Catalonia, active until 2010, states that health promotion and the prevention of illness together with equity, efficiency, quality services and citizen satisfaction are the axes around which interventions and priority actions are developed.

Among the projects prioritised in the Master Plan for Mental Health and Addictions published in 2007 which establishes strategic direction until 2010, promotion and prevention programs, mental health in primary care, and care for the child and juvenile population⁸ are emphasised.

The new Law of Public Health⁹ in Catalonia awaiting Parliamentary approval (Title II. Article 5) includes the promotion of population mental health and the prevention of risk factors. The Catalan healthcare plan

⁸<http://www.gencat.cat/salut/depsalut/html/ca/dir2124/Dn2124/smemolina.pdf>

⁹<http://www.gencat.net/salut/depsalut/html/ca/dir2107/rfspac303.pdf>

proposes a model of community mental health, through the coordination of primary care services with specialised mental health services. The goal is to improve prevention and early detection.

Other legislation indirectly related

- The Organic Law 5/2000, of the 12th January, regulates the penal responsibility of the minors, and includes some article that affect the CAMH.
- Law 27/2001, of 31 December, of juvenile justice, for mental health assistance of minors in juvenile justice centres.
- The Secretariat of Childhood and Adolescence of the Department of Social Affairs and Citizenship¹⁰, is a key department involved in preventive programmes, and is carrying out a Master for Childhood and Adolescence and a new Law of Childhood.

Examples of programs and activities for areas of action

1.SCHOOL

- *"Health and School Programme". (Mental health promotion (in some centres) and secondary prevention)*

An interdepartmental program between the Department of Health and the Department of Education. The target population is pupils aged 14 to 18 years old. In June 2008 the coverage was 89% of Catalan pupils (106 534 young people).

The programme includes a reference primary health care nurse at the school, and an open consultation for students. If necessary they are referred to specialised mental health centres. Some additional preventive actions, such as prevention of drug use and eating disorders, are included in the programme.

- *"My friends, my garden" (Health promotion and primary prevention)*

Activities developed to prevent drug addictions, from the general perspective of preventing mental health problems in children from 6 to 8 years old.

- *"The Adventure of the Life" (Health promotion and primary prevention)*

An educational intervention for children attending primary school, based on a concept of health as a way of living autonomously, joyously and in solidarity. It started with a course in 1999-2000 and in 2007-2008 achieved a participation rate of 22123 children, 1316 parents and 1003 teachers and teaching assistant.

- *"Pack Escoles" 2007/2008"¹¹ (Health promotion and primary prevention)*

Workshops from the Secretariat of Youth, targeting issues such as self-esteem, body image, peer pressure, prevention of drug use and eating disorders.

- *"Health-Promoting Schools" (Health promotion)*

A program of the Department of Education in collaboration with the European Network of Health Promoting Schools.

The promotion of emotional health for 0 to 18 year old children is worked from four axes: emotional welfare, healthy habits, safety and risks, and affectivity and socialization.

2. FAMILY

- *"Growing with you"¹² (Mental health promotion and primary prevention)*

Workshops for parents with children 0 to 36 months old, where they can share the anxieties, fears, doubts and the gratification of parenthood, as well as improve their role in the educational process (especially the affective bond with the children).

- *"Learning with you" (Mental health promotion and primary prevention)*

Workshops for parents with children 3 to 16 years old to provide information and resources that give support to the educational process. Examples workshops include: "Connect with your children. Let's talk about drugs"; "Losses and changes in the family environment. Helping our sons and daughters overcome them"; and, "Family diversity: different models of family".

3.HEALTH CARE

- *Mental health protocol of the Healthy Child Monitoring Programme*

(Mental health promotion and primary and secondary prevention)

One of the goals of the Health Plan for Catalonia in 1996-1998 was the early detection of mental health problems and of situations of risk, as well as the incorporation of a section on mental health in the protocols of preventive medicine for paediatricians.

A recent addition is the incorporation of a section specific to health education within the protocol on mental health.

Through the protocol, it is intended that, the paediatric team is capable of detecting, at least the symptoms of the most serious psychopathological structures during childhood, and the early detection of mental health problems.

- *"Program of support to primary care" (Mental health promotion, and secondary and tertiary prevention)*

A program in many mental health centres, in which mental health specialists advise paediatricians, family doctors and nurses about early detection of mental disorders in children and the juvenile population.

- *"Program of care for the emerging psychotic disorder" (Secondary and tertiary prevention)*

This program is in the process of introduction and aims at promoting the detection and early treatment of psychotic disorders in children and adolescents at higher risk, as well as informing the general population, primary care staff and other professionals that are in contact with adolescents and youngsters.

4.COMMUNITY AND ON-LINE RESOURCES

¹⁰<http://www.gencat.cat/benestar/secretariainfancia/index.htm>

¹¹<http://www20.gencat.cat/portal/site/Joventut/menuitem.cdbc7cbd8182c114f538d610b0c0e1a0/?vgnnextoid=73c2f800f2eae010VgnVCM1000008d0c1e0aRCD&vgnnextchannel=73c2f800f2eae010VgnVCM1000008d0c1e0aRCD&vgnnextfmt=detail&contentid=b082a3bccd28d010VgnVCM1000008d0c1e0aRCD>

¹²<http://www.gencat.cat/benestar/families/SPFDC/suport/formacio/creixer/index.htm>

- *“Telephone for the childhood and the adolescence” (Secondary and tertiary prevention)*

The Directorate-General for Children and Adolescents provides a 24-hour-a-day free call service for issues (conflicts, violations of rights)trucades related to children and/or adolescents, made by them or by adults.

- *“Kolocat” (Mental health promotion and primary and secondary prevention)*

The Secretariat for Youth created two web pages (www.elpep.info and www.laclara.info) for young people 13 to 16 years old (more educational) and 6 years (more informative), respectively. The main goal is to function as a preventive intervention, providing professionals and social agents with a tool to offer information about drugs, sexuality and new technologies.

- *“Online information” (Mental health promotion and primary and secondary prevention)*

The Secretariat for Youth offers an information and prevention service through the web page www.jove.cat. It addresses subjects of sexuality, drug addictions, behavioural disorders, nutrition and relationships, with fast, direct answers.

- *“SOMNIA: Service of orientation and mediation in childhood and adolescence” (Primary and secondary prevention)*

Problems highlighted include: intergenerational conflicts (30.3%), parental separations (17.4%), mental health (10.7%) and family conflicts (9.7%).

5. MULTIPLE AREAS

- *“Program of care for the severe mental disorder” (Secondary and tertiary prevention)*

A program that provides multisectoral interventions and includes a protocol to improve early detection in primary care centres, child education centres, and residential centres for children and adolescents (CRAE - Centres residencials de d'acció educativa) and to guarantee linkages with the child and adolescent mental health centres (CSMIJ). It introduces the utilization of the Checklist for Autism in Tooddlers (CHAT) by paediatricians and teachers.

- *“Program of mental health support to juvenile justice outreach activities” (Secondary and tertiary prevention)*

The program offers attention at the ambulatory level to the mental health of adolescents and young people cared for within the juvenile justice system. This is interdisciplinary work developing joint strategies with the educational services within the juvenile justice system. Also it offers specialized mental health advice to those workers in juvenile justice in the areas of mediation, technical advice and outreach activities. The specific goals are the diagnosis, treatment management, and family support.

- *Program “I like myself as I am” for the prevention of eating disorders¹³ (Secondary and tertiary prevention)*

The Foundation Image and Self-Esteem in collaboration with the Association Against Anorexia and Bulimia

have developed a plan for prevention that focuses on strengthening those factors that clinical studies have demonstrated can make people more resistant to suffering an eating disorder, for example, self-esteem, social Skills, etc. Detection has become one of the principal functions along with referral to suitable services.

3.1.2. Other general policies related to CAMH

In the following section, some examples of policies which impact on the mental health of children and adolescents are introduced. This does not claim to be an exhaustive list as the authors acknowledge that some examples in other relevant areas such as housing or divorce and custodies, have not been included. Nor is it an exhaustive list of examples from the included areas.

Social Welfare

The regional Law on social services¹²/2007, of 11 October 14, outlines a new system of social services, which starts from the principle of universal access; and the Decree 151/2008, of 29 July, approves the Social Services Portfolio 2008-2009 (section 4.2.)

Other relevant legislation includes:

- Catalan National plan for Youth 2000-2010.
- Law concerning family support.¹⁵

Child protection

The future Law Regarding Childhood¹⁶ establishes, in title IV, the creation of a research centre on the maltreatment of children which could contribute to providing scientific evidence for action. Likewise, the law introduces planning and evaluation of plans for children and adolescents and/or plans for for supporting a families.

Decree 129/2006, of 9 May establishes the creation of an Observatory for the Rights of the Child ascribed to the Department of Welfare and Family through the Directorate General for Childhood and the Adolescence. It has as a mission to contribute to the promotion and respect to the rights of the children.

Education and school programmes

The regional decree 78/1990 of March, establishes the approval and application of a program of education for health in schools. The Decree 4915-29/06/07, Article 3, incorporates all aspects of healthy behaviour including social aspects.

At present the Law of Education which regulates the Catalan education system is being prepared. The Law is not concerned in detail with the contents of the educational curricula, but more with how to make it possible that education best responds to the diversity of the pupils, so that the school institution can adopt at all times concrete means of satisfying the current range of

¹³www.f-ima.org

¹⁴http://www.gencat.cat/benestar/pdf/llei_ss_resum.pdf

¹⁵<http://www.gencat.cat/diari/3926/03185006.htm>

¹⁶<http://www.gencat.cat/benestar/actualitat/lleinf/index.htm>

complex and changing social situations. Its development includes participation by citizens through a web page.¹⁷

Day care legislation/policy for preschool children¹⁸

During recent years there have been several initiatives for promoting the growth options in early childhood education and the regulation of its functioning. Law 5/2004, of 9 July establishes the creation of quality nursery schools.; the Organic law 2/2006, of 3 May, reinforces the educational component of this stage of education; and Decree 282/2006, of 4 July is charged with its regulation.

Policies related to the conciliation of work and family life

- Spanish law. 39/1999, of 5 of November, to promote work-life balance.
- Law concerning family support 8/2003 of 4 July.

Adoption, fostering

- Law 13/1997, of 19 of November, for the creation of the Catalan Institute for Adoption and Asylum.
- Decree 62/2001, of 20 of February, for the protection of adopted and unprotected minors.
- Law 37/91, of 30 December, concerning measures for minors' protection and for adoption.
- Decree 2/97, of 7 January, Regulations regarding the protection of adopted and vulnerable minors.
- Decree 337/95, of 28 December, concerning the accreditation and functions of Collaborative Institutes for family Integration.

Poverty and social exclusion

With the current economic crisis, an increase in child poverty can be expected. In accordance with the report from the Institute of Childhood and the Urban World (CIIMU)¹⁹, welfare policies have a very limited impact in reducing child poverty in Spain which could partly be explained by the fact that in our country only rates of child poverty higher than the nearby European environment (UE-15) are registered. Only 11% of homes with children aged 16 years receive family benefits and child assistance. Only 6% of these minors escape poverty thanks to the social welfare payments from public administrations.

Ombudsman forparapara children and adolescents

In 1997 the first Ombudsman for Children was designated and at present there are two web sites for consultations of children up to 12 years of age²⁰, and of adolescents of 12 to 18 years old²¹.

3.2. Availability of programs for CAMH promotion and mental disorder prevention

Note: The data in this table has been based on estimates made by the Department of Health, health professionals, and NGOs. It does not reflect objective data, but a general vision that can be used as a starting point of the current situation.

Table 4. Availability of mental health promotion and prevention of mental disorders programs in children and adolescents in Catalonia

	0%	1-25%	26-50%	51-75%	76-100%
Home-based for infants and children		x			
Parenting programmes (general population)		x			
Parenting programmes (population at risk)		x			
Promotion of mental health at the school (e.g. education of welfare skills)			x		
Preventive programs for specific populations at school (e.g. Anti - bullying)			x		
Drug and alcohol abuse prevention			x		
Promotion/prevention at hospitals/hospitals		x	x		
In churches, recreation centres, clubs		x			
Promotion/prevention via Internet		x			
Protective services				x	
Custodial settings				x	
Community settings				x	
Telephone counselling			x		

¹⁷<http://www.lleieducacio.cat/>

¹⁸Extraordinary report: The education of 0 to 3 years in Catalonia. Ombudsman of Catalonia: September 2007. https://www.sindic.cat/site/unit-Files/2165/53_Escolaritzacio0a3anys.pdf ¹⁹Institute of Childhood and Urban World (CIIMU). Consortium formed by the Town Council of Barcelona, the Regional Government of Barcelona, the University of Barcelona, the Autonomous University of Barcelona and the Open University of Catalonia. www.ciimu.org

²⁰<http://www.sindic.cat/infants/castella/infants.html>

²¹<http://www.sindic.cat/infants/castella/joves.html>

The available information about programs and interventions in promotion and prevention in mental health is scarce. There is no register of interventions or material or human resources and the data picked up during the preparation of this report indicates that prevention and promotion programs are scarce. Major programs are developed in schools and in the health area, especially in the primary care sector. Many of these programs are primarily focused on preventing eating disorders or drug addiction.

During the preparation of this report, the Directorate General of Public Health was working on the development of an online data base of programs and available resources in mental health prevention and promotion.

4. Organisation and resources for implementation

4.1. Institutions and organizations

Programs in mental health prevention are carried out mainly by those bodies that have the capacity to work in public health in collaboration with different entities (NGOs, other not-for-profit groups/organisations, etc). The main bodies responsible for the development of prevention programs with a broad population reach are departments of the Government of Catalonia (the Dept. of Health, Dep.t of Social Affairs and Citizenship, and the Dept. of Education), town councils, regional governments

orparapara the local boards. Some organisations can also develop prevention projects through grants from private institutions, such us financial institutions.

4.2. CAMH Services

Psychiatric and mental health assistance in Catalonia makes up a highly complex subsystem in the Catalan system of health. The resources and services for public mental health are organised on three basic levels: assistance in specialised primary care (mental health centres), hospitals (psychiatric emergencies, hospitalisation of acute and subacute cases, midmitjà and long term hospitalisation, partial hospitalisation, etc), and psychiatric community rehabilitation (day centres and employment centres).

The provision of different services in Catalonia is mostly arranged, in a way that comprises entities from religious organisations, professional associations, workers cooperatives and the not-for-profit foundations (this is one of the main differences between Catalonia and the other autonomous communities). At present there are 66 entities providing mental health services. These include large institutions capable of offering multiple services of different natures (hospitals, dispensaries, etc) through to associations that offer only a single service (like a day centre or mental health centre). Of these, the Catalan Institute of Health is the largest public provider of healthcare in Catalonia.

Psychiatric and psychological appointments

Table 5. Availability of services for CAMH in Catalonia

	0%	1-25%	26-50%	51-75%	76-100%
Child psychiatric appointments					x
Psychologist appointments					x
Social service appointments for children					x
Family therapy/counselling appointments					x
Infant-specific services					x
Adolescent-specific services					x
Group therapy			x		
School counselling			x		
Pharmacological treatment					x
Psychosocial rehabilitation for adolescents			x		
In-patient beds on child psychiatric ward					x
In-patient beds on general psychiatric ward					

There are 1.5 psychiatrists and 6 psychologists per 100000 of the general population of children under 18 years of age²². Among children and adolescents 0 to 14 years, parents declare that 2.5% (3.6% total; 1.3% of girls) and 6,4% (8% total; 4.7% of girls) have visited the psychiatrist and the psychologist during the last year,

respectively²³.

Appointments with social services / child protection
Of all children and adolescents who are under protection of the DGAIA²⁴ (approximately 7343), the majority are in foster care (49.1% with the natural family; 16.9% with the extended family), and the rest(34%) in centres or

²²<http://www.gencat.cat/salut/depsalut/html/ca/dir488/mapa07planif.pdf>

²³<http://www.gencat.cat/salut/depsalut/html/ca/dir488/mapa07planif.pdf>

²⁴The Directorate-General for Care for Children and Teenagers (DGAIA - Direcció General d'Atenció a la Infància i l'Adolescència).

assisted flats.

Examples of social assistance services and/or child protection:

- Services for children and adolescents at risk of social exclusion²⁵ (EAlA=45): Undertake diagnosis and appraisal of minors and families, plans for improvement for the minor and their family, and follow-up and advice to primary social services.
- Residential Shelter Centres²⁶: 305 posts (158 governmental ones, 147 collaborators). Residential services for minors at high social risk in urgent situations.
- Migrant reception centres and resources for socio-laboural integration offer foreign/migrant children and adolescents immediate attention on arrival in Catalonia.
- Open centres for children and adolescents²⁷: daytime services that carry out preventive activities outside the school schedule. They give support to children and to adolescents in situations of social risk.
- Residential centres for intensive education (CREI) and therapy. There is one for porpor mental health, and two for drug addictions.
- Family foster care of minors²⁸: A family or person is temporarily entrusted with the care, feeding and education of a child in need. There are three types of foster care depending on the needs of the children and of families.
- Postadoptive care services of the Catalan Institute of Foster Care and Adoption²⁹
- Collaborating institutions for family integration (ICIF): Entities whose purpose is the protection of minors.
- Unit for the Detection and Prevention of Child Maltreatment (UDEPMI)³⁰: An immediate attention phone service which connects children and adolescents directly to a child help line.

Family therapy

Clinical and welfare work in childhood and adolescence needs to include families and, in some cases, the treatment/therapy of the family or the guardian of the minor. For this reason in many CSMIJ family treatment and/or therapies are carried out.

Specific services for children and adolescents³¹

Child and adolescent mental health centres - CSMIJ (Child and adolescent mental health centres (CSMIJ)) take care of specialised ambulatory attention in mental health, and of substance abuse, for patients up to 18 years. The team is made up of psychiatrists, psychologists, social workers and nursing staff, among others. There are 44 CSMIJ (with a ratio of 3.71 per 100000 persons up to 18 years).

Some CSMIJ of Catalonia have a specific program:

Program of support and advice in residential education centres for children and adolescents (CRAE - Centres residencials de d'acció educativa) from 0 to 18 years of the DGAIA with the purpose of providing support to the educators in the centres, and for the clinical and welfare needs of the minors who require it.

Day hospitals

Health care team designated to provide clinical care without admission. They combine psychopharmacological treatments, psychotherapy and rehabilitation, within the framework of a relational and institutional intervention in an exclusively day hospitalisation regime. The goal is to achieve family, social and work rehabilitation. At present there are 256 posts in day hospitals by day for the infanto-juvenil population (with a ratio of 3.5 per 10 000 people under 18 years). Some of these hospitals offer care until 21 years to facilitate continuity.

Centres of Development and Early Attention (CDIAP).

At present there are 80 centres CDIAP that guarantee public care in all of Catalonia. These centres are designated for all the child population (0 to 5 years) that shows developmental disorders or that are in a situation of risk for them.

Group therapy

Although individual therapies, generally in combination with family sessions, are the most usual practice, in some centres there are also group therapies for specific disorders (i.e., eating disorders, adolescents with first psychotic episodes, etc) and for other developmental disorders or dysfunctions (e.g, parental therapy carried out parallel to that of children)

School Therapy/Advice

Is moderately available, since the legislation consider the figure of the psychologist in schools. In public schools there are teams of school counsellors (EAP), supported by the Department of Education, that give support to schools and refer students to the CSMIJ when mental disorders, situations of psychological risk or dysfunctions are detected.

Support units for special education

Give attention to pupils with development disorders and/or severe behavioural disorders, to promote their integration into mainstream schools and to minimise the risk of failure and exclusion.

Pharmacological treatment

Is widely available. The national health system covers part of the pharmaceutical expenses of the patient.

Psychological rehabilitation in centres for children

²⁷http://www10.gencat.net/sac/AppJava/servei_fitxa.jsp?codi=2318 ²⁸http://www10.gencat.net/sac/AppJava/servei_fitxa.jsp?codi=3097 ²⁹http://www10.gencat.net/sac/AppJava/servei_fitxa.jsp?codi=12486

³⁰http://www10.gencat.net/sac/AppJava/servei_fitxa.jsp?codi=9993

and adolescents

There are residential education centres for children and adolescents (CRAE - Centres residencials de d'acció educativa³²): 89 centres: 1676 posts (513 governmental, 1163 collaborators) the function of which is to offer the child an alternative resource where the family environment does not exist, has deteriorated or where there are severe difficulties in covering basic needs. They look after physical and psychological health, and design an individual educational project from the diagnosis or initial evaluation, and work in coordination with other services and professionals who intervene to provide attention and protection for minors.

Rehabilitation Programs for adolescents (16-18 years) in Community Rehabilitation Services

At present there are three programs on community integration, developing employment skills, and integration into the workforce.

Child psychiatric beds¹⁵

Subacute units (includes UCA): 20 beds, with a ration of 0.17 per 10000 people under 18 years.

Acute units (includes UCA and URPI): 89 beds, with a ration of 0.75 per 10000 people under 18 years.

4.3. Funding

As a general trend, according to data from the Department of Health, the allocation of resources for prevention of the mental disorders in children and adolescents has increased slightly during the last years. However, according to a report from the Ombudsman, the resources are still not sufficient. It is difficult to corroborate this trend with concrete data because in general they are not clearly identifiable either in the municipal budgets, or in the autonomous region level or in the NGO budgets.

However, an example of this trend in this area is the increase in assistance from the Secretariat of Childhood and Adolescence, through the Directorate General for Childhood and the Adolescence for the prevention of cases of boys/girls and adolescents at risk. From 2004 the promotion of preventive actions for risk in childhood and adolescence has been defined, and in the year 2007 8.4M€ were designated for subsidising social initiatives in prevention action (29% than the previous year³³).

4.4. Training of professional workforce

Training in child and adolescent mental health is not always part of the curriculum of university education, and if it is present it is often as an optional subject. Doctors in general, primary care doctors included, are offered an optional subject in child psychiatry. Psychiatrists have

a 4 month rotation in infanto-juvenile mental health services. In psychology exist various subjects in child psychopathology and developmental disorders, but as optional subjects in the second cycle. In nursing, pedagogy, occupational therapy, social education or social work, this training is not considered as a specific subject, however in nursing there is a portion on general mental health. Not only is this training scarce, but it is directed fundamentally at treatment, and training in prevention and health promotion is scarce. At postgraduate level at present there is a course recognised by the "Institute of Health Studies" (Institut d'Estudis de la Salut (IES))³⁴ of the Government of Catalonia in health promotion and prevention of risks in adolescence, where there is a section related to mental health (drugs, addictions, eating disorders, suicidal behaviour and self-harm, aggression and sexual violence). The IES is an autonomous organisation ascribed to the Department of Health of the Government of Catalonia, created in the year 1980, by the Decree of the Department of Health and Social Security, in order to develop competencies on the subject of programs of research, training, retraining and professional development of the professionals in the service of the health administration.

For the implementation of the programs, training the involved professionals is necessary. The IES is the main organisation involved in the dissemination of information for maintaining health professionals knowledge, and has collaborated, for example, in the training of professionals in the program "Health and School".

Other bodies such as universities, professional colleges and various not-for-profit organisations also organise courses and postgraduate courses or masters of interest for in child and adolescent mental health. For example, a masters in emotional education at the University of Barcelona.

It is notable that as yet there is no specialisation in Child Psychiatry in Catalonia nor in Spain, although in April of 2009 one communiqué of the Ministry of Health announced that it will be created, and that in the first places could be offered in the year 2011.

5. Monitoring and evaluation of the actions for the promotion and prevention in mental health

At present there are no rigorous studies about the state of the application of the current policies or of the programs, their efficiency and effectiveness. Some programs have developed a descriptive analysis of the use of the services, but there is an absence of the evaluation

³²<http://www.gencat.cat/benestar/dgaia/crae.htm>

³³<http://www.gencat.net/benestar/persones/infants/dgaia/programes/subvencions/index.htm>

In the year 2003 2.3M € were destined, in 2004 3.2M € (increase of 39%), in 2005 4.6M € (increase of 43.7%), and in 2006 6.5M € (increase of 41.3%).

³⁴<http://www.gencat.cat/salut/ies/Du11/html/ca/dir1288/doc3879.html>

of the effectiveness of the actions in promotion and prevention. The situation is still less developed with respect to economic evaluation of the interventions.

For example, the program "Health and School" made a descriptive evaluation of the needs, services and involved professionals. In the 2006-2007 course, of 31289 consultations, 15 % were in mental health, 85.7% of consultations came from pupils (77% were girls), and the rest were from teachers. Of all consultations, 2.5% were referred to a CSMIJ. From the 5 074 preventive activities carried out (135 in mental health), 95.4% of the consultations was aimed towards the pupils, 2.8% towards teachers and 11.8% to the parents. The interventions were carried out by the tutors (24.9%), the nurses (27.1%) and primary care centre staff (20.3%). 3.2% of all the consultations (of a total of 27 557 ones given during course 2007-2008) were referred to the CSMIJ.

Another example is the child and adolescent telephone line "Infancia Responde", which during year 2007 attended 5875 calls (3264 for boy/ace, 2611 for adults). 47% make reference to the conflicts in the family situation itself, 24% to maltreatment. In 2007 there were less calls related to immigration, and those related to bullying at school have increased slightly.

6. Research and dissemination

As for studies about psychiatric disorders in children and adolescents in Catalonia, one of the main studies made at the institutional level was developed within the framework of ESCA 2006. The Strengths and Difficulties Questionnaire (SDQ) was used in a representative sample of 2200 children from 4 to 14 years from Catalonia and a screening for eating disorders in adolescents was undertaken using the SCOFF³⁵ questionnaire. There are other studies developed mainly by centres of research, and by some CSMIJ in collaboration with the university (as for example "Qualitative study of the psychosocial factors implicated in the evolution of the TMG". 2000-02, Nou Barris Foundation CSMIJ and Autonomous University of Barcelona)

In the area of care evaluation and in health promotion and mental disorder prevention, there are almost no studies on the child and adolescent population. One exception has been within the framework of a European project. During 2007-2008 a study was carried out by the Mental Health Service - Area of Child Psychiatry of the Corporación Sanitaria Parque Taulí de Sabadell and funded by the European Alliance Against Depression (EAAD). An evaluation of the knowledge, attitudes and prevalence of depression was undertaken in the adolescent population of Sabadell with a sample of 1242 adolescents (15-16 years), later the acquired knowledge and attitudes about depression prior to and after the implementation of an informative and preventive programme were evaluated. This study was developed in collaboration with the resources of the

Health and School programme.

The Institute of Childhood and the Urban World (CIMU - Instituto de Infancia y Mundo Urbano³⁶) is a consortium made up of the Town Council of Barcelona, the Regional Government of Barcelona and three universities: the University of Barcelona, the Autonomous University of Barcelona and the Open University of Catalonia. It has as a goal the transfer from knowledge between the university world and the local world, making the improvement of professional practice and public policy directed at children and families the aim of research. In the last years the CIIMU has consolidated areas and projects of research and produces, among other things, a Biannual Report on the state of children and families in Catalonia.

The Catalan Observatory of Mental Health (OSAMCAT - Observatorio de salud mental de Cataluña) is an organ of research and training born from the initiative of the Corporación Sanitaria Parque Taulí and the Fundación Park Taulí, and fruit of the convergence of the trajectory of several Catalan institutions belonging to the world of research and social action. The observatory, proposes to become "a centre of mental health studies, primarily in the area of risk factors and, from the generated knowledge, to explore the possibilities for initiating primary prevention strategies in mental health". It is foreseen that with the creation of the OSAMCAT, Catalonia will have a specialised centre of research that will work in the identification of the main mental health problems of the population and factors of psychosocial risk, as well as proposing to the relevant administrations the lines to be social and health in the deployment of resources and devices.

At present, the Government of Catalonia (resolution of the Parliament of Catalonia 18 July of 2007) commissioned a study from the OSAMCAT to analyze the complexity of problems of child and adolescent behaviour, which will allow among other issues, those affected by attention deficit hyperactivity disorder (ADHD) to be studied. This research, which has a budget of 150000 euros, aims to identify the educational needs of those affected and establish the best strategies for intervening and improve their education.

7. Challenges, opportunities and advances in the field

7.1. Key recent advances

- Political awareness of the importance of mental health promotion.
- Development of guidelines for the detection of risk situations (e.g., eating disorders).
- Examples of intersectoral success: "Health and

³⁵<http://www.foruminternacional.ciimu.org>

- School” programme (Department of Health and Department of Education), mental health support to centres of the DGAIA (Department of Health and Department of Social Action and Welfare)
- The Master Plan on Mental Health and Addictions aims at integrating a public health perspective in mental health care and changing the model from one centred in services to one centred on the needs of the person.
 - Improvements attributable to the introduction of specific programmes: for example, with the programme of care for severe mental disorders the detection and care of child psychoses and autism have increased 290% and 252%, respectively.
 - Implementation of the new model of coordination of specialised mental health services with primary care, with the goal of improving prevention and early detection.
 - Improved evidence based practice in some centres.

7.3. Youth involvement

Children and adolescents are generally not included in the processes of planning and decision making about programs of policy in mental health and their application. However, there are some initiatives supported by the Secretariat of Childhood and Adolescence (Department of Social Affairs and Welfare) through which the voice of children and adolescents has been transmitted to politicians. For example, on the 23rd February 2007 a hundred young people under the protection of the Government of Catalonia claimed the right not to be discriminated against in the Hall of Sessions of the Parliament of Catalonia³⁷. One hundred and eighteen young people under the protection of the Government of Catalonia and twenty-one educators participated. Four of these young people, on behalf of all, spoke about the rights of the children.

There are also initiatives involving adolescents in the design of material, for example, in the drug addiction prevention programs of the Program on Substance Abuse of the Health Department of the Government of Catalonia.

7.2. Difficulties and proposals for further development

Difficulties:

- Treatment focus versus preventive approach: even though the legislation recognises the importance of prevention, health practice is focused mainly on the treatment of already established disorders.
- Training not directed at prevention: at present professional training is almost totally centred

on the disorder, which hampers professionals in their ability to carry out preventive tasks in the day to day.

- Lack of coordination at different levels (care, institutional). For example, in the welfare area, the same children can be receiving different approaches for the same problem from different professionals: at the mental health centre and in the school. At the institutional level, there are similar programs which overlap.

Proposals for the future:

- Integration between the fields of drug addiction and general psychiatry, as well as the inclusion of substance use problems in admissions to the URPIs, UCAs, and adolescent days hospitals.
- Implementation of university training of specialists in clinical child psychology, including mental health promotion and mental disorder prevention.
- Conducting a census of existing programs and recommend prevention programs or mental health promotion using available evidence: Establishing programs of action based on the available scientific evidence, and providing guidelines, instruments and materials for facilitating their implementation in the local context.
- Support monitoring and evaluation to gauge efficiency and effectiveness through providing suitable technical support and specialised training.
- Support the interdepartmental worktreball to improve efficiency and the efficiency of developed programs and interventions which are carried out with young people.
- As public primary care services are the first points of care for emerging disorders among children and adolescents, more resources should be allocated for research into prevention and prevalence of mental disorders.
- More research in child and adolescent mental health.

8. Summary and conclusions

During the last years, some good examples of programs and policies including mental health promotion and mental disorder prevention for children and adolescents have been born in Catalonia. Although they represent a starting point, the scope of these initiatives is still not sufficient, and much work in this field is still needed. Some of the challenges in Catalonia include a need for coordination amongst the diverse range of bodies and providers, a wider culture of prevention and promotion, stable and specific funding, and more needs oriented research.

³⁷<http://www.gencat.cat/benestar/dgaia/sessio.htm>

UNITED KINGDOM, ENGLAND

Prepared by Rachel Jenkins, Howard Meltzer and Brian Jacob

1. Introduction

1.1 Policy at a glance

Mental health has long been regarded as the impoverished health service in England, and mental health services for children and adolescents and mental health promotion and prevention especially so. However, the situation is changing: three key documents which set out the overall current national policy are *Every Child Matters*¹, the *Children Act 2004*², and parts of the *National Service Framework (NSF) for Children, Young People and Maternity Services*³, particularly Standard 9. In addition, relevant systematic government policies to address poverty and social exclusion are available⁴.

There are also general programmes for benefits and payments for disabled people, and policy for disabled children is set out in the *Children, Young People and Families Programme - Aiming High for Disabled Children: short breaks implementation guidance*⁵.

There are also a number of specific CAMH-related programmes being implemented including:

- Surestart, a national nursery programme for infants and toddlers⁶,
- parenting support provision led by the National Academy of Parenting Practitioners⁷,
- Connexions⁸,
- National Suicide Prevention Strategy for England⁹ which covers children and young people.

The *Youth Crime Action Plan*¹⁰ is a comprehensive, cross-government analysis of what the government is going to do to tackle youth crime. Policies to divert young people deemed to be at risk from becoming involved in crime are addressed in the *On Track: Children and Families At Risk* initiative and the *Respect Action Plan*¹¹ is an attempt to tackle the root causes of anti-social behaviour. The Government has also made *Tackling School Bullying* a key priority¹².

Steps to prevent disorders in children associated with parental mental health problems and parental alcohol and drug abuse are set out in the *National Service Framework for Children, Young People and Maternity Services*.

1.2 Process to prepare the country story

This paper synthesizes information on children's and adolescents' mental health in England, based on the completion of a detailed questionnaire devised for the purpose, and contributed to by a multi-sectoral and multidisciplinary group of stakeholders from policy, academic and service backgrounds. Where possible the information is provided for the national level. The information was gathered by a combination of individual face to face meetings and email communications with key people, and a workshop to convene as many key stakeholders as possible. The workshop was hosted by an

¹<http://www.dcsf.gov.uk/everychildmatters/about/aims/aims/>

²http://www.opsi.gov.uk/acts/acts1989/Ukpga_19890041_en_1.htm

³<http://www.dh.gov.uk/en/Healthcare/Children/index.htm>

⁴The policies are described on the following websites: <http://www.dfes.gov.uk/>; [http://www.cabinetoffice.gov.uk/social_exclusion_task_force/Reaching Out: An Action Plan on Social Inclusion](http://www.cabinetoffice.gov.uk/social_exclusion_task_force/Reaching_Out:_An_Action_Plan_on_Social_Inclusion;); http://www.socialinclusion.org.uk/publications/reaching_out_full.pdf) *Tackling Health Inequalities: A Programme for Action*; http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008268

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086395

⁵http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086395

⁶<http://www.dcsf.gov.uk/everychildmatters/publications/0/>

⁷<http://www.parentingacademy.org/>

⁸<http://www.connexions.gov.uk/>

⁹http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009474

¹⁰<http://www.homeoffice.gov.uk/documents/youth-crime-action-plan/>

¹¹<http://www.homeoffice.gov.uk/documents/respect-action-plan>

¹²<http://www.teachernet.gov.uk/wholeschool/behaviour/tacklingbullying/>

independent consultancy firm and was chaired by Rachel Jenkins. A project officer was appointed to compile the information and the data sources, and to search for missing information. There was an iterative process whereby the interim drafts were emailed to contributors to check and fill in missing sections. Dawn Rees coordinated inputs from the Department of Health.

The following people, among others, supported the preparation of the country profile:

- Rachel Jenkins, Director of WHO Collaborating Centre and Head of section on mental health policy, Institute of Psychiatry, Kings College London.
- Howard Meltzer, Professor of Mental Health and Disability, University of Leicester.
- Brian Jacobs, Institute of Psychiatry.
- Tami Kramer, Senior Clinical Research Fellow, Imperial College.
- Marjorie Smith, Co-director, Thomas Coram Research Unit.
- Morris Zwi, Department of Health.
- Dawn Rees, Care Service Improvement Partnership (CSIP).
- Eric Taylor, Professor of Child and Adolescent Psychiatry. Dept. of Child and Adolescent Psychiatry at the Institute of Psychiatry.
- Deborah Hart, Head of Communications and policy, The Royal College of Psychiatrists.

2. What we know about children and adolescents in England and their mental health

2.1 Prevalence of mental disorders in children and young people

England has fairly extensive data on the prevalence of mental disorders in children and young people from the British Psychiatric Morbidity Survey Programme, which comprises a series of national surveys, conducted since 1993. To date there have been two surveys of children and adolescents, conducted through schools, and based on interviews with children, parents and teachers. The first survey was carried out by the National Office of Statistics, and the second by the national survey agency NATCEN. The most recent data on prevalence of mental disorders in children and adolescents for Britain is given in Table 1 below. This information is available at national level (for Britain), and regional level, but the numbers are insufficient for smaller area estimates.

Table 1. Prevalence of various mental disorders in general population of children and adolescents

Disorder	Prevalence (%) to 1 decimal place (or not available code)	Age range	Reference period (week, month, year, lifetime)	Instrument and version used to measure	Year of most recent data collection
Anxiety disorders	3.3%	5-16	Current	SDQ, DAWBA	2004
Depression (moderate to severe diagnosis)	0.9%	5-16	Current	SDQ, DAWBA	2004
Bipolar disorder (Manic-depressive)	Data not reported				2004
Attention-Deficit/Hyperactivity Disorder (ADHD)	Hyperkinetic disorder 1.5%, wider ADHD 2.5%	5-16	Current	SDQ/DAWBA	2004
Learning disorders	4-8%			N/SPEC	2004
Conduct disorder (act out their feelings or impulses in destructive ways)	5.8%	5-16	Current	DAWBA	2004
Eating disorders	0.3%	5-16	Current	DAWBA	2004
Autism and pervasive developmental disorders	0.9%	5-16	Current	DAWBA	2004
Schizophrenia	Extremely low rates so no good prevalence data exists				2004
Self-mutilation or self harm	3% by parents' reports, 7% by young persons' reports	11-16		DAWBA	2004
Childhood/Adolescent Suicide	8 per 100,000 M and 3 per 100,000 F	15-19	Incidence	Death registration	2000-update for 2006
Alcohol-hazardous or harmful drinking	68 per 1000 F	15-19	Prevalence	AUDIT	1993
	113 per 1000 M 320 per 1000 F 423 per 1000 M	16-24			2007

2.2 Vulnerable child population

England also has some information available on its vulnerable child populations (See Table 2).

Table 2. Prevalence of illness in vulnerable child populations

Vulnerable child populations	% of child population (or total number)	Age-range	Reference period	Instrument and version used to measure	Description of the data given
Children living in poverty	27-31%	0-18	Not known	Not known	60% below mean household income; national data DWP
Homeless children	110,360 Living in temporary accommodation	Dependent Children, up to 16, or 18 if in full time education	Not known	Not known	Shelter
Early school leavers	11.7% persistent absentees = >63 half days of absence/year= approximately >20% absent)	11 Years 15-16	Not known	Not known	Pupil Absence In Secondary Schools In England, 2005/06 ¹³
Children experiencing bullying	A couple of times in the last four weeks - 17% About once a week - 4 % Two or three times a week - 3% Most days - 5%	Year 8,6,10 (12-15 yr olds)	Not known	Survey	ellus 3 Survey National Report ¹⁴
Youth unemployment	25.10%	16-17	March 2008	Not known	Labour Force Survey ¹⁵
Children in care (living in any residential places other than families)	0.5% of children in England of whom 18% are in residential places	0-18	Past year	DCSF statistical reports	
Asylum seeker children	2,965 from applications from unaccompanied under 18 2,560 decisions made (5% granted asylum;1% granted humanitarian protection;15% refused;69% granted discretionary leave)	0-18	2005	Home Office information	
Traveller children	Not known				
Juvenile offenders (cautioned or prosecuted)	1.600 in juvenile institutions 5.2% in young offenders institutions		1999	Prison population	ONS ¹⁶
Children abandoned due to parental migration for employment	Not known				
Disabled children	Mild disability - 19% boys, 17% girls; Severe disability - 11 per 10,000 boys, 5 per 10,000 girls	Under 20	2000		ONS ¹⁷
Child abuse	Not known				
Adolescents at transition from CAMHS to adolescent mental health service	Estimated annual average number of cases considered suitable for transfer to AMHS, per CAMHS team (mean 12.3) range 0–70, SD 14.5, n = 37) was greater than the annual			The TRACK study surveyed CAMHS teams greater London area	Singh et al. ¹⁸

¹³http://www.dcsf.gov.uk/rsgateway/DB/SFR/s000718/SFR11-2007_3.pdf

¹⁴<http://www.ofsted.gov.uk/ofsted-home/Publications-and-research/Browse-all-by/Documents-by-type/Statistics/TellUs3-National-Report>

¹⁵<http://www.statistics.gov.uk/StatBase/expodata/files/679190494.csv>

¹⁶<http://www.statistics.gov.uk/StatBase/expodata/files/679190494.csv>

¹⁷<http://www.statistics.gov.uk/cci/nugget.asp?id=795>

¹⁸Singh S, Paul M, Ford T, Kramer T, & Weaver T. Transitions of Care from Child and Adolescent Mental Health Services to Adult Mental Health Services (TRACK Study): A study of protocols in Greater London. BMC Health Services Research (2008) <http://www.biomedcentral.com/1472-6963/8/135>

2.3. Positive child and adolescent mental health

In relation to positive CAMH, England has the following information sources (see Table 3).

Table 3. Information about positive mental health in children and adolescents

Positive child and adolescent mental health	Prevalence (%) to 1 decimal place	Age range	Reference period	Instrument and version used to measure	Year of most recent data collection
Wellbeing/self-esteem	83.5 %	1, 13, 15	Percentage of young people rating their health as 'fair or poor', aged 11, 13 and 15		2001 ¹⁹
Quality of Life	Data cannot be used to produce a prevalence rate				2005/6 ²⁰
Resilience	Data cannot be used to produce a prevalence rate		Social aptitudes and children's strengths in 2004 children's psych morbidity survey		2004

3. Actions for promotion and prevention in mental health

From a historical perspective, the government mission to promote mental health and prevent mental disorders, and their associated mortality in people of all ages, was set out in the 1992 Health of the Nation Strategy (Department of Health, 1992) which was superseded in 1999 by Saving Lives: Our Healthier Nation²¹.

A variety of national public policy documents have been published which relate to mental health policies for children and adolescents. Two key documents which set out overall current national policy are Every Child Matters and parts of the National Service Framework (NSF) for Children, Young People and Maternity Services.

The legislative framework currently guiding CAMHS is provided by the Children Act 2004 and the Mental Health Act 2007:

The Children Act. In March 2005, the first Children's Commissioner for England was appointed under the Children Act 2004 to give children and young people a voice in government and in public life. The Commissioner will pay particular attention to gathering and putting forward the views of the most vulnerable children and young people in society, and will promote their involvement in the work of organisations whose decisions and actions affect them.²²

Mental Health Act 2007 – amends the Mental Health Act

1983. Changes to consent provisions, age appropriate environment for under 18s, introduction of supervised community treatment. Provisions being introduced from 2008 through to 2010. Age appropriate environment for under 18s provision not due to be available until April 2010 to allow the NHS time to develop sufficient facilities, etc.²³

3.1. Specific policies and large-scale programmes for CAMH

The most important mental health policies relating to children's and adolescents' mental health are described below:

Every Child Matters is a new approach to the well-being of children and young people from birth to age 19. The Government's aim is for every child, whatever their background or their circumstances, to have the support they need to be healthy, stay safe, enjoy and achieve, make a positive contribution, achieve economic well-being. This means that the organisations involved with providing services to children, from hospitals and schools to police and voluntary groups, will be teaming up in new ways, sharing information, and working together to protect children and young people from harm and help them to achieve what they want in life. Children and young people will have far more say about issues that affect them as individuals and collectively²⁴.

The National Service Framework for Children, Young

¹⁹UNICEF report <http://www.unicef.org/media/files/ChildPovertyReport.pdf>

²⁰http://www.ofsted.gov.uk/assets/Internet_Content/CSID/files/National_Summary.pdf

²¹<http://www.archive.official-documents.co.uk/document/cm43/4386/4386.htm>

²²A summary of the Children Act 2004 is set out at http://www.everychildmatters.gov.uk/_files/F4A24DB36FCD661650973F58754657AB.pdf

²³<http://www.statutelaw.gov.uk/content.aspx?activeTextDocId=1729080>. An outline guide to the Act can be found at: <http://www.mind.org.uk/Information/Legal/OGMHA.htm>

²⁴Further documentation can be found at <http://www.everychildmatters.gov.uk/publications/>.

People and Maternity Services has two standards directly relevant to the mental health of children:

Standard 9 – The Mental Health and Psychological Well-being of Children and Young People. All children and young people, from birth to eighteenth birthday, who have mental health problems and disorders to have access to timely, integrated, high quality, multi-disciplinary mental health services to ensure effective assessment, treatment and support, for them and their families.

Standard 1 – Promoting Health and Well-being, Identifying Needs and Intervening Early. Updated by Child Health Promotion Programme Guide (CHPP) – Standard 1 sets out an evidence-based early intervention and preventative public health programme that lies at the heart of all universal services for children and families. The CHPP update strengthens delivery in pregnancy and the first five years of life. Effective implementation should lead to strong parent-child attachments and positive parenting, resulting in better social and emotional wellbeing among children.

Child Health Promotion Programme Guide²⁵

Updated June 2008.

A progress report in November 2006 noted that there had been significant advances in a relatively short period of time and set out recommendations concerning the planning of medium term service improvements. The Family Nurse Partnership programme is an integral part of CHPP and is being tested in 30 sites in England. It is an evidence-based programme which has been developed over 30 years in the US with three randomised control trials demonstrating significant impacts on children's wellbeing at 15 years compared to control groups.

National Suicide Prevention Strategy²⁶ 2002. First introduced in 1992 (Health of the Nation) and carried forward in Our Healthier Nation (1999). Covers children and young people as well as adults. The hitherto increasing suicide rate in young men has declined since the strategy started. Liaison with the media to prevent both glamorisation of suicide and the reporting of the method has fallen by the wayside in recent years; otherwise implementation going well.

Family Intervention Projects²⁷ (FIPs), launched as a national network in January 2006, aim to reduce anti-social behaviour perpetrated by the most anti-social and challenging families, prevent cycles of homelessness

due to anti-social behaviour and achieve the five Every Child Matters outcomes for children and young people. At the end of 2008 there were over 50 FIPs nationally. Following successful outcomes of the FIPs, in July 2008 the Government made a commitment in the Youth Crime Action Plan²⁸ to extend FIPs to 20,000 families in England by 2010.

Multi-Systemic Therapy²⁹ is a family and community-based treatment programme for young people with complex clinical, social, and educational problems such as violent behaviour, drug abuse and school expulsion. In November 2007 the government announced that Multi-Systemic Therapy would be piloted in a further ten sites, in addition to the two sites already successfully running. SEAL (Social and Emotional Aspects of Learning)³⁰ is a voluntary programme designed to develop the social and emotional skills of all school pupils in the areas of self-awareness, managing feelings, empathy, motivation and social skills.

Families at Risk Review³¹ considered families with multiple and complex problems such as worklessness, poor mental health or substance misuse. The final report, Think Family: Improving the Life Chances of Families at Risk³² was published in January 2008. It sets out a vision for a local system that improves the life chances of families at risk and helps to break the cycle of disadvantage. Following publication of the report, work on families at risk is now being taken forward by the Department of Children, Schools and Families: the Family Pathfinder programme³³ was launched in May 2008 and will develop the 'Think Family' approach. 15 local areas will test innovative ways of supporting vulnerable families.

Think Research: Using Research Evidence to Inform Service Development for Vulnerable Groups³⁴. The Social Exclusion Task Force (SETF), in partnership with Barnardo's, Research in Practice (RIP) and the National Foundation for Educational Research (NFER) have developed a user friendly tool to assist commissioners and service providers to select and monitor evidence based services for vulnerable people.

3.2 Contribution to CAMHS policy and practice by non-governmental organisations

A number of non-governmental organisations (private enterprise, research institute, NGO, professional, etc.) have also made significant contributions to both policy and practice in the child and adolescent mental health field.

²⁵http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_083645

²⁶http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PolicyAndGuidance/DH_4009474

²⁷<http://www.respect.gov.uk/members/article.aspx?id=8678>

²⁸<http://www.homeoffice.gov.uk/documents/youth-crime-action-plan/youth-crime-action-plan-08?view=Binary>

²⁹ http://www.cabinetoffice.gov.uk/social_exclusion_task_force/multi_systemic.aspx

³⁰http://www.cabinetoffice.gov.uk/social_exclusion_task_force/multi_systemic.aspx http://www.teachernet.gov.uk/teachingandlearning/social-andpastoral/seal_learning/

³¹http://www.cabinetoffice.gov.uk/social_exclusion_task_force/families_at_risk.aspx

³²http://www.cabinetoffice.gov.uk/media/cabinetoffice/social_exclusion_task_force/assets/think_families/think_family_life_chances_report.pdf

³³http://www.cabinetoffice.gov.uk/social_exclusion_task_force/news/2008/080504_15_local_areas.aspx

³⁴http://www.cabinetoffice.gov.uk/social_exclusion_task_force/think_research.aspx

The Royal College of Psychiatrists:

- Focus³⁵ initiative promoting effective practice in children's and adolescents' mental health.
- Mental Health and Growing Up³⁶, factsheets for parents, teachers and young people.
- Quality Improvement Network for Multi-agency Child and Adolescent Mental Health Services³⁷ (QINMAC). This quality improvement programme brings together professionals from health services, social services, education and the voluntary sector, in order to improve the specialist provision of 'Tiers 2 and 3' Child and Adolescent Mental Health Services.
- Quality Network for Inpatient Child and Adolescent Mental Health Services³⁸ (QNIC). Developed in 2001, the network aims to demonstrate and improve the quality of inpatient child and adolescent psychiatric inpatient care through a system of review against the QNIC service standards.

The **Children's Commissioner for England**, established under the Children Act 2004 to be the independent voice of children and young people, published in 2007 Pushed into the Shadows³⁹ – young people's experience of adult mental health facilities.

The **University of Oxford Centre for Suicide Research** has published much on suicide and self-harm, including *By Their Own Young Hand: Deliberate Self-harm and Suicidal Ideas in Adolescents*⁴⁰.

The following English charities have produced many useful and relevant documents:

- Young Minds.
- The Mental Health Foundation.
- The Samaritans, a charity which focuses on prevention of suicide, have a schools initiative which includes the DEAL (Developing Emotional Awareness and Learning) programme which helps schools develop the skills that young people aged 14-16 need to cope with life's challenges and develop their emotional health and wellbeing. They are also developing a suicide and self-harm response service for secondary school communities to utilise in the aftermath of an attempted/completed suicide or self-harm.
- The Family and Parenting Institute has produced *Children at Risk 2002-2003: Government initiatives and commentaries on Government policies*.
- The National Children's Bureau has worked to bring about sustainable change to the ways

in which agencies work with families where a parent/carer has a severe and enduring mental illness or disorder – the CAPE project.

- The King's Fund in *Paying the Price* has examined the cost of mental health care in England to 2026 which includes a chapter on disorders affecting children and adolescents.
- The Joseph Rowntree Foundation has published, inter alia, *Ending Child Poverty in a Changing Economy, Resilience and Young People Leaving Care*, and *Mentoring for Vulnerable Young People*.
- Mind has produced several fact sheets concerning the mental health of children and young people including *About Self-harm: A Guide for Young People*.
- The National Society for the Prevention of Cruelty to Children (NSPCC) has produced policy briefings and responses to consultations.

3.3 Other wider policies which impact on CAMHS

Addressing poverty and social exclusion: There have been systematic government policies to address poverty and social exclusion:

Sure Start⁴¹ is a government programme which aims to achieve better outcomes for children, parents and communities by increasing the availability of childcare for all children, improving health and emotional development for young children, supporting parents as parents and in their aspirations towards employment. The first Sure Start local programmes were set up in 1999.

Social Exclusion Task Force⁴². The role of the Task Force is to coordinate the Government's drive against social exclusion, ensuring that the cross-departmental approach delivers for those most in need. The Task Force champions the needs of the most disadvantaged members of society within Government, ensuring that, as with the rest of the public service reform agenda, we put people first. Progress on the social exclusion agenda is described in:

- *Working to Prevent the Social Exclusion of Children and Young People*.
- *The Progress of the Social Exclusion Task Force*.
- *Reaching Out: An Action Plan on Social Inclusion*.

Addressing disability and ill-health: In addition

³⁵<http://www.rcpsych.ac.uk/researchandtrainingunit/focus.aspx>

³⁶<http://www.rcpsych.ac.uk/mentalhealthinformation/mentalhealthandgrowingup.aspx>

³⁷<http://www.rcpsych.ac.uk/researchandtrainingunit/centreforqualityimprovement/qinmaccamhs.aspx>

³⁸<http://www.rcpsych.ac.uk/researchandtrainingunit/centreforqualityimprovement/qnic.aspx#intro>

³⁹<http://www.11million.org.uk/resource/m8vtedhs9cbqx3aid5stkdrc.pdf>

⁴⁰<http://cebhm.warne.ox.ac.uk/csr/recentpubs.html>

⁴¹<http://www.surestart.gov.uk/>

⁴²http://www.cabinetoffice.gov.uk/social_exclusion_task_force.aspx

to overarching efforts to address poverty and social exclusion, there are specific programmes for benefits and payments for disabled people. Policy for disabled children is set out in Aiming High for Disabled Children⁴³ launched in 2007.

Healthy Lives, Brighter Futures: The Strategy for Children and Young People's Health⁴⁴ was launched in February 2009 and covers young people up to the age of 19 years. This joint Department of Health/Department for Children, Schools and Families strategy presents the Government's vision for children and young people's health and wellbeing. It sets out how progress will be built on through world-class outcomes; high quality services; excellent experience in using those services; and minimising health inequalities.

Parenting and parental mental health: The prevention of disorders in children associated with parental mental health problems and parental alcohol and drug abuse is set out in the National Service Framework (NSF) for Children, Young People and Maternity Services⁴⁵. In order to support parents, the National Academy of Parenting Practitioners⁴⁶ works to transform the quality and size of the parenting workforce across England, so that parents can access the help they need to raise their children well.

Education: Education is compulsory from age 5-16. By 2013 young people between 16 and 18 years will be required to be in some form of training. Nursery provision has been greatly expanded. Education policy, day care policy for pre-school children, family friendly workplace policies, adoption and fostering policies, and divorce and custody policies in relation to children are set out⁴⁷.

Child protection: Child protection is taken very seriously in England by government and by the professional and charitable agencies working with children, and recent policies can be found⁴⁸.

Legislation to reduce stigma and discrimination (racism, bullying, homophobia) is set out in the Disability Discrimination Acts of 1995 and 2005⁴⁹. Tackling bullying in schools is a key government priority and government policy is set out in Don't Suffer in Silence⁵⁰.

Crime: There seems to be a growing problem of knife and gun crime amongst young people in inner cities which requires vigorous action. In July 2008 the Government published the Youth Crime Action Plan⁵¹, a comprehensive, cross-government analysis of what further is needed to tackle youth crime. It sets out a 'triple track' approach of enforcement and punishment where behaviour is unacceptable, non-negotiable support and challenge where it is most needed, and better and earlier prevention.

The Respect Action Plan⁵², launched in 2006, to "rebuild the bonds of community" focuses on 6 strands of work: supporting families, a new approach to the most challenging families, improving behaviour and attendance in schools, activities for children & young people, strengthening communities and effective enforcement & community justice.

On Track53, a long-term initiative aimed at children at risk of becoming involved in crime, was introduced in December 1999 and there are now 22 On Track projects in England in high deprivation areas, each covering around 2,000 children. In each an enhanced range of evidence-based preventive services (including parent training, home school partnerships, structured pre-school education, home visiting and family therapy) is being developed for children aged between 4-12 and their families.

Housing: Planning permission is required for all buildings, whether domestic or industrial, and government and municipal efforts are made to regenerate towns, enhance leisure and transport facilities and to protect green space. The State does provide housing for low income and vulnerable groups, although the availability of state housing is much less than it used to be a few decades ago, following deliberate policies to encourage tenants to buy their properties. See Communities and Local Government - Housing reform, strategy and performance⁵⁴.

3.4 Availability of programs for CAMH promotion and the prevention of mental disorder

A Review of CAMHS⁵⁵ reported in November 2008 setting out a clear vision for how we can all take responsibility for promoting children's psychological well-being and mental health and how best to achieve a step change

⁴³<http://www.everychildmatters.gov.uk/socialcare/ahdc/>

⁴⁴http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_094400 ⁴⁵<http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ChildrenServices/ChildrenServicesInformation/fs/en>

⁴⁶<http://www.parentingacademy.org/>

⁴⁷<http://www.dfes.gov.uk/>

⁴⁸<http://www.direct.gov.uk/en/index.htm>; <http://www.savethechildren.org.uk/>; <http://publications.teachernet.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=DFES-04217-2006&>

⁴⁹http://www.direct.gov.uk/en/DisabledPeople/RightsAndObligations/DisabilityRights/DG_4001068

⁵⁰<http://publications.teachernet.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=DfES%200064%202000&>

⁵¹<http://www.homeoffice.gov.uk/documents/youth-crime-action-plan/>

⁵²<http://www.crimereduction.homeoffice.gov.uk/antisocialbehaviour/antisocialbehaviour54.htm>

⁵³<http://www.crimereduction.homeoffice.gov.uk/crpinit/crpinit.htm>

⁵⁴<http://www.communities.gov.uk/housing/strategiesandreviews/>

⁵⁵<http://www.dcsf.gov.uk/CAMHSreview/>

in the quality and consistency of services at all levels. Twenty recommendations were made of which the government accepted 2 for immediate implementation, 12 in principle and 6 for further consideration.

There has also been an extensive mapping of CAMHS⁵⁶ with the aim of creating an inventory of all specialist CAMHS Tier 2 to 4 provided in England and the investment in them. Its purpose is to:

- Support the development of the National Service Framework for Children, Young People and Maternity Services (Department of Health, 2004) and help provide, inter alia, a focus on dedicated child health and CAMHS.
- Support the commissioning of services by providing a description of service provision.
- Assist in the bid for resources for service development.
- Provide comparative data on the progress in achieving service frameworks and delivery plan targets, for the range of inspectorial and supervisory bodies.

There are targets set for CAMHS in the Public Service Agreements reached between HM Treasury and the Department of Health. Progress in realising these objectives, which relate to improving life outcomes of children with mental health problems through year-on-year improvements in access to crisis and children's and adolescents' mental health services, is set out in the most recent Departmental Report⁵⁷.

4. Organisation and resources for implementation

4.1. Institutions and organisations

The main institutions that implement programmes relating to children's and adolescent's mental health care and services, including mental health promotion and the prevention of mental disorder, are the Department of Health and the Department for Children, Schools and Families.

4.2. Services

The NHS Health Advisory Service's (HAS) report, *Together We Stand*, (Health Advisory Service, 1995) was the first national review of CAMHS. The review revealed wide variations across the country in relation to staffing and practices – a situation which, although improving, still persists today in the patchy availability of CAMHS services.

The present four-tier structure for children's and adolescents' mental health services and the introduction of **Primary Mental Health Workers** (PMHWs) to bridge

the service gap between primary care services and CAMHS resulted from the review's recommendations. The PMHW role, as envisaged by the review, is to i) provide support to Tier 1 workers to improve their ability to manage children and adolescents with mental health problems instead of relying on CAMHS as the main service provider; ii) to undertake more complex clinical cases at the Tier 2 level; and iii) to improve the pathways between Tier 1 services and CAMHS. More recently Standard 9⁵⁸ of the National Service Framework for Children, Young People and Maternity Services also recommended that the access to and location of mental health services for children and young people should be diversified in order to improve the availability of services and reduce stigma.

The number of PMHWs has increased steadily as shown by data from the CAMHS mapping exercise:

Year	2005/6	2006/7	2007/8
Whole Time Equivalent	505.770	547.320	6.865

Figures published in March 2008 indicate that 71% of the NHS Trusts supporting a CAMHS now have established PMHW posts⁵⁹.

4.3 Funding

A profile of child health, child and adolescent mental health and maternity services in England 2007⁶⁰ stated that in 2005/6 reported CAMHS expenditure was £461m, 10% of the total budget. The estimated expenditure on the other service areas indicated that children's hospital services accounted for £1,502m (33% of the total budget for child health, child and adolescent mental health and maternity services), maternity services for £1,372m (31% of the total budget, universal services £563m (13%) and targeted services £496m (11%). Expenditure on individual care or spot purchasing for children and young people with complex needs accounted for £110m, 2% of the total budget.

In recent years, the resource allocation to children's and adolescents' mental health services in general has significantly increased. Figures from the profile show that the spend on CAMHS in 2003/4 was £322m rising to £508m in 2006/7. It should be noted that this increase has been from a low base and much of the money has gone into specific multi-agency projects with relatively little going into supporting core CAMHS services. There has been an expectation that projects will then be taken into core funding later which has often not been possible, or other services have been lost as a result. By contrast some services have undoubtedly benefited. The growth money has now ceased and cuts seem to be the order of the day.

⁵⁶<http://www.childhealthmapping.org.uk/>

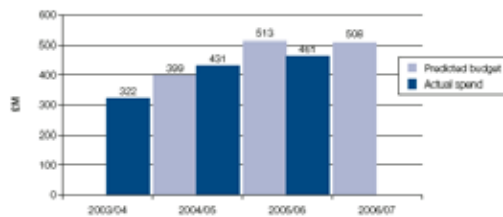
⁵⁷http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/DH_084908

⁵⁸http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4094607

⁵⁹<http://www.csip.org.uk/silo/files/primary-mental-health-worker-report.pdf>

⁶⁰http://www.childhealthmapping.org.uk/reports/CH_CAMHS_MS_Atlas_200607.pdf

Fig. 2.4: Trends in CAMHS commissioning budget 2003 to 2007



Evidence-based and community-oriented / family-focused services: There has been a large increase in resources but the effect of this investment has been variable. In some areas it has been targeted at community-based and voluntary services, and overall it has variably been made available to tier 3 CAMHS. This has been associated with an uneven improvement geographically in CAMHS services as surveyed by the Royal College of Psychiatrists in 2008.

Evidence-based mental health promotion activities: There has only been a small increase in resources here. There have been various age appropriate projects for evidence-based health promotion including information from websites and from leaflets produced by the Royal College of Psychiatrists and Young Minds, a voluntary organisation. Within education there have been anti-bullying programmes for some years. These are variably implemented. There is no country-wide consistent programme for mental health promotion focussed on children and adolescents and organised centrally.

Treatment and care in residential institutions. There has been a small decrease in resources, with increased private provision for adolescents, and decreased NHS provision for children.

Funds dedicated to children’s and adolescents’ mental health are not clearly identifiable in the most recent Department of Health report⁶¹. On the other hand, funds dedicated to children’s and adolescent’s mental health are clearly identifiable in the budgets of non-governmental institutions (foundations, private institutes, welfare societies, professional groups, associations, etc). The main donors of funds to non-governmental organizations are the Department of Health, local authorities and charitable donations.

4.4 Training of professional workforce

Children and Young People in Mind⁶², the final report of the national CAMHS review published in November 2008, highlighted the “need for better basic knowledge of child development and mental health and psychological well-being across the children’s workforce”. A key recommendation is that “the Government should ensure that all bodies responsible for initial training provide basic training in child development and mental health and psychological well-being. This should be in place within two years. The children’s workforce development

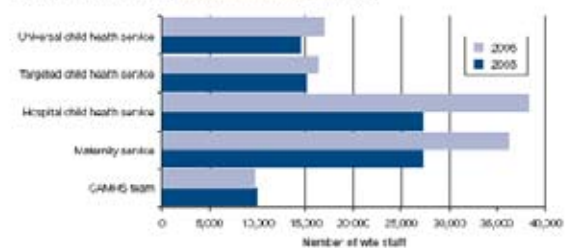
strategy should set out minimum standards in relation to key knowledge of mental health and psychological well-being, to cover both initial training and continuing professional development”.

The National CAMHS Support Service is sponsored by the Department of Health and the Department for Children, Schools and Families. Nested within it is the National CAMHS Workforce programme which delivers targeted support to local teams using tried and tested methodology. The National CAMHS Workforce programme together with the Health and Social Care Advisory Service have been promoting workforce planning for specialist CAMHS and have piloted the use of a workforce planning tool across the regions.

Training in CAMH issues is included in the curricula of relevant higher education qualifications to some extent, with a small and variable amount in medical undergraduate training, hardly any in the training of primary care doctors and public health professionals, a patchy amount in the training of paediatricians and psychologists, three months training for general psychiatrists, and relevant placements for psychiatric nurses. Training is now being introduced for staff in young offender institutions⁶³.

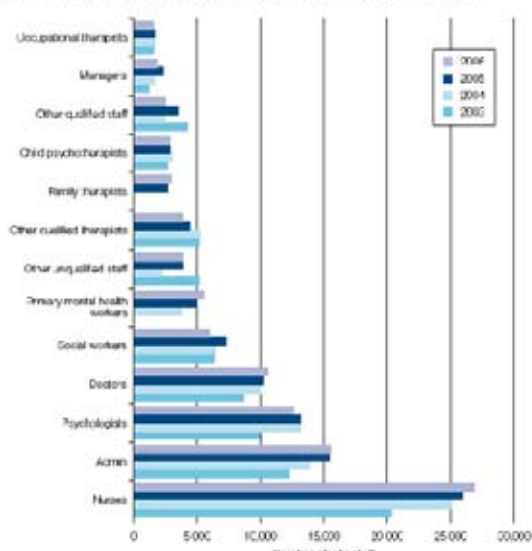
Specialist CAMH services exist in England, and are given in Figure 3.1.

Fig. 3.1: Trends in total workforce 2005 to 2006 (w/e)



CAMHS is the only area with a drop 2005 to 2006.

Fig. 3.3: Trends in CAMHS workforce by professional group 2003 to 2006



⁶¹http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/DH_084908 ⁶²<http://www.dcsf.gov.uk/CAMHSreview/downloads/CAMHSReview-Bookmark.pdf>

⁶³<http://www.yjb.gov.uk/en-gb/yjs/Custody/YoungOffenderInstitutions/>

5. Monitoring and evaluation of the actions for the promotion and prevention in children's and adolescents' mental health services

The National Service Framework requires that all services should routinely audit and evaluate their work and the results used to inform service development. The NSF and Every Child Matters both set out a framework for monitoring. The remit of primary care mental health workers also requires them to actively engage in mental health promotion and mental disorder prevention strategies (Audit Commission, 1999). CAMHS services are evaluated and supported through the National CAMHS Support Service. A scoping presentation, *Measuring Outcomes in CAMHS: Progress, Pitfalls and Persistence* (Law & Wolpert, 2006) sets out the issues involved. The Health of the Nation Outcome Scales for Children and Adolescents have been developed as a routine outcome measurement tool to provide a means of evaluating the success of attempts to improve the health and social functioning of mentally ill children and adolescents.

Examples of evaluations of mental health promotion are the SEAL programme (Social and Emotional Aspects of Learning) and Sure Start, the Government programme to deliver the best start for every child.

6. Research and dissemination

England has a significant research programme and knowledge base on children's and adolescents' mental health. Cross sectional and longitudinal surveys of large samples, including birth cohorts, provide information on prevalence and incidence and elucidate risk factors. The OPCS/ONS surveys of psychiatric morbidity aim to provide up-to-date information about the prevalence of psychiatric problems among people in Great Britain, as well as their associated social disabilities and use of services. There have been two surveys, in 1999 and repeated in 2004, of the mental health of children and young people in Great Britain.

There are a range of dedicated research programmes in the fields of developmental and service related research, and the need for and the provision of services in respect of childhood mental health e.g. the Institute of

Psychiatry, King's College London's research programme. The CAMHS mapping exercise provides key information on the distribution of CAMH services.

In the field of the prevention of mental disorder and its counterpart, the promotion of mental health, examples of work in progress include the Nuffield Foundation which is undertaking studies of resilience in children, the ALSPAC longitudinal study, and the research programme of Professor Stephen Scott at the Institute of Psychiatry, King's College London.

The main bodies involved in information dissemination to keep health care professionals informed include: Association of Child and Adolescent Mental Health⁶⁴

British Psychological Society⁶⁵
 Care Services Improvement Partnership⁶⁶
 Department for Children, Schools and Families⁶⁷
 Department of Health⁶⁸
 NICE⁶⁹
 Royal College of General Practitioners⁷⁰
 Royal College of Psychiatrists⁷¹
 SANE⁷²
 Social Care Institute of Excellence⁷³
 Social Exclusion Task Force⁷⁴
 UK Cochrane Centre⁷⁵

7. Challenges, opportunities and advances in the field

7.1 Key recent advances

The key recent advances in England relating to children's and adolescents' mental health care include:

- CAMHS mapping,
- intersectoral and interdisciplinary working,
- early intervention services, including early intervention in psychosis,
- starting to deal with regional variations in need and services,
- the development of NICE guidelines,
- the development of CAMH services extending to age 18 and for learning disabilities,
- DH commissioning of a national service improvement team for CAMHS, the National CAMHS Support Service, to support the delivery of a comprehensive service as set out in the

⁶⁴<http://www.acamh.org.uk/>

⁶⁵<http://www.bps.org.uk/>

⁶⁶<http://www.cypf.csip.org.uk/camhs>

⁶⁷<http://www.dfes.gov.uk/>

⁶⁸<http://www.dh.gov.uk/>

⁶⁹<http://www.nice.org.uk/>

⁷⁰<http://www.rcgp.org.uk/>

⁷¹<http://www.rcpsych.ac.uk/>

⁷²<http://www.sane.org.uk/>

⁷³<http://www.scie.org.uk/>

⁷⁴http://www.cabinetoffice.gov.uk/social_exclusion_task_force/

⁷⁵www.cochrane.co.uk

- children's National Service Framework,
- increased use and understanding of psychopharmacology,
- the development of more specialised services within CAMHS teams – e.g. for neuropsychiatry (autism, ADHD); intensive parenting; specific anxiety disorders.

The key recent advances in England relating to **children's and adolescents' mental health promotion or prevention of mental disorder include:**

- joint schools/CAMHS projects encouraging experiments,
- introduction of SEAL – Social and Emotional Aspects of Learning – into schools,
- realisation of the need to more actively promote mental health,
- Office of National Statistics datasets and surveys,
- targeting mental health in schools,
- online training in the understanding of basic principles of mental health for everyone working in universal and mainstream children's services,
- development and publication of core competencies for primary mental health workers working with children and young people,
- widespread development of parent training courses for high risk groups.

7.2 Youth Involvement

Children and adolescents are included to some extent, but not systematically so, in the process of policy decision-making and programme planning and implementation, which aims to affect their mental health and well being. This includes means by which children are consulted, through surveys or focus groups for opinion and information as well as their involvement as active agents in programme implementation (e.g. in peer-led initiatives).

The CAMHS Review “established a children and young people's reference group and web forum to ensure that their views and perspectives informed planning and decision-making throughout the process of the Review”.

The National Children's Bureau and Young Minds have children on their boards, and the National CAMHS Support Service has a user participation lead. A number of local authorities hold focus groups with children and adolescents. Leeds' CAMHS, in conjunction with the children's charity Barnardos, have a lone appointee who works “closely with CAMHS practitioners and managers to develop the participation and involvement of all users and carers within Leeds CAMHS and to give children, young people, parents and carers a clear voice and

active role within the services they receive. The service operates on the premise that it is the right of all children, young people, parents and carers to have a say and be informed about issues that affect their life”.

The Mental Health Act 1983 Code of Practice⁷⁶ requires that “the child or young person's views, wishes and feelings should always be considered”. The National Society for the Prevention of Cruelty to Children, NSPCC, consults children and young people. The most successful example of consulting children and young people about services is in the field of looked-after children. Otherwise consultation tends to be tokenism rather than serious consultation. More evaluative research on the best methods to achieve effective consultation is needed.

7.3. Difficulties and proposals for further development

In relation to tackling inequalities in service provision, the data routinely being collected on CAMH issues in England are used effectively to monitor services and to understand population needs. However, there is an additional important need to conduct more longitudinal studies especially of vulnerable cohorts e.g. looked-after children.

The most important sectors for the promotion of children's and adolescents' mental health in England are preschool provision, where there is very little at present; schools; the care workforce if up-skilled; and non-governmental organisations.

It can reasonably be said that there is an overload on policy but implementation is very patchy, there is a lack of policy integration across sectors and there needs to be a shift of focus from conduct disorder to anxiety and depression. Obstacles to working across sectors for children and adolescents include budgets, culture and training.

A good example of inter-sectoral working is Youth Offending Teams (YOTs). There is a YOT in every local authority in England and Wales made up of representatives from the police, probation service, social services, health, education, drugs and alcohol misuse and housing departments. These teams have managed to overcome many of the obstacles faced in inter-sectoral working, possibly by focussing on a unitary purpose-crime prevention in young people. (To what extent their work has reduced crime is a much wider debate).

Looked-after children is another area where good inter-sectoral work is developing. CAMHS mapping for 2006/07 shows that ‘The number of targeted and dedicated worker teams with a focus on looked-after children and social services continued to increase but the numbers

⁷⁶http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084597

were small – 59 targeted teams and 23 dedicated worker teams. The majority of the 9,454 looked-after children on the 2006 CAMHS caseload were supported by a range of services; 56% by generic teams, 31% by targeted teams⁷⁷, 8% by dedicated worker teams⁷⁸ and 6% by tier 4 teams’.

Children’s and adolescents’ mental health services would be improved with more:

- resources,
- basic and joint training-basic and CPD,
- up-skilling of service commissioners,
- better understanding of outcome measurement,
- more evaluation,
- more focus on implementation and less on new policies.

8. Summary and conclusions

There has been significant effort and investment in research, needs assessment, policy, human resource and service developments in CAMHS over the last 20 years, leading to much more detailed understanding and availability of services. However, most of the emphasis has been on assessment and management of difficulties, with much less attention to mental health promotion (Barry and Jenkins, 2007). There remains a lack of epidemiological information about specific issues such as the prevalence of well being, resilience and quality of life in children and the prevalence of child abuse in the community, numbers of traveler children, numbers of asylum seeker children and their mental health.

The recent Foresight project⁷⁹ on Mental Capital and Wellbeing draws attention to the need for a pan-government approach to mental capital and wellbeing, to incentivize government departments to work together to ensure intervention by one department that will address the priorities and interests of other departments, strengthened attention to developmental disorders including dyslexia and dyscalculia (by training teachers and front line child care professionals), and an improved strategy to reduce alcohol and substance abuse in young people to reduce social harm, violence and brain damage.

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⁷⁷Targeted teams provide for children with particular problems or requiring particular types of therapeutic intervention.

⁷⁸Dedicated worker teams: Dedicated workers are fully trained CAMHS professionals who are out-posted in teams that are not specialist CAMHS teams but have a wider function, such as a youth offending team or a generic social work children’s team.

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Annex 1: CAMHEE Work Package 4 Partners

Leaders of CAMHEE work package 4.

Department of Health of Catalonia (Spain) – WP leader

Institute of Psychiatry (United Kingdom, London) – WP co-leader

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Bulgarian Centre for Human Relations (Bulgaria)

Tartu University (Estonia)

Child Psychiatric Clinic, University of Turku, (Finland)

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Centre for Research and Prevention of Injuries (CEREPRI) University of Athens (Greece)

National and Kapodistrian University of Athens (Greece)

Institute of Behavioural Sciences, Semmelweis Medical University (Hungary)

Riga's City "Child of care" (Latvia)

State Mental Health Center (Lithuania)

Vilnius University (Lithuania)

Training Research and Development Centre (Lithuania)

SINTEF Health Research Center (Norway)

Maria Grzegorzewska Academy of Special Education (Poland)

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University of Primorska of Slovenia (Slovenia)

